Moderator: Jill Darling
December 10, 2019
3:45 pm ET

Coordinator: Good afternoon and thank you all for standing by. I'd like to inform all participants that your lines will be on a listen-only mode until the question-and-answer session of the call. I would also like you to know that this call is being recorded. If there are any objections, you may disconnect at this time. I will now turn the call over to Ms. Jill Darling. Thank you, you may begin.

Jill Darling: Great, thank you (Kristy). Good morning and good afternoon everyone and welcome to today's special open door forum Healthcare Price Transparency. I'm Jill Darling in the CMS Office of Communications. As always we always appreciate your patience. We did have a number of folks dialing in so we tried to get as many folks in as we could. So before we begin I have one brief announcement this special open door forum is open to everyone but if you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov. And I will now handle a call off to Terri Postma.

Terri Postma: Great, thanks Jill. Hi everyone and welcome. Today I'm going to be covering the CY 2020 Hospital Outpatient Prospective Payment System policy changes related to hospital price transparency requirements. This is a final rule that we published in November of this year. And it finalizes policies that follow directives in a recent Executive Order entitled Improving Price and Quality Transparency in American Healthcare to Put Patients First which creates the foundation for a patient driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for

hospital items and services. The policies in this final rule will further advance the agency's commitment to increasing price transparency. And it includes requirements that would apply to each hospital operating in the United States. You can find more information about this in our fact sheet and also in the Federal Register where the final rule is available for your viewing.

So as I mentioned in June this year the President signed an Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First noting that "it is the policy of the federal government to increase the availability of meaningful price and quality information for patients." The Executive Order 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. We believe that healthcare markets work more efficiently and provide consumers with high value healthcare if we promote policies that encourage choice and competition. In short as articulated by our Administrator Seema Verma we believe that "transparency in healthcare pricing is critical to enabling patients to become active consumers so that they can leave the drive towards value."

This final rule implements Section 2718(e) of the Public Health Service Act and it improves on prior agency guidance that required hospitals to make public their standard charges upon request starting in 2015 and subsequently online in a machine readable format starting in January 1 of 2019. Section 2718(e) requires each hospital operating within the United States to establish, and update and make public a yearly list of the hospital standard charges for items and services provided by the hospital including for diagnosis related groups. In the final rule we finalized the following: First, definitions of hospital, standard charges, and items and service; Second, requirements for making public a machine readable file online that includes all standard charges for all hospital items and services; Third, requirements for making

public discounted cash prices, payer specific negotiated charges and de-identified minimum and maximum negotiated charges for at least 300 shoppable services that are displayed and packaged in a consumer friendly manner; and Fourth, monitoring for hospital noncompliance and actions to address hospital noncompliance and the process for hospitals to appeal those penalties. CMS is finalizing that these policies would be effective January 1, 2021.

So first I want to go over the definition of hospital. In the final rule we finalized the definition of hospital to mean any institution in any state in which state or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law or is approved by the agency of such state or locality responsible for licensing hospitals as meeting the standards established for such licensing.

For purposes of this definition we finalized a policy that a state includes each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Island. So 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 by a state as a hospital or approved as meeting licensing requirements of the state. Federally owned or operated hospitals, for example, hospitals operated by the Indian Health Program, the US Department of Veterans Affairs or the US 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 their standard charges because their charges for hospital provided services are publicized to their patients, for example, through the Federal Register.

Next, I'd like to review the definition of standard charges. So what do we mean by standard charges? This final rule finalized several types of standard charges to include the following: Number one, the gross charge. This is the charge for an individual item or service that is reflected on a hospitals charge master absent any discounts. The second type of standard charge is the discounted cash price. This is the charge that applies to an individual who pays cash or a cash equivalent for a hospital item or service. The third type of standard charge is the payer specific negotiated charge. This is the charge that hospital has negotiated with a third party payer for an item or service it provides. The fourth type of standard charge is the de-identified minimum negotiated charge. That is the lowest charge that a hospital has negotiated across all third party payers for an item or service. And finally the fifth type of - the fifth type of standard charge is the de-identified maximum negotiated charge. That is the highest charge that a hospital has negotiated across all third party payers for an item or service it provides.

So what's a hospital item or service? In the final rule we finalized a definition of hospital items item or service 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. Some examples of items and services would be supplies, procedures, room and board use of a facility or other items -- sometimes these are called facility fees -- services of employed physicians or employed non-physician practitioners -- generally these are reflected as professional charges -- and any other items or services for which a hospital has established a standard charge.

There are two ways that CMS is requiring hospitals to make public their standard charge information. The first required way is via a machine readable format. This would be a single file with all standard charges for all items and

services that the hospitals provide. The second required way that hospitals must make public their standard charge information is through displaying at least 300 shoppable services in a consumer friendly manner. I'm going to go through both of these separately. But I do want to make clear that hospitals are required to make public their standard charge information in these two ways. This is a requirement. These are not options.

First, requirements for making public all standard charges for all items and services in a comprehensive machine readable format. For each hospital location, hospitals must make public their - all their standard charges. That means all five types -- the gross charges, the payer specific negotiated charges, the de-identified minimum and de-identified maximum negotiated charges, and the discounted cash prices -- for all items and services a hospital provides, online in a single digital file in a machine readable format. The machine readable format file must include a description of each item or service including both individual items and services as well as service packages and any code for example HCPCS codes used by the hospital for purposes of accounting or billing.

The file must be displayed prominently and clearly identify the hospital location with which the standard charge information is associated on a publicly available Web site using a CMS specified naming convention. Hospitals must ensure these data are easily accessible without barriers including ensuring the data is accessible free of charge, does not require a user to establish an account, or password, or submit personal identifying information and is digitally searchable. And finally for the machine readable file the hospitals must update these data at least annually and clearly indicate the date of the last update either within the file itself or otherwise clearly associated with the file. We believe this information and this format is most directly useful for employers, providers and tool developers who could use

these data in consumer friendly price transparency tools or who may integrate the data into electronic medical records and shared decision making tools at the point of care.

The second way that hospitals are required to make public their standard charge information is by displaying 300 shoppable services in a consumer friendly manner. Hospitals must make public standard charges for at least 300 shoppable services (and this includes 70 CMS specified and 230 hospital selected shoppable services) in a consumer friendly manner. In the final rule we defined shoppable service to mean a service that could be scheduled by a healthcare consumer in advance. We believe these requirements will allow healthcare consumers to make apples to apples comparisons of payer specific negotiated charges across health care settings.

Specifically, for this requirement hospitals must do the following: First, the hospital must display payer-specific negotiated charges, the de-identified minimum and de-identified maximum negotiated charges, and the discounted cash prices for at least 300 shoppable services including the 70 CMS specified shoppable services and the 230 hospital selected shoppable services. If by chance a hospital does not provide one or more of those 70 CMS specified shoppable services, then the hospital must select additional shoppable services such that the total number is at least 300. If a hospital doesn't provide 300 shoppable services, the hospital must list as many shoppable services as they provide.

The hospitals must also include a plain language description of each shoppable service, an indicator when one or more of the CMS specified shoppable services are not offered by the hospital, and the location at which each shoppable service is provided including whether the standard charges for the shoppable service apply at the location to the provision of that shoppable

service in the inpatient setting, the outpatient setting or both. Hospitals must select such services based on utilization or billing rates of the services.

So for those 230 hospitals selected services the hospital should select each service based on the utilization or billing rate of those services. In other words, the shoppable services selected for display by the hospital should be commonly provided to the hospital's patient population. Hospitals must include charges for services that the hospital customarily provides in conjunction with the primary shoppable service that's identified by a common billing code for example a HCPCS code.

Hospitals must also make sure that the charge information is displayed prominently on a publicly available Web page and clearly identifies the hospital location with which the standard charge information is associated. Hospitals must also ensure the data is easily accessible, without barriers, including ensuring the data is accessible free of charge, does not require a user to register, establish an account, or password, or submit personal identifiable information and is searchable by service description, billing code, and payer. Hospitals must update the shoppable service information at least annually and clearly indicate the date of the last update.

An exception to this is that CMS will deem a hospital as having met these requirements for making public standard charges for 300 shoppable services in a consumer-friendly manner if the hospital maintains an Internet-based price estimator tool that meets several requirements including that the tool provides estimates for as many of the 70 CMS specified shoppable services that are provided by a hospital and as many additional hospital selected services as is necessary for a combined total of at least 300 shoppable services. The price estimator tool must also allow healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be

obligated to pay for a shoppable service by the hospital. And the tool must be prominently displayed on the hospital's Web site and accessible to the public without charge and without having to register or establish a user account or password. Submitting personal identifying information is okay for the Internet-based estimator tool.

Now I'd like to talk a little bit about monitoring and enforcement of this rule. Under the final rule CMS has authority to enforce compliance with section 2718(e) of the Public Health Service Act by evaluating complaints made by individuals or entities to CMS, reviewing an individual's or entity's analysis of noncompliance, and auditing hospital's Web sites. Should we conclude that a hospital is noncompliant with one or more of those requirements to make public their standard charges, we may assess a monetary penalty after providing a warning notice to the hospital or after requesting a corrective action plan from the hospital if it's noncompliance constitutes a material violation of one or more of the requirements of the final rule.

If the hospital fails to respond to CMS's request to submit a corrective action plan or comply with requirements of a corrective action plan we may impose a civil monetary penalty on the hospital not in excess of $300 per day and publicize the penalty on a CMS Web site. The rule also establishes an appeals process for hospitals to request a hearing before an administrative law judge of the civil monetary penalty. Under this process the administrator of CMS at her discretion may review in whole or in part the administrative law judge's decision.

And once again and finally, in response to comments we have extended the effective date to January 1, 2021 to ensure hospital compliance with these regulations. Before I open to questions I just want to mention our email box is available. The email box is 'price transparency hospital charges' - all one

word - at cms.hhs.gov. That's pricetransparencyhospitalcharges@cms.hhs.gov. Thanks Jill.

Jill Darling: All right. All right, thanks Terri. (Kristy), we'll open the line for questions please.

Coordinator: Thank you. At this time if you would like to ask a question please press Star 1. Please state your name clearly when prompted. Again that is Star 1 to ask a question. One moment while we wait for questions to come in. Our first question comes from (Ina Bender). Your line is open.

(Ina Bender): Yes, good afternoon. Can you please clarify when you said the description and you mentioned something about CMS? Is there expectation that the description needs to follow CMS standard descriptions for codes or can we use our own descriptions? That's question number one. And question number two, what are the requirements for January 2020? Is the requirement to publish the chargemaster which we've had the requirements since last year still in the fact that 2020 with added criteria of what should be included in the chargemaster or that requirement goes in fact in 2021?

Terri Postma: Yes, thanks for the question. So in terms of the description their – hospitals - have relative flexibility in determining what description you want to put. So for the machine - the comprehensive machine readable file - it probably makes sense to use a shorter description. For example, the description that is found in your chargemaster or in your rate sheets with your payers. So that's for the comprehensive machine readable file.

For the consumer-friendly information though, it - the description - should be in plain language. And we haven't been any more prescriptive than that except to just ensure that the description that you use for the 300 shoppable services

and the consumer friendly - those consumer friendly information - it is in fact consumer-friendly. So, plain language. And there's a link in the final rule to some plain language guidance that you're not required to use but could help provide some additional information.

(Ina Bender): Okay. And then…

Terri Postma: For your second, yes so the second question - currently the guidance that is in place starting January 1, 2019 will continue until these new rules take effect on January 1, 2021.

(Ina Bender): So just to clarify the form that the Web was published in 2019 can continue to be followed for 2020 but in 2021 we might need to add additional information as required by the regulations?

Terri Postma: Yes, that's correct, with one caveat - that per the prior guidance you'll just have to update that information January 1, 2020.

(Ina Bender): Okay, thank you.

Coordinator: Thank you. Again if you would like to ask a question please press Star 1 on your touch-tone phone. At this time, I'm showing no questions.

Jill Darling: All right, well thank you. Next we have Matthew Lynch.

Matthew Lynch: Great, thank you everybody. The transparency and coverage propose rules that were posted for display on November 15, 2019 and published in the Federal Register on November 27, 2019 were developed by the Department of Health and Human Services, the Department of Labor and the Department of Treasury. These rules are currently open for a 60-day comment period that

runs through January 14, 2020. At the end of this I will give more detail on where to go to submit comments. I want to give a high level overview of what these proposed rules cover. These rules were meant to deliver on the President's Executive Order on Improving Price and Quality Transparency in the American Healthcare system to Put Patients First. This rule has three requirements that are in the proposed rule along with two requests for information.

The first is to disclose cost information to participants, beneficiaries and enrollees. The second is to disclose pricing information to the public. The third is to require that issuers can include shared savings in their MLR calculation. And the final two items are tied to requests for information one being whether API or Application Programming Interface technology should be used for the release of this type of information in the future, and how best to incorporate quality information along with price information.

Now going into more detail into each one of these proposals; for the first item where we discussed price disclosure to participants, beneficiaries and enrollees we propose to require group health plans and insurers offering health insurance coverage in the individual and group market to make available to participants, beneficiaries or enrollees, or their authorized representatives, personalized out of pocket cost information for all covered health care items and services through an Internet based self-service tool, and in paper form upon request. This information is intended to be used as if it were an advanced Explanation of Benefits or an EOB for all of those covered items and services.

The second that we propose to require is for plans and insurers to make available to the public is in-network negotiated rates and historical payments of out of network unique allowed amounts. The idea is to have issuers and plans publish two standardized and regularly updated machine readable files.

The first file would include information regarding rates negotiated for covered items and services furnished by in-network providers. The second file would include historical data showing allotted amounts paid for covered items and services furnished by out of network providers. The departments are proposing that these price transparency rules would become effective for plan years, or in the individual market policy years, beginning on or after one year after finalization of this rule. We request comment on these - on the timing necessary to develop these. This comment period is open through January 14.

Now the third proposed provision that's included in this rule is that we propose to allow issuers to take credit for shared savings payments in their medical loss ratio calculations. The intent here is that issuers would be encouraging consumers to shop for services for lower cost, high value providers. HHS proposes that the amendment to the MLR requirements would become effective beginning with the 2020 MLR reporting year for reports filed by July 31, 2021. The final two aspects of our proposed rule were tied into the request for information. There were two. We request comment and further information on whether plans and issuers should also be required to make available, through a standards-based Application Programming Interface or an API, the information that is being proposed to be disclosed through the information I just discussed. And the second is how healthcare quality information can be incorporated into the price transparency proposals included in the proposed rules.

Again, I'd like to make sure that folks know that the comment period is open for 60 days. The two options to submit a comment is either to go to the Federal Register and type in CMS-9915-P transparency and coverage or going directly to regulations.gov and again searching CMS-9915-P. The comment period is 60 days and open until January 14. Thank you and back to you Jill.

Jill Darling: All right, well thank you everyone. That is today's call. We appreciate your patience in dialing in as always. You'll get some time back in your day and happy holidays and happy New Year. Thanks everyone.

Coordinator: Thank you. That does conclude today's conference. You may disconnect at this time. Thank you and have a good day.

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