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HFMA Summary
Negotiated Rate Posting Requirement
CY 2020 OPPS Proposed Rule

Overview: As part of the CY2020 Outpatient Prospective Payment System (OPPS) proposed rule, the Centers for Medicare and Medicaid Services (CMS) expanded its prior interpretations of section 2718 of the Public Health Service Act. The proposed rule would require all hospitals to make a list of both gross charges and negotiated rates for all services in the hospital CDM as well as a set of shoppable services publicly available. The rule specifies the manner and format in which the lists are to be made publicly available. Hospitals that do not comply with the requirement may be subject to Civil Monetary Penalty (CMP) of up to $300 per day. Below is a summary of key provisions of the proposal.

Which hospitals are covered under the requirement? CMS proposes to define a hospital for purposes of this requirement as an institution in any State that is licensed as a hospital pursuant to governing law or is approved, by the agency of the State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. This covers all non-governmental hospitals (e.g. general acute hospitals including Critical Access Hospitals (CAHs) and Sole Community Hospitals (SCHs), psychiatric hospitals, rehabilitation hospitals and others previously identified in CMS guidance[1]).

The requirement does not apply to governmental hospitals (e.g. Veterans Affairs (VA), Department of Defense (DOD) or Indian Health Service (IHS) facilities). It also does not apply to entities such as ambulatory surgical centers (ASCs) or other non-hospital sites-of-care from which consumers may seek healthcare items and services.

What items and services are covered? “Items and services” covered by the proposal 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 the hospital has established a standard charge.

Example items and services include, but are not limited to:

- Supplies, procedures.
- Room and board.
- Use of the facility and other items (generally described as facility fees).
- Services of employed physicians and employed non-physician practitioners (generally reflected as professional charges) provided in a hospital setting.
- Any other items or services for which a hospital has established a charge.

[1] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/Downloads/Additional-Frequently-Asked-Questions-Regarding-Requirements-for-Hospitals-To-Make-Public-a-List-of-Their-Standard-Charges-via-the-Internet.pdf.

CMS also states that its definition of "items and services" should include not just all DRGs but also all other "service packages" provided by the hospital, including, for example, service packages the hospital provides in an outpatient setting for which a hospital may have established a standard charge. Therefore, the proposed definition of "items and services" includes both individual items and services and service packages.

How is CMS Redefining Standard Charges? The rule expands the definition of "standard charges" to two separate concepts – "Gross Charges" and "Payer-Specific Negotiated Charges."

A **Gross Charge** is the charge for an individual item or service that is reflected on a hospital's chargemaster (or outside the CDM in the case of pharmaceuticals), absent any discounts. The proposed rule clarifies the chargemaster does not include charges that the hospital may have negotiated for service packages, such as per diem rates, DRGs or other common payer service packages, and therefore this type of standard charge would not include standard charges for service packages.

The **payer-specific negotiated charge** is defined as all charges that the hospital has negotiated with third-party payers for an item or service. While this would not include health plans whose payment structures are not negotiated — for example "traditional" Medicare and Medicaid — it would include Medicare Advantage plans. Nothing in the proposed rule prohibits hospitals from including payment rates for Medicare and Medicaid services in their postings.

How will hospitals make their charge/price data public? Hospitals will make public their standard charges in two ways: (1) a comprehensive (one single, digital) machine-readable file that makes public all standard charge information for all hospital items and services, and (2) a consumer friendly display of common "shoppable" services derived from the machine-readable file. See below for additional details on the "consumer-friendly" file.

Examples of machine-readable formats include, but are not limited to, .XML, JSON and .CSV formats. PDF is not considered a machine-readable format.

How are shoppable services defined? Shoppable services are those that are routinely provided in non-urgent situations that do not require immediate action or attention to the patient, thus allowing patients to price shop and schedule a service at a time that is convenient for them. The rule states the charges for shoppable services should be displayed as a grouping of related services, meaning that the charge for the shoppable service (primary service) is displayed along with charges for ancillary items and services the hospital customarily provides as part of or in addition to the primary shoppable service. This will help consumers see the cost of the service in the same way they experience the service.

The rule clarifies that ancillary items and services 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. They may also include other special items and services for which charges are customarily made in addition to a routine service charge.

CMS requires hospitals to post at least 300 shoppable services. CMS anticipates that this number of services will increase over time. The proposed rule lists 70 common shoppable services (See Appendix I) that all hospitals must post charge and price data for by payer. For the remaining 230 (or more)

shoppable services, each hospital will provide a list based on the utilization or billing rate of the services in the past year.

If a hospital does not provide one or more of the 70 common shoppable services, the hospital is to indicate NA in the file for the payer in question (or all payers if applicable) and select an additional shoppable service to bring the total list to at least 300.

What data elements are required? Both the machine-readable and "consumer-friendly" lists of shoppable services have common data elements.

The **machine-readable** list must include the following as applicable, for each item or service:

- Description of each item or service (including both individual items and services and service packages).
- The corresponding gross charge for each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- The corresponding payer-specific negotiated charge (price) that applies to each item or service (including charges for both individual items and services as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Note, each list of payer-specific charges must be clearly associated with the name of the third-party payer.
- Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, DRG, National Drug Code (NDC) or other common payer identifier.
- Revenue code, as applicable.
- Item descriptions (e.g. HCPCS short text description) for each item or service.

The **consumer-friendly display** of payer-specific negotiated charge information must contain the following corresponding information:

- A plain-language description of each shoppable service. The proposed rule suggests hospitals review (but does not require them to use) the Federal plain language guidelines[2].
- The payer-specific negotiated charge that applies to each shoppable service. Each payer-specific charge must be clearly associated with the name of the third-party payer.
- A list of all the associated ancillary items and services that the hospital provides with the shoppable service, including the payer-specific negotiated charge for each ancillary item or service.
- The location at which each shoppable service is provided by the hospital (for example, Smithville Campus or XYZ Clinic), including whether the payer-specific negotiated charge for the shoppable service applies at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting or both.
- Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, but not limited to, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the DRG or other commonly used service billing code.

[2] https://plainlanguage.gov/guidelines/

Finally, CMS states that nothing in this proposed rule prevents or restricts hospitals from including additional data elements that help consumers understand the hospital's charges for shoppable services. As an example, CMS states a hospital could choose to display the cash price the hospital would accept as payment in full for the shoppable service from a consumer.

Where on a hospital's website should these files be posted? The proposed rule provides hospitals the discretion to choose the internet location it uses to post its file containing the list of "standard charges" (both machine-readable and separate list of shoppable services) so long as the file is displayed on a publicly-available webpage, it is displayed prominently and clearly identifies the hospital location with which the standard charges information is associated, the standard charge data are easily accessible (without barriers) and the data can be digitally searched. Appendix II provides additional details related to the concepts of "displayed prominently," "easily accessible" and "without barriers."

How frequently should the lists of standard charges be updated? Once every twelve months from the date of last update. Hospitals will need to indicate the date of their last update. This can either be in the file or on the webpage where the file is posted.

How will CMS police the charge/price posting requirement? The proposed rule states that CMS's monitoring methods may include, but are not limited to, the following:

- CMS evaluation of complaints made by individuals or entities to CMS.
- CMS review of analysis of noncompliance by individuals or entities.
- CMS audit of hospitals' websites.

What happens if a hospital does not comply? If a hospital is found to be non-compliant, CMS proposes that it may take the following steps.

- CMS may provide a written warning notice to the hospital of the specific violation(s).
- CMS requests a corrective action plan (CAP) from the hospital if its noncompliance constitutes a material violation of one or more requirements.
- If the hospital fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP, CMS may impose a CMP on the hospital of up to $300 per day for non-compliance. It may also publicize the penalty on a CMS website.

The rule clarifies that it may deviate from this sequence of compliance actions at its discretion.

Appendix I: Proposed Rule Table 37 - List of 70 CMS-Specified Shoppable Services

Evaluation & Management Services	2020 CPT/HCPCS Primary Code
Psychotherapy, 30 min	90832
Psychotherapy, 45 min	90834
Psychotherapy, 60 min	90837
Family psychotherapy, not including patient, 50 min	90846
Family psychotherapy, including patient, 50 min	90847
Group psychotherapy	90853
New patient office or other outpatient visit, typically 30 min	99203
New patient office of other outpatient visit, typically 45 min	99204
New patient office of other outpatient visit, typically 60 min	99205
Patient office consultation, typically 40 min	99243
Patient office consultation, typically 60 min	99244
Initial new patient preventive medicine evaluation (18-39 years)	99385
Initial new patient preventive medicine evaluation (40-64 years)	99386
Laboratory & Pathology Services	**2020 CPT/HCPCS Primary Code**
Basic metabolic panel	80048
Blood test, comprehensive group of blood chemicals	80053
Obstetric blood test panel	80055
Blood test, lipids (cholesterol and triglycerides)	80061
Kidney function panel test	80069
Liver function blood test panel	80076
Manual urinalysis test with examination using microscope	81000 or 81001
Automated urinalysis test	81002 or 81003
PSA (prostate specific antigen)	84153-84154
Blood test, thyroid stimulating hormone (TSH)	84443
Complete blood cell count, with differential white blood cells, automated	85025
Complete blood count, automated	85027
Blood test, clotting time	85610
Coagulation assessment blood test	85730
Radiology Services	**2020 CPT/HCPCS Primary Code**
CT scan, head or brain, without contrast	70450
MRI scan of brain before and after contrast	70553
X-Ray, lower back, minimum four views	72110
MRI scan of lower spinal canal	72148
CT scan, pelvis, with contrast	72193
MRI scan of leg joint	73721
CT scan of abdomen and pelvis with contrast	74177
Ultrasound of abdomen	76700
Abdominal ultrasound of pregnant uterus (greater or equal to 14 weeks 0 days) single or first fetus	76805
Ultrasound pelvis through vagina	76830
Mammography of one breast	77065
Mammography of both breasts	77066
Mammography, screening, bilateral	77067

Appendix I: Proposed Rule Table 37 - List of 70 CMS-Specified Shoppable Services (continued)

Medicine and Surgery Services	2020 CPT/HCPCS/DRG Primary Code
Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities	216
Spinal fusion except cervical without major comorbid conditions or complications (MCC)	460
Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (MCC).	470
Cervical spinal fusion without comorbid conditions (CC) or major comorbid conditions or complications (MCC).	473
Uterine and adnexa procedures for non-malignancy without comorbid conditions (CC) or major comorbid conditions or complications (MCC)	743
Removal of 1 or more breast growth, open procedure	19120
Shaving of shoulder bone using an endoscope	29826
Removal of one knee cartilage using an endoscope	29881
Removal of tonsils and adenoid glands patient younger than age 12	42820
Diagnostic examination of esophagus, stomach, and/or upper small bowel using an endoscope	43235
Biopsy of the esophagus, stomach, and/or upper small bowel using an endoscope	43239
Diagnostic examination of large bowel using an endoscope	45378
Biopsy of large bowel using an endoscope	45380
Removal of polyps or growths of large bowel using an endoscope	45385
Ultrasound examination of lower large bowel using an endoscope	45391
Removal of gallbladder using an endoscope	47562
Repair of groin hernia patient age 5 years or older	49505
Biopsy of prostate gland	55700
Surgical removal of prostate and surrounding lymph nodes using an endoscope	55866
Routine obstetric care for vaginal delivery, including pre-and post- delivery care	59400
Routine obstetric care for cesarean delivery, including pre-and post-delivery care	59510
Routine obstetric care for vaginal delivery after prior cesarean delivery including pre-and post-delivery care	59610
Injection of substance into spinal canal of lower back or sacrum using imaging guidance	62322-62323
Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance	64483
Removal of recurring cataract in lens capsule using laser	66821
Removal of cataract with insertion of lens	66984
Electrocardiogram, routine, with interpretation and report	93000
Insertion of catheter into left heart for diagnosis	93452
Sleep study	95810
Physical therapy, therapeutic exercise	97110

Appendix II: Definitions/Clarification of "Displayed Prominently," "Easily Accessible" And "Without Barriers."

1. **Displayed prominently** means the value and purpose of the webpage[3] and its content[4] is clearly communicated, there is no reliance on breadcrumbs[5] to help with navigation and the link to the standard charge file is visually distinguished on the webpage[6].
2. **Easily accessible** means standard charge data are presented in a single machine-readable file that is searchable and that the standard charges file posted on a website can be accessed with the fewest number of clicks[7].
3. **Without barriers** means the data can be accessed free of charge, users would not have to input information (such as their name, email address or other personally identifying information (PII) or register to access or use the standard charge data file.

CMS encourages hospitals to review 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.

[3] https://webstandards.hhs.gov/guidelines/49
[4] https://www.nngroup.com/articles/most-violated-homepage-guidelines/
[5] https://webstandards.hhs.gov/guidelines/78
[6] https://webstandards.hhs.gov/guidelines/88
[7] https://webstandards.hhs.gov/guidelines/181