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HFMA Summary
Negotiated Charge Posting Requirement
Final Rule

Overview. On November 15, 2019, CMS finalized its expanded interpretations of section 2718 of the Public Health Service Act. The final rule requires all hospitals to make a list of gross charges, negotiated charges, a self-pay "walk-in rate" and a minimum and maximum negotiated charge for all services in the hospital charge description master (CDM) publicly available in a machine-readable format. It also defines a list of 300 shoppable services that must be made publicly available in a searchable, consumer-friendly format. 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. The new rule is effective on January 1, 2021.[1]

Which hospitals are covered under the requirement? CMS defines 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 nongovernmental hospitals (e.g., general acute hospitals including critical access hospitals and sole community hospitals, psychiatric hospitals, rehabilitation hospitals and others previously identified in CMS guidance).[2]

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

How are hospitals with multiple locations or off-campus provider-based clinics treated? 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.

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. However, hospitals need not post separate files for each clinic operating under a consolidated state hospital license; it is sufficient for a hospital to post a single file of standard charges for a single campus location, if the file includes charges for all items and services offered at the single campus location.

[1] The final rule notes that existing CMS guidance requires that hospitals make public their gross charges for items and services as found in the chargemaster online in a machine-readable format. This guidance remains in effect until the effective date of the regulations established with this final rule.
[2] CMS. Additional frequently asked questions regarding requirements for hospitals to make public a list of their standard charges via the Internet.

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 nonphysician practitioners (generally reflected as professional charges) provided in a hospital setting
- Any other items or services for which a hospital has established a charge

Despite acknowledging the wide variation and complexity of physician employment models and contracting relationships, CMS declined to codify a definition of employment in the final rule.

CMS’s final policies require that the standard charges for each shoppable service (including ancillary services) be listed separately, not summed.[3] CMS provides an example of how hospitals could format and display their gross charges, which is included in Appendix 1. The rule states that hospitals will list physician services separately so patients/consumers can clearly identify when the cost of physician services is included in the “payer-specific negotiated charge.”

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 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 five separate concepts.

- A **gross charge** is the charge for an individual item or service that is reflected on a hospital’s CDM (or outside the CDM in the case of pharmaceuticals), absent any discounts. The rule clarifies the CDM 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

[3] For service packages, CMS does not intend each and every individual item or service within the service package to be separately listed. For example, if a hospital has a payer-specific negotiated charge (base charge) for a DRG code, the hospital would list that payer-specific negotiated charge and associated DRG code as a single line-item on its machine-readable file.

payment structures are not negotiated — for example “traditional” Medicare and Medicaid — it would include Medicare Advantage plans. Nothing in the rule prohibits hospitals from including payment rates for Medicare and Medicaid services in their postings.

- The **de-identified minimum negotiated charge** is defined as the lowest charge a hospital has negotiated with all third-party payers for an item or service (see Appendix 2).
- The **de-identified maximum negotiated charge** is defined as the highest charge that a hospital has negotiated with all third-party payers for an item or service (see Appendix 2).
- The **discounted cash price** is defined as the standard charge offered by the hospital to a group of individuals who are self-pay. The “discounted cash price” would reflect the discounted rate published by the hospital, unrelated to any charity care or bill forgiveness that a hospital may choose or be required to apply to a particular individual’s bill.

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.

The final rule clarifies that it is possible to make this information public in a single comprehensive machine-readable file by, for example, using multiple tabs in an XML format. One tab could show a list of individualized items and services and associated gross charges derived from the hospital’s CDM while another tab could display the individualized items and services and service packages for a specific payer’s plan based on the rate sheet derived from the hospital’s contract with the payer.

How are shoppable services defined? A shoppable service is defined as a service that can be scheduled by a healthcare consumer in advance. 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. Ancillary services mean an item or service a hospital customarily provides as part of, or in conjunction with, a shoppable primary 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 rule finalizes a list of 70 common shoppable services (see Appendix 3) for which all hospitals must post charge and price data 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.

The final rule recognizes that the codes numbers listed for DRG procedures are MS-DRG codes and not APR-DRGs or other third-party payer service package codes. This could also be the case for other CMS-specified services that are routinely negotiated by hospitals with third-party payers as packaged services. For example, the same or similar shoppable service may be paid as a service package by two different payers that use two different common billing codes (for example, an MS-DRG by Medicare versus an APR-DRG by another third-party payer). As such, CMS will permit hospitals to make appropriate substitutions and cross-walks, as necessary, to allow them to display their standard charges for the shoppable services across all their third-party payers.

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. In cases where a hospital does not provide 300 services that could be scheduled by consumers in advance, the hospital must list as many of the services it provides that could be scheduled by patients in advance (that is, the hospital must list as many shoppable services as it provides).

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.
- The corresponding *de-identified minimum negotiated charge* 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.
- The corresponding *de-identified maximum negotiated charge* 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.
- The corresponding *discounted cash 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.

- Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the CPT code, HCPCS code, DRG, National Drug Code or other common payer identifier.[4]

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

- 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
- The payer-specific negotiated charge that applies to each shoppable service (and to each ancillary service, as applicable). Each list of payer-specific negotiated charges must be clearly associated with the name of the third-party payer and plan.
- The discounted cash price that applies to each shoppable service (and corresponding ancillary services, as applicable). If the hospital does not offer a discounted cash price for one or more shoppable services (or corresponding ancillary services), the hospital must list its undiscounted gross charge.
- The de-identified minimum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).
- The de-identified maximum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).
- The location at which the shoppable service is provided, including whether the standard charges for the hospital's 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, as applicable, the CPT code, the HCPCS code, the DRG, or other common service billing code.

CMS finalizes a policy that provides hospitals flexibility on how best to display their standard charge data and associated data elements to the public in a consumer-friendly manner online, so long as the online information is easily accessible to the public. This approach permits some flexibility for hospitals to, for example, post one or more files online with a list of payer-specific charges for the shoppable services and associated data elements, or, for example, to integrate such data into existing price estimate tools. Appendix 4 provides a sample display of shoppable services.

Further, hospitals that offer Internet-based price estimator tools are deemed to have met the requirement to post charges in a consumer-friendly format. To qualify, the price estimator tool must:

- 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

[4] The final rule notes that gross charges for some supplies, such as gauze pads, found in the hospital CDM may not have a corresponding common billing code. Therefore, common billing codes as a required data element may be included as applicable.

- 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
- Be prominently displayed on the hospital's website and be accessible without charge and without having to register or establish a user account or password. A price estimator tool would be considered Internet-based if it is available on an Internet website or through a mobile application.

The final rule encourages, but does not require, the following from price estimator tools:

- Provide appropriate disclaimers in their price estimator tools, including acknowledging the limitation of the estimation
- Advise the user to consult, as applicable, with his or her health insurer to confirm individual payment responsibilities and remaining deductible balances
- Make estimates 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
- Provide notification of the availability of financial aid, payment plans and assistance in enrolling for Medicaid or a state program
- Indicate the quality of care in the healthcare setting

Hospitals that have a qualifying online price estimation tool would still be required to publish all standard charges in a machine-readable file, consistent with the requirements finalized in section II.E of the rule.

Finally, CMS states that nothing in this rule prevents or restricts hospitals from including additional data elements that help consumers understand the hospital's charges for shoppable services. To that end, the final rule emphasizes that hospitals are not precluded from providing customized one-on-one financial counseling to consumers.

Where on a hospital's website should these files be posted? The final 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 an appropriate publicly available webpage for purposes of making public the standard charge information for shoppable services in a consumer-friendly format, it is displayed prominently and clearly identifies the hospital location with which the standard charges information is associated, the standard charge data are available free of charge, easily accessible (without barriers) and the data can be digitally searched by service description, billing code and payer. Appendix 5 provides additional details related to the concepts of "displayed prominently," "easily accessible" and "without barriers."

CMS also finalized the following naming convention that must be used for the file: <ein>_<hospital-name>_standardcharges.[json|xml|csv] in which the EIN is the employer identification number of the hospital, followed by the hospital name, followed by "standardcharges" followed by the hospital's chosen file format.

How frequently should the lists of standard charges be updated? Lists should be updated once every 12 months from the date of last update. Hospitals will need to indicate the date of their last update. The date must either be clearly indicated either within the file or otherwise clearly associated with the file.

How will CMS police the charge/price posting requirement? The 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[5]
- 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 noncompliant, CMS 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.[6]
- If the hospital fails to respond to CMS's 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 noncompliance. 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.

[5] CMS has established an email address (PriceTransparencyHospitalCharges@cms.hhs.gov), through which individuals and entities may report to CMS concerns about hospital compliance with requirements to make public standard charges, including complaints about and analysis of noncompliance.

[6] A hospital's CAP must include, among other elements, a description of the corrective actions the hospital will take to address the deficiency or deficiencies identified by CMS.

Appendix 1. Example Displays of Gross Charges

TABLE 1—SAMPLE DISPLAY OF GROSS CHARGES[142]

Hospital XYZ Medical Center					
Prices Posted and Effective [month/day/year]					
Notes: [insert any clarifying notes]					
Description	**CPT/ HCPCS Code**	**NDC**	**OP/ Default Gross Charge**	**IP/ER Gross Charge**	**ERx Charge Quantity**
HB IV INFUS HYDRATION 31-60 MIN	96360		$1,000.13	$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		$251.13	$383.97	
HB IV INFUSION THERAPY 1ST HR	96365		$1,061.85	$1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				$2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				$2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				$2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				$2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			$3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			$1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			$6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	$251.13	$383.97	12 Each
PHENYLEPHRINE HCL 10 % OP DROP		17478020605	$926.40	$1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	$0.00	$0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		$185.00		
GENETIC COUNSEL 15 MINS	S0265		$94.00		
DIALYSIS TRAINING/COMPLETE	90989		$988.00		
ANESTH, PROCEDURE ON MOUTH	170		$87.00		

Appendix 2. Methodology for Calculating the Minimum and Maximum Negotiated Charge

To identify the minimum negotiated charge and the maximum negotiated charge, the hospital considers the distribution of all negotiated charges across all third-party payer plans and products for each hospital item or service. We note that this distribution would not include non-negotiated charges with third-party payers. The hospital must then select and display the lowest and highest de-identified negotiated charge for each item or service the hospital provides. CMS intends for the de-identified minimum negotiated charge and de-identified maximum negotiated charge to be severable, one from

the other, and from payer-specific negotiated charge, such that each of these three types of standard charges could stand alone as a type of standard charge.

Appendix 3. 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 or other outpatient visit, typically 45 min	99204
New patient office or 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

Appendix 3. List of 70 CMS-Specified Shoppable Services (continued)

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
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
Medicine and Surgery Services	**2020 CPT/HCPCS/DRG Primary Code**
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

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Appendix 4. Sample Display of Shoppable Services

TABLE 2—SAMPLE OF DISPLAY OF SHOPPABLE SERVICES

Hospital XYZ Medical Center			
Prices Posted and Effective [month/day/year]			
Notes: [insert any clarifying notes or disclaimers]			
Shoppable Service	**Primary Service and Ancillary Services**	**CPT/ HCPCS Code**	**[Standard Charge for Plan X]**
Colonoscopy	primary diagnostic procedure	45378	$750
	anesthesia (medication only)	[code(s)]	$122
	physician services	Not provided by hospital (may be billed separately)	
	pathology/interpretation of results	Not provided by hospital (may be billed separately)	
	facility fee	[code(s)]	$500
Office Visit	New patient outpatient visit, 30 min	99203	$54
Vaginal Delivery	primary procedure	59400	[$]
	hospital services	[code(s)]	[$]
	physician services	Not provided by hospital (may be billed separately)	
	general anesthesia	Not provided by hospital (may be billed separately)	
	pain control	Not provided by hospital (may be billed separately)	
	two day hospital stay	[code(s)]	[$]
	monitoring after delivery	[code(s)]	[$]

Appendix 5. Definitions/Clarification of "Displayed Prominently," "Easily Accessible" And "Without Barriers"

1. **Displayed prominently** means the value and purpose of the webpage[7] and its content[8] is clearly communicated, there is no reliance on breadcrumbs[9] to help with navigation and the link to the standard charge file is visually distinguished on the webpage.[10]
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.[11]

   CMS further clarifies that for hospitals that lack resources, flat files posted online may be the simplest and least expensive option to fulfill the searchable requirement. In such cases, it would be permissible under the final rules related to the consumer-friendly display of shoppable services for a hospital to post one file of shoppable services for each set of standard charges displayed. For example, the hospital could post one consumer-friendly file for each list of the payer-specific negotiated charges the hospital has established with each payer for its list of 300 shoppable services, a stand-alone consumer-friendly file of discounted cash prices for shoppable services, and a stand-alone consumer-friendly file of the de-identified minimum and maximum negotiated charges for each of the shoppable services. In this way, consumers could search for and review only the charges that are standard for their particular insurance plan for 300 shoppable services provided by the hospital in a consumer-friendly format. Self-pay individuals could search for and review a file focused on providing them with discounted cash price information for each of the shoppable services.

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) 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.

[7] https://webstandards.hhs.gov/guidelines/49
[8] Nielsen Norman Group. The Ten Most Violated Homepage Design Guidelines.
[9] https://webstandards.hhs.gov/guidelines/78
[10] https://webstandards.hhs.gov/guidelines/88
[11] https://webstandards.hhs.gov/guidelines/181