



SW Ohio HFMA 2025 Spring Conference

Compliant & Meaningful Price Transparency Data: Can Both Be Achieved?

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LATEST CMS TRANSPARENCY REQUIREMENTS



Hospital Price Transparency Timeline



FY19 IPPS Final Rule

- Initiated requirements for hospitals to comply with language in the Affordable Care Act
- Required hospitals to make available a list of their current standard charges via the Internet in a machine-readable format and to update this information at least annually



CY20 OPPS FINAL RULE ON TRANSPARENCY

- Introduced clarifications and definitions for language in the FY19 IPPS Final Rule
- A definition of “hospital” that requires nearly all hospitals to comply with the rule,
- Definitions for five types of “standard charges” – including, payer negotiated charges
- A definition of hospital “items and services” that includes employed professional fees
- Requirements for disclosing data in two formats: a machine-readable file (MRF) and a “consumer friendly” display
- Non-compliance monitoring, actions, civil monetary penalties, and appeal process



CY22 OPPS Final Rule

- Significantly increased the monetary penalties for non-compliance
- Language to prohibit the use of barriers to automatic download of the MRF on a hospital’s website

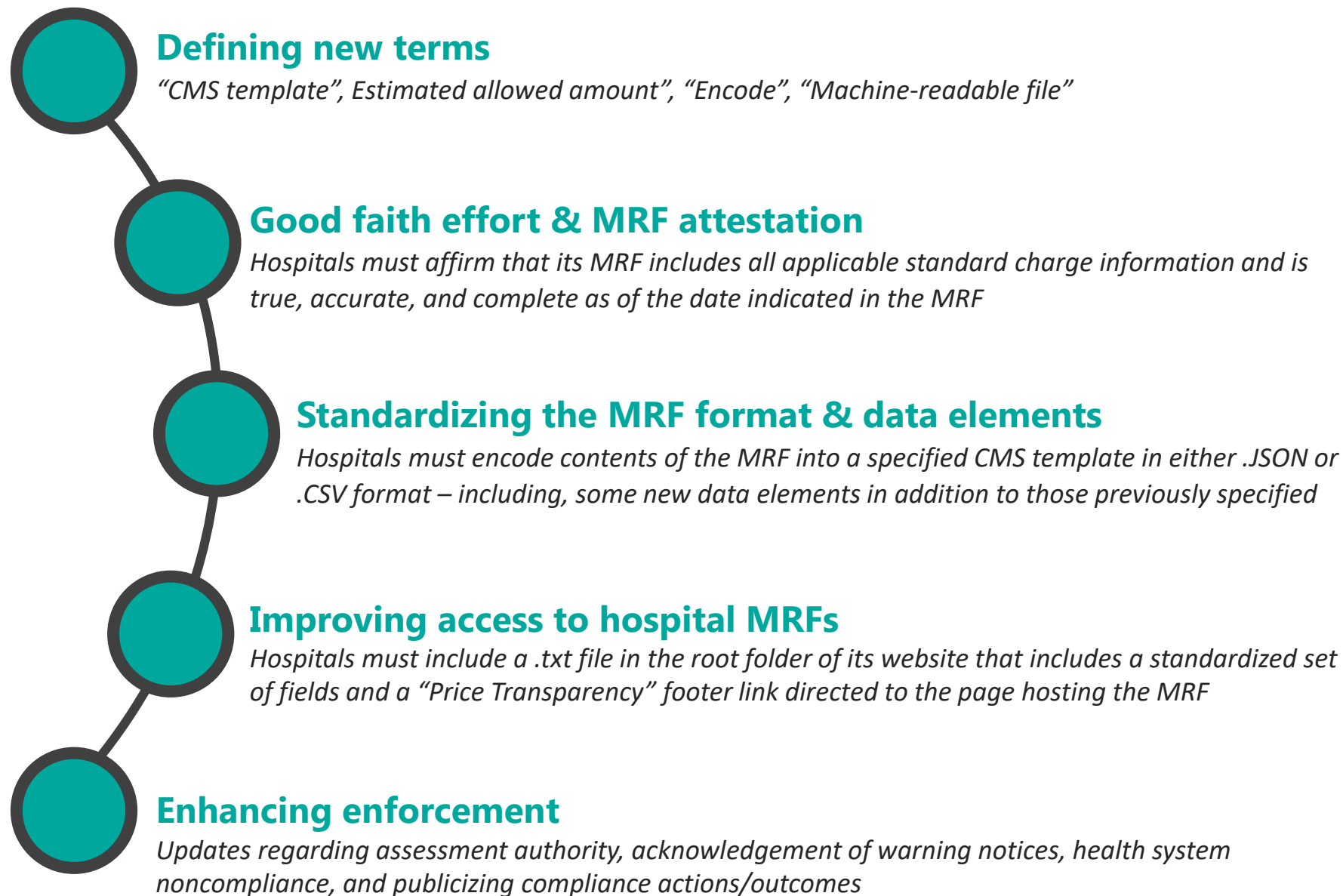


CY24 OPPS Final Rule

- New requirements for website footer and .txt file for easier access to the MRF
- Implemented a required file schema in either .JSON or .CSV for the MRF. Among the new fields included in the template are charge method, algorithm, estimated allowed amounts, modifiers, and drug unit and type of measurement



5 UPDATE CATEGORIES FOR CY24





CY24 CHECKLIST BY DATE



1/1/2024

- .TXT file in website footer
- Price Transparency web link
- Good faith effort
- Prep for added assessment activities



7/1/2024

- Utilize CMS MRF template in .JSON or .CSV
- Include all required data fields in template
- Include attestation in MRF



1/1/2025

- Estimated Allowed Amount, Modifier, Drug Unit of Measurement, and Drug Type of Measurement become required data elements in MRF



TWO REQUIRED TRANSPARENCY DISCLOSURES

1

MACHINE READABLE FILE

Single, comprehensive machine-readable file (MRF) with all standard charges for all items and services

2

CONSUMER FRIENDLY

Display of standard charges for 300 shoppable services in a consumer-friendly format (file or valid web-based patient estimation tool)



1) MAIN CMS HOSPITAL PRICE TRANSPARENCY WEBSITE

<https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency>

2) CMS TECHNICAL RESOURCES

<https://github.com/CMSgov/hospital-price-transparency>

3) CMS TOOLS

MRF Validation, MRF Naming Wizard, MRF .TXT File Generator

<https://cmsgov.github.io/hpt-tool/>



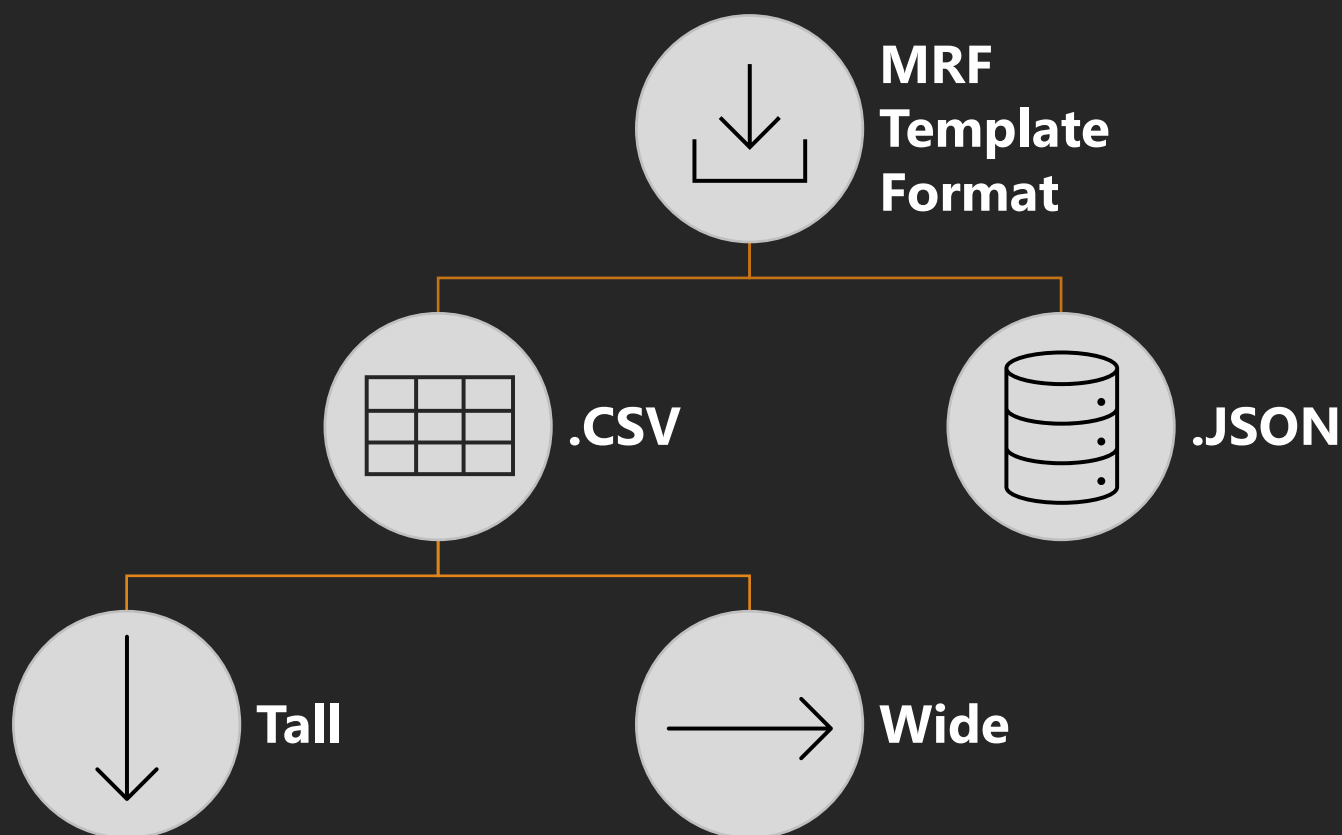
CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA

- 1 CHOOSE YOUR MRF TEMPLATE FORMAT TYPE
- 2 UNDERSTAND DATA ELEMENTS
- 3 IDENTIFY APPLICABLE DATA SOURCES
- 4 DERIVING VALUES FROM DATA SOURCES
- 5 FILE VALIDATION



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: CHOOSE YOUR MRF TEMPLATE FORMAT TYPE

Beginning July 1, 2024, CMS requires hospitals to encode contents of the MRF into a specified template. The template is in either a .JSON or .CSV format. In addition, there are new required data elements in addition to those previously specified (e.g., five types of standard charges). Some new data elements have a delayed implementation date of January 1, 2025.



MRF FORMATS

CMS will now restrict the display of the MRF to three digital formats:

- 1) JSON schema
- 2) CSV “tall” – with static headers and all payer data contained in additional rows
- 3) CSV “wide” – with variable column headers unique for each negotiated payer

Previously, other digital formats were permitted, but the new CMS templates are now only available and permitted in the above formats.



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA

- 1 CHOOSE YOUR MRF TEMPLATE FORMAT TYPE
- 2 UNDERSTAND DATA ELEMENTS**
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CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

REQUIRED DATA ELEMENTS

CMS VERSION 2.0 TEMPLATE DATA ELEMENTS (AS OF 11/04/2024)

*All data elements in the MRF are required beginning July 1, 2024, except those indicated with * which begin January 1, 2025*

MRF

- MRF date
- CMS template version
- Affirmation statement

Hospital

- Name(s)
- Location(s)
- Address(es)
- Licensure information

Standard Charges

- Gross charge
- Discounted cash price
- Payer name, Plan name
- Standard charge method
- Payer-specific negotiated charge – Dollar amount, Percentage, & Algorithm
- Estimated allowed amount*
- De-identified min & max negotiated charge
- Addl generic and payer specific notes

Items & Services

- Description
- Setting
- Drug unit and type of measurement*

Coding/Billing

- Billing/Accounting Code
- Code type
- Modifier*



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

Standard Charges

- Gross charge
- Discounted cash price
- Payer name, Plan name
- Standard charge method
- Payer-specific negotiated charge – Dollar amount, Percentage, & Algorithm
- Estimated allowed amount*
- De-identified min & max negotiated charge
- Addl generic and payer specific notes

ADDITIONAL INFORMATION ON DATA ELEMENTS

STANDARD CHARGE METHOD

Describes the type of contracting method used to establish the payer-specific negotiated standard charge. Valid values are Case Rate, Fee Schedule, Percent of Billed Charges, Per Diem, and Other. Please note that “Other” will likely be best when the payer specific negotiated charge is represented as an algorithm (more information to follow).



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

Standard Charges

- Gross charge
- Discounted cash price
- Payer name, Plan name
- Standard charge method
- **Payer-specific negotiated charge – Dollar amount, Percentage, & Algorithm**
- Estimated allowed amount*
- De-identified min & max negotiated charge
- Addl generic and payer specific notes

ADDITIONAL INFORMATION ON DATA ELEMENTS

PAYER-SPECIFIC NEGOTIATED CHARGE (DOLLAR, PERCENTAGE, ALGORITHM)

CMS recognizes that payer specific negotiated charges are not always able to be expressed as a dollar value and may not be the same for all patients depending on service utilization. Given this, CMS is requiring that hospitals indicate through new data elements whether the payer specific negotiated charge *“should be interpreted by the user as a dollar amount, or if the standard charge is based on a percentage or algorithm. Additionally, if the standard charge is based on a percentage or algorithm, the MRF must also describe the percentage or algorithm that determines the dollar amount for the item or service.”*

CMS does agree that detailing the algorithm in the MRF would be *“unwieldy and burdensome”* so it will allow hospitals to describe and not specify the algorithm. *“Descriptions for algorithms could include, for example, a link to the algorithm used, a descriptor of a commonly understood algorithm, or a list of factors that would be used to determining the individualized or variable allowed amount in dollars.”*



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

Standard Charges

- Gross charge
- Discounted cash price
- Payer name, Plan name
- Standard charge method
- Payer-specific negotiated charge – Dollar amount, Percentage, & Algorithm
- **Estimated allowed amount***
- De-identified min & max negotiated charge
- Addl generic and payer specific notes

ADDITIONAL INFORMATION ON DATA ELEMENTS

ESTIMATED ALLOWED AMOUNT *(originally proposed as “Consumer Friendly Expected Allowed Amount”)*

If a hospital indicates that the payer-specific negotiated charge is based on an “algorithm” or “percentage” then it must encode data into this new element. The “estimated allowed amount” is defined as *“the **average** dollar amount that the hospital has **historically** received from a third-party payer for an item or service.”* There are several points to note:

- 1) The proposed rule indicated this value needed to be based on a prospective understanding of payment, but the final rule edits this to historical payment presumably to make this easier for hospitals to obtain.
- 2) CMS preserves the flexibility for hospitals to derive this value from various sources but does specifically share that *“using information from the EDI 835 electronic remittance advice (ERA) transaction...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.”*



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

Items & Services

- Description
- Setting
- Drug unit and type of measurement*

ADDITIONAL INFORMATION ON DATA ELEMENTS

DRUG UNIT & TYPE OF MEASUREMENT

Beginning January 1, 2025, hospitals must provide a “unit” and “type” for all drugs where an established standard charge exists. These are separate from the description field.

The pharmaceutical charge environment can be complex and variable, so practical guidance in development could be, as follows:

- 1) The unit and type of measure should directly tie to the standard charge. Meaning, the charge should be reflective of the number of units contained in the field. Some hospitals may consider dispensing unit(s) as a strategy for developing the display of this data.
- 2) If drug charges are “dynamic” based on application of markup policy to current drug reference points (cost, AWP, etc.) the hospital can remember that this data need only be updated once annually. Also, if no “charge” is maintained, patient claim data could be used to derive the unit charge.
- 3) If the drug type in the hospital’s billing environment is not among the seven identified for valid values, a type of “EA” (each) and unit of “1” could be used with a “crosswalk” to this information contained in the “additional generic notes” field.

All data elements in the MRF are required beginning July 1, 2024, except those indicated with * which will begin January 1, 2025



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

ADDITIONAL INFORMATION ON DATA ELEMENTS

DRUG UNIT & TYPE OF MEASUREMENT

Example:

description	code 1	code 1 type	code 2	code 2 type	drug_unit_of_ measurement	drug_type_of_ measurement	standard_charge gross	PAYER NEGOTIATED DATA	additional_generic_notes
ALPHA1 PROT INHIB 1000MG(BU10)	6171248	CDM	13533070501	NDC	1000	ME	19.90	MAY NOT HAVE PAYER NEGOTIATED DATA ESTABLISHED AT THIS CODE TYPE LEVEL	
AMPHOTER B LIPID 100MG (BU 10)	6171250	CDM	57665010141	NDC	100	ME	92.27		
ANAKINRA INJ 100MG/0.67ML SYRG	6171251	CDM	66658023407	NDC	1	EA	1830.68		
PEG INTERFERON ALFA 2A 180MCG	6174696	CDM	82154045104	NDC	1	EA	3963.49		NDC EA = 180 MCG

Example above is illustrative, not all required data elements are displayed because of slide size constraints



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

Coding/Billing

- Billing/Accounting Code
- Code type
- **Modifier***

ADDITIONAL INFORMATION ON DATA ELEMENTS

MODIFIER

Hospitals must include any modifier(s) that may change the standard charge that corresponds to a hospital item or service, including a description of the modifier and how it changes the standard charge. CMS allows hospitals flexibility in their approach and has provided an example of one approach on the HPT Data Dictionary GitHub Repository. While this example applies to payment logic the definition applies to all standard charges. Meaning, gross charge modifier information should be provided where these values exist.

Conditional Requirement:

If a modifier is encoded without an item or service, then a “Description” and one of the following is the minimum information required: “Payer-specific Negotiated Charge: Dollar Amount”, “Payer-specific Negotiated Charge: Percentage”, “Payer-specific Negotiated Charge: Algorithm”, “Additional Generic Notes”, or “Additional Payer-Specific Notes”. Required beginning 1/1/2025.



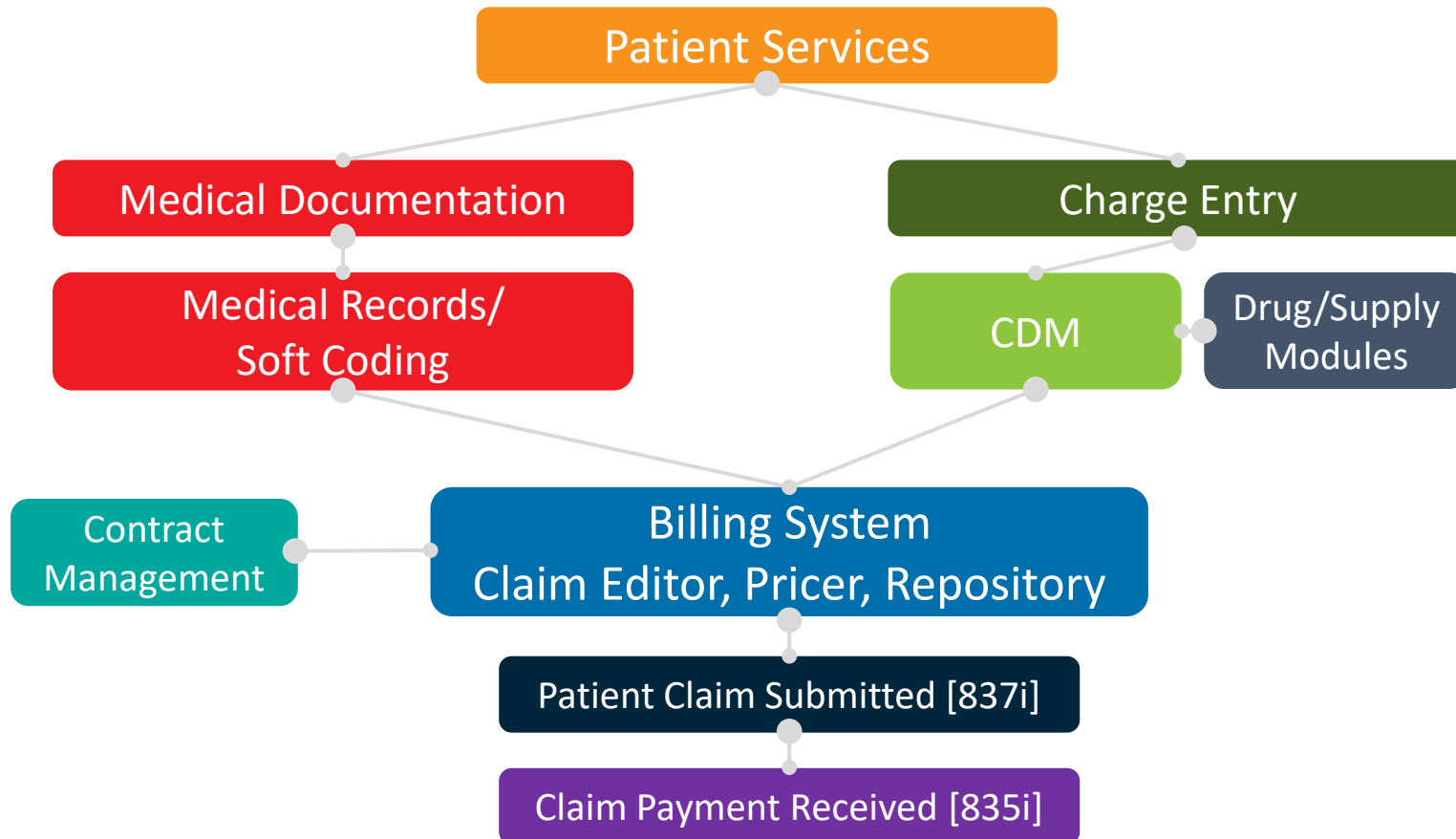
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CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: IDENTIFY APPLICABLE DATA SOURCES FOR COMPLIANCE

HOSPITAL BILLING ENVIRONMENT



MAIN POINT:

All primary data needed to create the MRF lives in the hospital's billing environment. Understanding where to pull this information, however, can be more challenging.



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: IDENTIFY APPLICABLE DATA SOURCES FOR COMPLIANCE

CLEVERLEY + ASSOCIATES GUIDANCE FOR DATA ELEMENTS

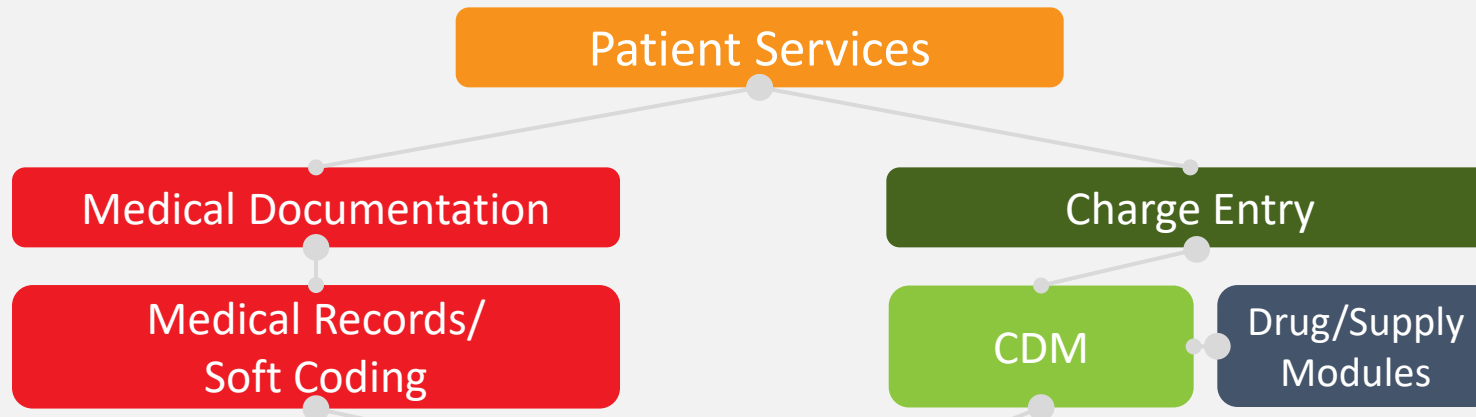
CMS requires that “each hospital must encode, as applicable, all standard charge information corresponding to each required data element in its MRF.” The table below illustrates how to assemble the applicable data elements given the definitions of standard charges for items, services, and service packages.

		CMS DEFINITION OF ITEMS, SERVICES, & SERVICE PACKAGES		
		HOSPITAL/TECHNICAL		PROFESSIONAL
		Items/Services	Service Packages	Items/Services
		Per Unit (Examples: CDM, HCPCS)	Aggregation of individual items and services into a single service with a single charge (Examples: Per Diems, MSDRGs)	Per Unit (Examples: CDM, HCPCS)
CMS DEFINITION OF STANDARD CHARGES	Gross Charges	✓ CHARGEMASTER	✗ NOT TYPICALLY CREATED	✓ MUST PROVIDE IF EMPLOYED (<i>no codified definition of employment exists to date</i>). PRESENTATION OF DATA COULD EXIST AT A HCPCS LEVEL AS MANY PROFESSIONAL SETTINGS HAVE GROSS CHARGES AND PAYER-SPECIFIC NEGOTIATED RATES ESTABLISHED WITH THESE CODES.
	Discounted Cash Price	✓ MUST PROVIDE IF DEVELOPED, POLICIES CAN INCLUDE PRICING PER SERVICE AND/OR PACKAGED SERVICE		
	Payer-Specific Negotiated Charges	✗ PAYER CONTRACTS RARELY, IF EVER, CONTAIN ONLY LINE LEVEL RATES AND APPLICATION. IN ALMOST ALL SITUATIONS, PAYMENT IS AT THE CLAIM LEVEL AFTER EVALUATING ALL PATIENT SERVICES AND PAYER CONDITIONS.	✓ PAYER-SPECIFIC NEGOTIATED CHARGES FOR ALL ITEMS, SERVICES, AND SERVICE PACKAGES ARE DETERMINED THROUGH CLAIM-LEVEL ANALYSIS TYING PATIENT SERVICES TO PAYER CONDITIONS.	
	De-identified minimum negotiated charges			
	De-identified maximum negotiated charges			



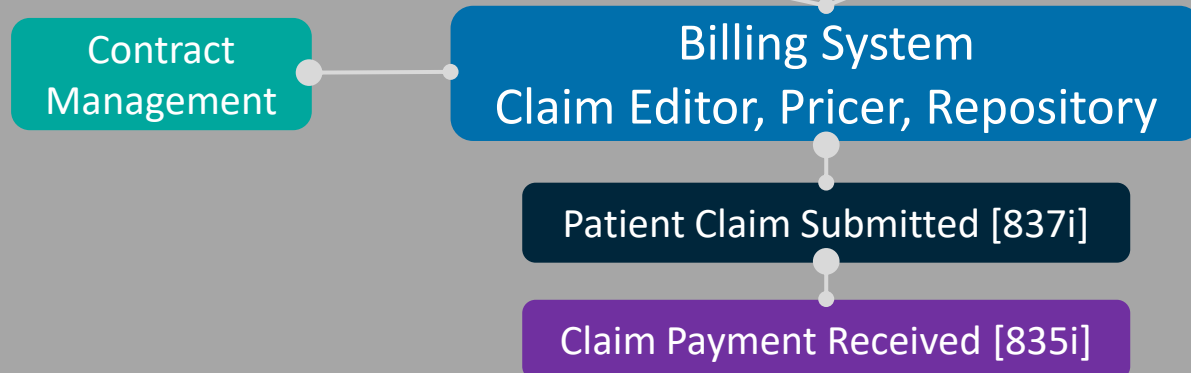
CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: IDENTIFY APPLICABLE DATA SOURCES FOR COMPLIANCE

HOSPITAL BILLING ENVIRONMENT



MRF AREAS:

- GROSS CHARGES
- MODIFIERS
- DRUG UNIT/TYPE OF MEASURE



MRF AREAS:

- PAYER-SPECIFIC NEGOTIATED CHARGES
- CHARGE METHOD
- MODIFIERS
- ESTIMATED ALLOWED AMOUNT



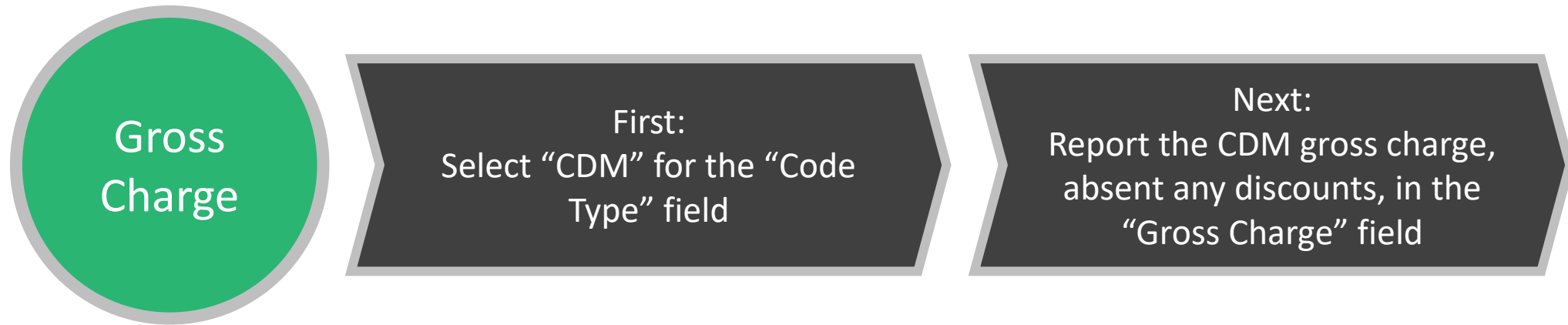
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CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

CMS has provided a means for displaying the unique gross charge and payer-specific negotiated charge information within the required template. The CDM gross charges are very straight-forward:



Discounted Cash Price Note:

Hospitals are required to disclose this price, if established. Many hospitals have a discount percentage that is applied uniformly across the CDM. If so, the resulting price at the CDM level can be encoded in the “Discounted Cash Price” field next to the “Gross Charge” value. If pricing is established at a different “Code Type” level then the hospital should report for that code type/description.



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

Case example portion of MRF to show how gross charges and discounted cash price information could be displayed:

description	code 1	code 1 type	standard_ charge gross	standard_ charge discounted_ cash	payer_ name	plan_ name	standard_ charge negotiated_ dollar	standard_ charge negotiated_ percentage	standard_charge negotiated_algorithm	estimated_ amount	standard_charge methodology	additional_generic_notes
HC PRIVATE ROOM DAILY	XXX01	CDM	2450	2205								
✓ APPLICABLE GROSS CHARGE (AND OFTEN DISCOUNTED CASH PRICE) ARE ESTABLISHED AT THE “CDM” CODE TYPE LEVEL					✗ NOT APPLICABLE PAYER-SPECIFIC NEGOTIATED CHARGES ARE NOT ESTABLISHED FOR INDIVIDUAL CDM CODES SO THESE FIELDS ARE NOT APPLICABLE							

Example above is illustrative, not all required data elements are displayed because of slide size constraints

CY2024 OPPI Final Rule Support: “Moreover, as explained in the CY 2020 HPT final rule, such payer-specific negotiated charges often do not reside in the hospital’s chargemaster.”



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

Payer-specific negotiated charges require the hospital to clarify the type of data that is being displayed. First, the hospital must specify the type of charge method that the negotiated payer uses to determine patient reimbursement. Valid values are, as follows:

VALID VALUES FOR CHARGE METHOD	
Reporting Value	CMS Description
Case rate	A flat rate for a package of items and services triggered by a diagnosis, treatment, or condition for a designated length of time.
Fee schedule	The payer-specific negotiated charge is based on a fee schedule.
Percent of total billed charges	The payer-specific negotiated charge is based on a percentage of the total billed charges for an item or service. This percentage may vary depending on certain pre-determined criteria being met.
Per diem	The per day charge for providing hospital items and services.
***	***



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

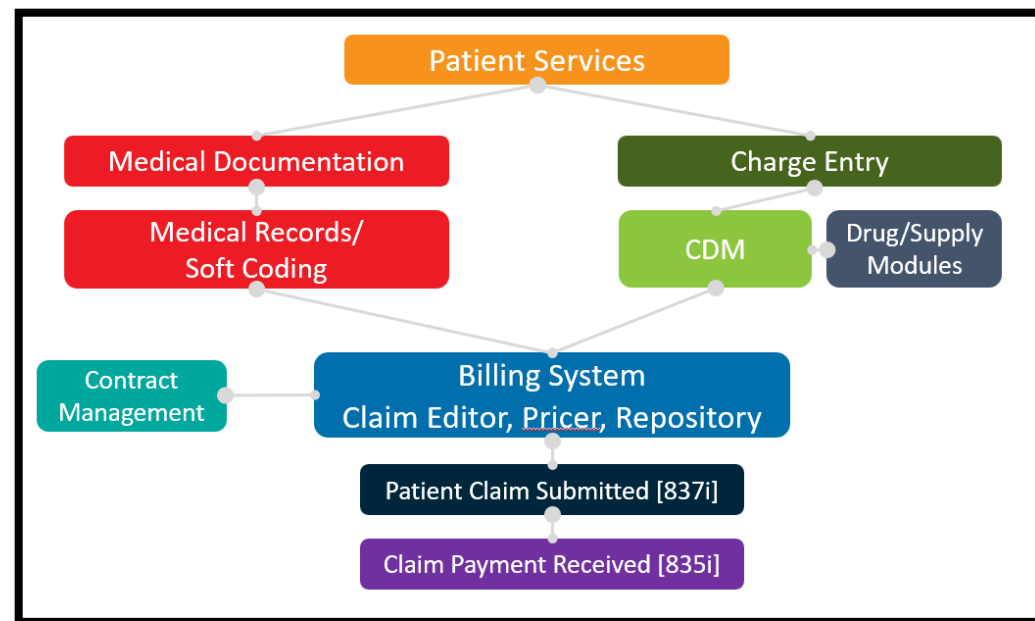
KEY CHALLENGE: HOW TO SELECT A CHARGE METHOD?

The issue: The user must choose one “charge method” and report it at one “code type” level for each line:

Charge Method Valid Values
Case rate
Fee schedule
Percent of total billed charges
Per diem

Code Type Valid Values
CPT
NDC
HCPCS
RC
ICD
DRG
MS-DRG
R-DRG
S-DRG
APS-DRG
AP-DRG
APR-DRG
APC
LOCAL
EAPG
HIPPS
CDT
CDM
TRIS-DRG

When the payer-specific negotiated charges for all items, services, and service packages includes numerous methods and types:

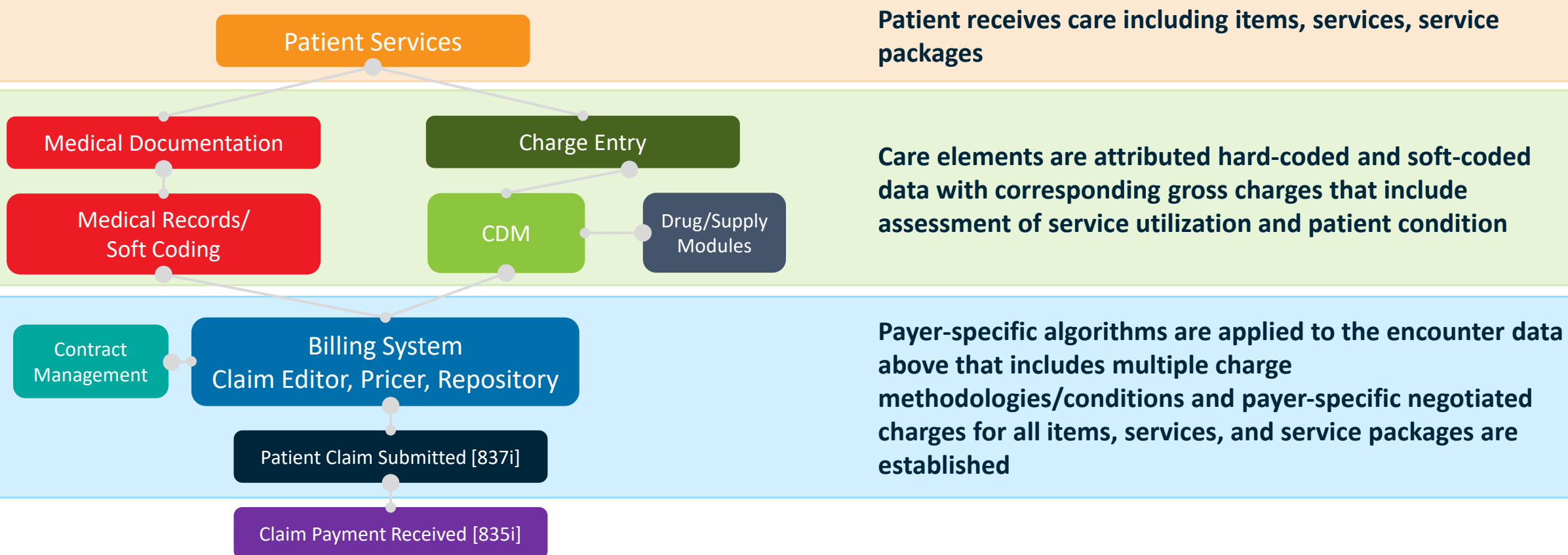




CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

KEY CHALLENGE: HOW TO SELECT A CHARGE METHOD?

TYPICAL PAYER-SPECIFIC NEGOTIATED CHARGE SCENARIO





CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

How does CMS define “algorithm” situations? From CY24 OPPS Final Rule:

*“At other times, however, hospitals and payers establish the payer-specific negotiated charge by agreeing to an algorithm that will determine the dollar value of the allowed amount on a case-by-case basis after a pre-defined service package has been provided. This means that the standard charge that applies to the group of patients in a particular payer’s plan **can only** prospectively **be expressed as an algorithm**, because the resulting allowed amount in dollars will be individualized on a **case-by-case basis** for a pre-defined service package, and thus cannot be known in advance or displayed as a rate that applies to each member of the group.”*



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

CMS offers an “Other” Charge Method option:

VALID VALUES FOR CHARGE METHOD	
Reporting Value	CMS Description
Case rate	A flat rate for a package of items and services triggered by a diagnosis, treatment, or condition for a designated length of time.
Fee schedule	The payer-specific negotiated charge is based on a fee schedule.
Percent of total billed charges	The payer-specific negotiated charge is based on a percentage of the total billed charges for an item or service. This percentage may vary depending on certain pre-determined criteria being met.
Per diem	The per day charge for providing hospital items and services.
Other	If the standard charge methodology used to establish a payer-specific negotiated charge cannot be described by one of the types of standard charge methodology above, select ‘other’ and encode a detailed explanation of the contracting arrangement in the additional_payer_notes data attribute.



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

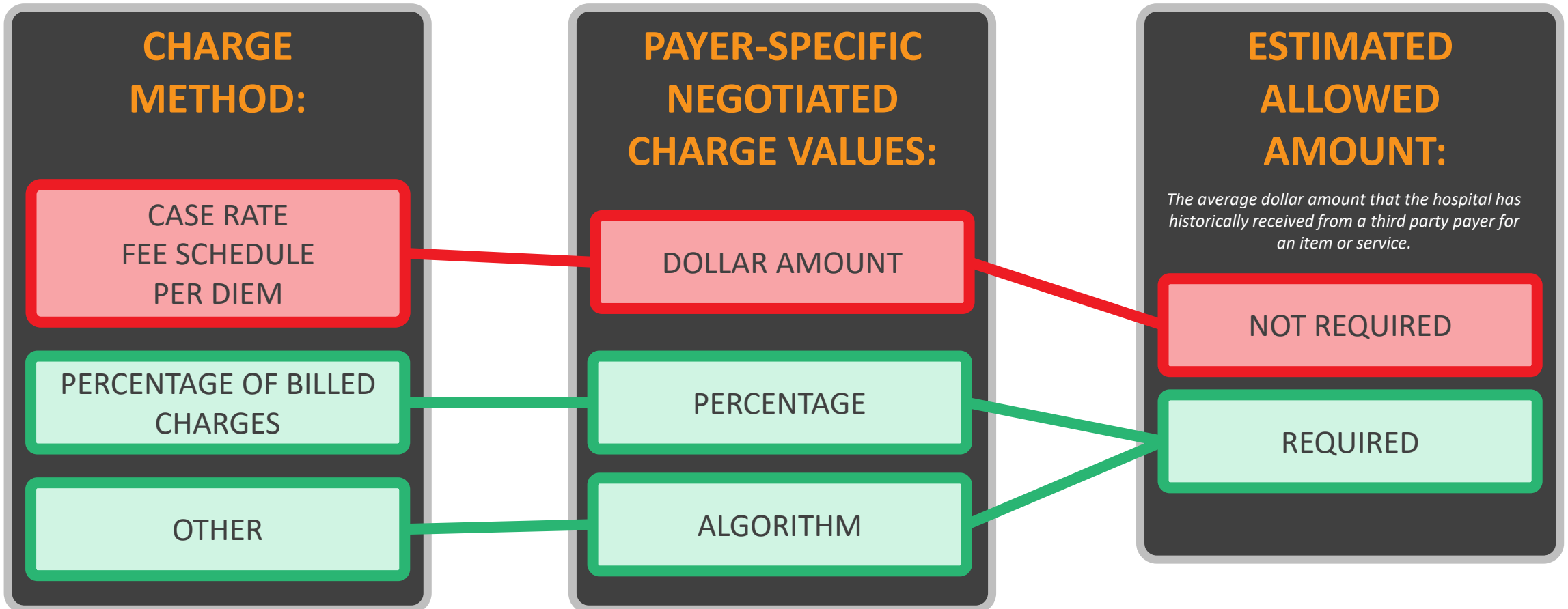
USING “OTHER” & “ALGORITHM” CLEVERLEY + ASSOCIATES CHARGE METHOD GUIDANCE

Reporting Value	When to use?
Case rate	Cleverley + Associates looks to the following quotes in the CY2024 OPPS Final Rule: <i>“TEP members indicated that including the contracting method within the MRF would bring necessary context to the payer-specific negotiated charges established by the hospital. For example, a hospital may have established a payer-specific negotiated charge as a ‘base rate’ for a service package. Without knowing that, a file user might assume that the listed payer-specific negotiated charge included every charge applicable to the provision of the item or service when, in fact, a ‘base rate’ charge likely would include non-standard adjustments and other added charges.”</i>
Fee schedule	<i>“The (TEP) members went on to discuss the potential benefits to both hospitals and the public if CMS required hospitals to display standard charge information that better described or contextualized their standard charges, including standard charge information related to complex contracting arrangements between hospitals and third party payers.”</i>
Percent of total billed charges	KEY POINT: VALUES PRESENTED MUST DESCRIBE THE <u>CONTEXT</u> OF ALL ELEMENTS AND THE <u>COMPLEXITY</u> CONTAINED WITHIN THE PAYER-SPECIFIC NEGOTIATED CHARGE
Per diem	C+A GUIDANCE: Hospitals should use these reporting values if they believe the payer-specific negotiated charges represented align with this approach entirely for the payer, plan, and code type(s) on each line.
Other	If, however, there is an algorithm that encompasses more than one of the elements above (or other elements not described), then the hospital should use the “Other” option and provide additional detail to support in order to be able to mark “true” for the affirmation statement that the provided information is “true, accurate, and complete.”



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

After the charge method has been selected, the hospital must report the negotiated value and the estimated allowed amount in the following way:



CY2024 FINAL RULE: "Beginning January 1, 2025, if the standard charge is based on a percentage or algorithm, the MRF must also specify the estimated allowed amount for that item or service."



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

IF OTHER/ALGORITHM ARE USED, ADDITIONAL INFORMATION IS REQUIRED

IF “OTHER” IS ENCODED FOR CHARGE METHOD:

- Encode a detailed explanation of the contracting arrangement in the additional_payer_notes data attribute.

IF STANDARD CHARGE IS BASED ON A PERCENTAGE OR ALGORITHM:

- The MRF must also describe the percentage or algorithm that determines the dollar amount for the item or service.



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

HOW DO I DEFINE A COMPLEX ALGORITHM IN A SINGLE CELL?



What does the algorithm logic include? Examples:

- Payer specific code categorizations and carveouts with multiple payment methodologies dependent on claim-level conditions defined by custom case categories, HCPCS/CPT® codes and/or ranges, revenue code values/ranges, procedure and diagnosis code values/ranges, etc.
- Surgical case grouping logic dependent on relative weights of thousands of soft-coded CPT®/HCPCS conditions and multiple-procedure discounting rules that exist with corresponding lists of conditions and codes
- MSDRG platform versions and corresponding lists of relative weights, base rates, and markup conditions
- Charge threshold logic for lesser-of and stoploss provisions that is dependent on claim-level criteria
- Packaging and exclusion logic based on claim level criteria based on lists of codes and/or code ranges
- Hierarchy rankings to determine when/how the payment is calculated based on the types of services provided and conditions listed above



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

HOW DO I DEFINE A COMPLEX ALGORITHM IN A SINGLE CELL?

CY2024 OPPTS FINAL RULE:

“in the interest of reducing burden and complexity of files, we will allow hospitals provide a description of the algorithm, rather than attempting to insert the specific algorithm itself in the MRF. We are therefore finalizing that if the standard charge is based on a percentage or algorithm, the MRF must also describe (instead of specify) what percentage or algorithm determines the dollar amount for the item or service. By describing, rather than specifying, what percentage or algorithm determines the dollar amount for the item or service, we believe this will balance the need for exact information versus MRF complexity, hospital burden, and the limitations of data processing.”

“Descriptions for algorithms could include, for example, a link to the algorithm used, a descriptor of a commonly understood algorithm, or a list of factors that would be used to determining the individualized or variable allowed amount in dollars.”

CURRENT CMS TEMPLATE EXAMPLES:

- MS-DRG
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/images/OP.jpg>
- The adjusted base payment rate indicated in the standard_charge|negotiated_dollar data element may be further adjusted for additional factors including transfers and outliers.

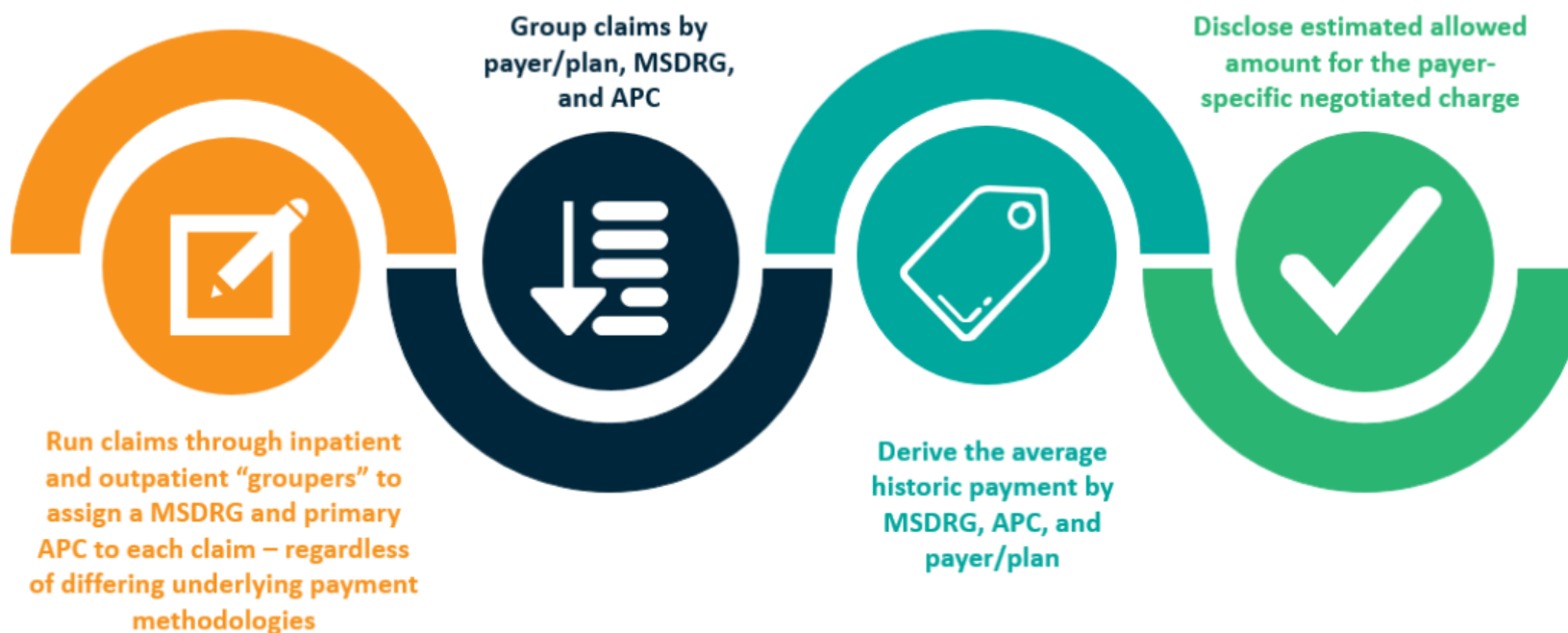


CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

HOW DO I ENCODE ESTIMATED ALLOWED AMOUNTS FOR A CODE TYPE LINE?

We need a valid code type value that applies to the entire claim: MS-DRG (Inpatient) and primary APC (Outpatient).

Code Type Valid Values
CPT
NDC
HCPCS
RC
ICD
DRG
MS-DRG
R-DRG
S-DRG
APS-DRG
AP-DRG
APR-DRG
APC
LOCAL
EAPG
HIPPS
CDT
CDM
TRIS-DRG



Transparency advantage: data includes *all* standard gross and payer-specific negotiated charges and is standardized across all payers regardless of underlying percentage or algorithm logic.



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: DERIVING VALUES FROM DATA SOURCES

Case example portion of MRF to show how standard gross charge and payer-specific negotiated charge information are displayed:

description	code 1	code 1 type	standard_charge gross	standard_charge discounted_cash	payer_name	plan_name	standard_charge negotiated_dollar	standard_charge negotiated_percentage	standard_charge negotiated_algorithm	estimated_amount	standard_charge methodology	additional_generic_notes
HC PRIVATE ROOM DAILY	XXX01	CDM	2450	2205								
Level 3 Type A ED Visits	5023	APC			Aetna	HMO/PPO		85		1437	percent of total billed charges	No additional payer notes for this estimated amount.
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	470	MS-DRG			UHC	All plans			Conditional payment logic at the claim level including numerous contracting methods, hierarchical applications, and service utilization requirements.	34659	other	Contracting method is an algorithm described in the 'standard_charges algorithm' field. The estimated allowed amount provided accounts for the structural rates, conditions, and utilization elements inherent in the payer's algorithm.

Example above is illustrative, not all required fields are displayed because of slide constraints



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA

- 1 CHOOSE YOUR MRF TEMPLATE FORMAT TYPE
- 2 UNDERSTAND DATA ELEMENTS
- 3 IDENTIFY APPLICABLE DATA SOURCES
- 4 DERIVING VALUES FROM DATA SOURCES
- 5 **FILE VALIDATION**



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: FILE VALIDATION

CMS has provided a tool to test if the hospital's MRF conforms "to the required form and manner requirements (45 CFR 180.50(c)(2))." The Online Validator can be found here: <https://cmsgov.github.io/hpt-tool/online-validator/>

CMS ONLINE VALIDATOR SCREENSHOT – BEFORE

Hospital Price Transparency Tools Online Validator MRF Naming Wizard TXT File Generator

Upload file
Files must be in a required CMS template format (.json or .csv)

Drag file here or [choose from folder](#)

About This Tool

The V2.0 Online Validator tool assists your hospital in developing a machine- readable file (MRF) to ensure it conforms to the required form and manner requirements (45 CFR 180.50(c)(2)). These form and manner requirements are described in the [CY 2024 OPPS/ASC Final Rule](#), and detailed technical specifications can be found in the [Hospital Price Transparency Data Dictionary GitHub Repository](#).

CMS ONLINE VALIDATOR SCREENSHOT – AFTER

Validation results

Errors

✓ No errors found in file: [1111111111_cleverley-sample-hospital_standardcharges.json](#)

Warnings

✓ No warnings found in file: [1111111111_cleverley-sample-hospital_standardcharges.json](#)

A hospital should resolve any identified issues prior to posting its MRF. It should be noted that a message of “no warnings” or “no errors” does not mean that the MRF is fully compliant – only that it adheres to the required schema.



APPENDIX: ADDITIONAL CY24 TRANSPARENCY INFORMATION



CY24 OPPS Final Rule Updates: Enhancing Enforcement

ASSESSMENT ACTIVITIES	ACKNOWLEDGING WARNING NOTICES	ADDRESSING SYSTEM NONCOMPLIANCE	PUBLICIZING ACTIONS & OUTCOMES
CMS is strengthening its ability to assess a hospital's compliance position by: 1) Giving it the authority to conduct a comprehensive compliance review 2) Requiring hospitals, upon request, to have an authorized official certify the accuracy and completeness of MRF data 3) Requiring hospitals, upon request, to submit additional documentation (including payer contracts) to determine compliance	CMS will require hospitals to submit an acknowledgement of receipt of any CMS warning notice received by the hospital.	If a hospital found to be noncompliant is part of a health system, CMS includes language that would permit it to notify health system leadership of the action and work to address potential similar issues across other system hospitals.	CMS finalizes that it “may publicize on its website information related to the following: (1) CMS’ assessment of a hospital’s compliance. (2) Any compliance action taken against a hospital, the status of such compliance action, or the outcome of such compliance action. (3) Notifications sent to health system leadership.”



CMS CSV VERSION 2.0 TEMPLATE DATA ELEMENTS AS OF 11/04/2024

Name	Definition	Blanks Accepted	Requirement Date
Hospital Name	The legal business name of the licensee.	No	July 1, 2024
MRF Date	Date on which the MRF was last updated. Date must be in an ISO 8601 format (i.e. YYYY-MM-DD)	No	July 1, 2024
CMS Template Version	The version of the CMS Template used.	No	July 1, 2024
Hospital Location(s)	The unique name of the hospital location absent any acronyms.	No	July 1, 2024
Hospital Address(es)	The geographic address of the corresponding hospital location.	No	July 1, 2024
Hospital Licensure Information	The hospital license number and the licensing state or territory's two-letter abbreviation for the hospital location(s) indicated in the file.	Yes	July 1, 2024
Affirmation Statement	Required affirmation statement. Valid values: true and false. See additional affirmation notes for more details.	No	July 1, 2024
General Description	Description of each item or service provided by the hospital that corresponds to the standard charge the hospital has established.	No	July 1, 2024
Billing/Account Code(s)	Any code(s) used by the hospital for purposes of billing or accounting for the item or service.	Yes	July 1, 2024
Code Type(s)	The corresponding coding type for the code data element. There is a list of the valid values.	Yes	July 1, 2024
Setting	Indicates whether the item or service is provided in connection with an inpatient admission or an outpatient department visit. Valid values: "inpatient", "outpatient", "both".	No	July 1, 2024
Drug Unit of Measurement	If the item or service is a drug, indicate the unit value that corresponds to the established standard charge.	Yes	January 1, 2025
Drug Type of Measurement	The measurement type that corresponds to the established standard charge for drugs as defined by either the National Drug Code or the National Council for Prescription Drug Programs. There is a list of valid values.	Yes	January 1, 2025
Gross Charge	Gross charge is the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.	Yes	July 1, 2024
Discounted Cash Price	Discounted cash price is defined as the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.	Yes	July 1, 2024
Payer Name	The name of the third-party payer that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service.	Yes	July 1, 2024
Plan Name	The name of the payer's specific plan associated with the standard charge.	Yes	July 1, 2024
Modifier(s)	Include any modifier(s) that may change the standard charge that corresponds to hospital items or services.	Yes	January 1, 2025
Payer-specific Negotiated Charge: Dollar Amount	Payer-specific negotiated charge (expressed as a dollar amount) that a hospital has negotiated with a third-party payer for the corresponding item or service.	Yes	July 1, 2024
Payer-specific Negotiated Charge: Percentage	Payer-specific negotiated charge (expressed as a percentage) that a hospital has negotiated with a third-party payer for an item or service.	Yes	July 1, 2024
Payer-specific Negotiated Charge: Algorithm	Payer-specific negotiated charge (expressed as an algorithm) that a hospital has negotiated with a third-party payer for the corresponding item or service.	Yes	July 1, 2024
Estimated Allowed Amount	Estimated allowed amount means the average dollar amount that the hospital has historically received from a third party payer for an item or service. If the standard charge is based on a percentage or algorithm, the MRF must also specify the estimated allowed amount for that item or service.	Yes	January 1, 2025
De-identified Minimum Negotiated Charge	De-identified minimum negotiated charge is the lowest charge that a hospital has negotiated with all third-party payers for an item or service.	Yes	July 1, 2024
De-identified Maximum Negotiated Charge	De-identified maximum negotiated charge is the highest charge that a hospital has negotiated with all third-party payers for an item or service.	Yes	July 1, 2024
Standard Charge Methodology	Method used to establish the payer-specific negotiated charge. The valid value corresponds to the contract arrangement. There is a list of valid values, including "other."	Yes	July 1, 2024
Additional Generic Notes	A free text data element that is used to help explain any of the data including, for example, blanks due to no applicable data, charity care policies, or other contextual information that aids in the public's understanding of the standard charges.	Yes	July 1, 2024
Additional Payer-Specific Notes	A free text data element used to help explain data in the file that is related to a payer-specific negotiated charge. (Used in the CSV wide and JSON templates.	Yes	July 1, 2024
Optional data elements			
Hospital Financial Aid Policy	The hospital's financial aid policy. See additional financial aid policy notes for more details.	Yes	Optional
Billing Class	The type of billing for the item/service at the established standard charge. The valid values are "professional", "facility", and "both".	Yes	Optional
General Contract Provisions	Payer contract provisions that are negotiated at an aggregate level across items and services (e.g., claim level).	Yes	Optional



CMS VERSION 2.0 TEMPLATE DATA ELEMENTS AS OF 11/04/2024

VALID VALUES FOR CERTAIN NEW ELEMENTS

VALID VALUES FOR CHARGE METHOD

Reporting Value	CMS Description
Case rate	A flat rate for a package of items and services triggered by a diagnosis, treatment, or condition for a designated length of time.
Fee schedule	The payer-specific negotiated charge is based on a fee schedule. Examples of common fee schedules include Medicare, Medicaid, commercial payer, and workers compensation. The dollar amount that is based on the indicated fee schedule should be encoded into the Payer-specific Negotiated Charge: Dollar Amount data element. For standard charges based on a percentage of a known fee schedule, the dollar amount should be calculated and encoded in the Payer-specific Negotiated Charge: Dollar Amount data element.
Percent of total billed charges	The payer-specific negotiated charge is based on a percentage of the total billed charges for an item or service. This percentage may vary depending on certain pre-determined criteria being met.
Per diem	The per day charge for providing hospital items and services.
Other	If the standard charge methodology used to establish a payer-specific negotiated charge cannot be described by one of the types of standard charge methodology above, select 'other' and encode a detailed explanation of the contracting arrangement in the additional_payer_notes data attribute.

VALID VALUES FOR CODE TYPE

Reporting Value	Standard Name
CPT	Current Procedural Terminology
NDC	National Drug Code
HCPCS	Healthcare Common Procedural Coding System
RC	Revenue Code
ICD	International Classification of Diseases
DRG	Diagnosis Related Groups
MS-DRG	Medicare Severity Diagnosis Related Groups
R-DRG	Refined Diagnosis Related Groups
S-DRG	Severity Diagnosis Related Groups
APS-DRG	All Patient, Severity-Adjusted Diagnosis Related Groups
AP-DRG	All Patient Diagnosis Related Groups
APR-DRG	All Patient Refined Diagnosis Related Groups
APC	Ambulatory Payment Classifications
LOCAL	Local Code Processing
EAPG	Enhanced Ambulatory Patient Grouping
HIPPS	Health Insurance Prospective Payment System
CDT	Current Dental Terminology
CDM	Charge Description Master (chargemaster)
TRIS-DRG	TriCare Diagnosis Related Groups

VALID VALUES FOR DRUG TYPE

Reporting Value	Standard Name
GR	Grams
ME	Milligrams
ML	Milliliters
UN	Unit
F2	International Unit
EA	Each
GM	Gram



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

MRF

- MRF date
- CMS template version
- Affirmation statement

ADDITIONAL INFORMATION ON DATA ELEMENTS

MRF date:

Date on which the MRF was last updated. Date must be in an ISO 8601 format (i.e. YYYY-MM-DD). Remember files must be updated no less than annually.

CMS template version:

This represents the version of the CMS Template used ***not*** any subsequent numbering of the hospital's file reflecting an update for that year. Example: if you use the CMS 2.0.0 template than simply indicate (2.0.0) in this field (and not CSV tall).

Affirmation statement:

Use the affirmation statement language ***exactly*** as stated in the data dictionary and affirm the statement with "True" (compliant) or "False" (noncompliant).



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

Hospital

- Name(s)
- Location(s)
- Address(es)
- Licensure information

ADDITIONAL INFORMATION ON DATA ELEMENTS

LOCATION & ADDRESS

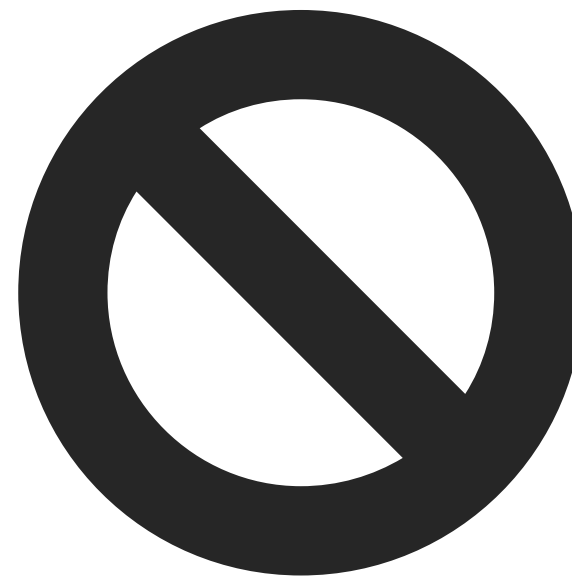
Only the names and addresses of hospital inpatient and standalone emergency department locations are required in the MRF. However, hospitals must still include all standard charge information for outpatient locations not encoded for this data element.



CREATING COMPLIANT & MEANINGFUL TRANSPARENCY DATA: UNDERSTAND DATA ELEMENTS

WHAT TO DO ABOUT NULL DATA?

CMS has changed previous guidance regarding null values. Previously, during an MLN call, CMS suggested that the inclusion of “N/A” could assist in communicating that the hospital did not intentionally leave a field blank. Now with the file attestation, that is no longer needed and CMS recommends that the hospital not include a “value or any type of indicators (e.g., “N/A”) if the hospital does not have applicable data to encode.” Clarifying notes could be included in the Additional Generic Notes or Additional Payer-Specific Notes fields. The only exception to this is for the “Estimated Allowed Amount” where CMS recommends a value of 999999999 (nine 9s) when a hospital does not have sufficient claims history to derive a value.





**THANK YOU FOR PARTICIPATING IN
TODAY'S PRESENTATION!**

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