# Hospital Price Transparency Final Rule Call

**Moderated by: Leah Nguyen**
**December 3, 2019, 1:30 pm ET**

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Leah Nguyen. Thank you. You may begin.

## Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this Medicare Learning Network Call on Hospital Price Transparency. CMS finalized policies that laid the foundation for a patient-driven health care system by making standard charges for items and services provided by all hospitals in the United States more transparent.

During this call, learn about provisions in the final rule effective January 1, 2021, including requirements to make public all standard charges for all items and services in a machine-readable format, requirements for displaying shoppable services in a consumer-friendly manner, and monitoring and enforcement. A question-and-answer session follows the presentation.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in. But please refrain from asking questions during the question-and-answer session. If you have inquiries, contact press@cms.hhs.gov. At this time, I'd like to turn the call over to Dr. Terri Postma from the Center for Medicare.

## Presentation

Dr. Terri Postma: Thanks, Leah. Hi, everyone, and welcome – and thank you for joining us today. On November 15, CMS finalized policies that laid 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 may pay for hospital items and services.

This final rule further advances CMS' commitment to increasing price transparency. And these requirements apply to each hospital operating in the United States effective January 1st, 2021. Specifically, this final rule establishes requirements for each hospital operating in the United States to establish, update, and make public a list of their standard charges for items and services that they provide.

We believe that these actions are necessary to promote price transparency in health care and to ensure public access to hospital standard charges. By disclosing hospital standard charges, we believe that the public, which would include patients, employers, clinicians, and other third parties, will have the information necessary to make more informed decisions. We believe the impact of these final policies will help to increase market competition and, ultimately, drive down the cost of health care services, making them more affordable for all patients.

## Increasing Price Transparency of Hospital Standard Charges

I'm on slide 4 now. As health care costs continue to rise, health care affordability has become an area of intense focus. Health care spending is projected to consume almost 20 percent of the economy by 2027. One reason for this upward spending trajectory is the lack of transparency in health care pricing.

Numerous studies suggest that consumers want greater health care pricing transparency. For example, a study of high-deductible health plan enrollees found that respondents wanted additional health care price information so they could make more informed decisions about where to seek care based on price.

Health economists and other experts state that significant cost containment cannot occur without widespread and sustained transparency and provider prices. We believe there is a direct connection between transparency and hospital standard charge information and having more affordable health care and lower health care coverage costs. We believe health care markets would work more efficiently and provide consumers with higher-value health care if we promote policies that encourage choice and competition.

As we have stated on numerous occasions, we believe that transparency and health care pricing is critical to enabling patients to become active consumers so that they can lead the drive towards value. Many empirical studies have investigated the impact of price transparency on markets, with most research, consistent with predictions of standard economic theory, showing that price transparency leads to lower and more uniform prices.

Traditional economic analysis suggests that if consumers were to have better pricing information for health care services, providers would face pressure to lower prices and provide better-quality care. Falling prices may, in turn, expand consumers' access to health care.

Presently, however, the information that health care consumers need to make informed decisions based on prices of health care services is not readily available. The Government Accountability Office, GAO, reported in 2011 – sorry – submitted a report in 2011 called "Health Care Price Transparency – Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care."

In that report, the GAO found that health care price opacity, coupled with the often-wide pricing disparities for particular procedures within the same market, can make it difficult for consumers to understand health care prices and to effectively shop for value. The report references a number of barriers that make it difficult for consumers to obtain price estimates in advance for health care services.

One of several barriers is the lack of access to pricing data. For example, the GAO report explores various pricing initiatives, including tools that consumers could use to generate price estimates in advance of receiving a health care service.

The report noted that pricing information displayed by tools varies across initiatives in large part due to limits reported by the initiative in their access or authority to collect certain necessary pricing data. According to the GAO report, transparency initiatives with access to, and integrated pricing data from, both providers and insurers were best able to provide reasonable estimates of consumers' complete costs.

Research suggests that making such consumer-friendly pricing information available to the public can reduce health care costs for consumer. For example, when New Hampshire launched a price transparency website, consumers who shopped for comparative rates on services like MRIs and X-rays selected lower-cost providers, resulting in millions of savings.

The state released payer- and provider-specific negotiated charges in their state-operated health cost database, which resulted in increased competition and reduced prices for health care services. In another example, Kentucky's public employee benefit program's price transparency shared savings initiative has saved state taxpayers $13 million since its inception in 2015, and almost $2 million in cash benefits have been shared with the state's public employees.

However, despite the growing consumer demand and awareness of the need for health care pricing data, there continues to be a gap in easily accessible and standardized pricing information for consumers to use for health care shopping purposes. As you may know, in June, the President issued an Executive Order on health care price transparency, which directs HHS to eliminate unnecessary barriers to price and quality transparency and to increase the availability of meaningful price and quality information for patients.

So, we are responding to that Executive Order through this final rule and building on the initiatives that we started over a year ago. This final rule further implements Section 2718(e) of the Public Health Service Act, which requires each hospital operating within the United States to establish and update and make public an annual list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under Section 1886(d)(4) of the Social Security Act.

Last year, for the first time, we required hospitals to post their chargemaster rates, that is, their gross or list price information, online in a machine-readable format. Prior to implementation and since then, we received feedback and input from many of you, including hospital CEOs, hospital billing personnel, clinicians, insurers, consumers, and patient advocates from across the country. And we are deeply grateful for that input.

Your input has helped inform this final rule as well as the recently released proposed rule entitled, "Transparency and Coverage," which would place complementary price transparency requirements on most individual and group market health insurance issuers and group health plans.

Specifically, the Transparency and Coverage Proposed Rule includes approaches to make health care price information accessible to consumers and other stakeholders, allowing for personalized and easy comparison shopping. The Transparency and Coverage proposed rule is currently open for public comment at the Federal Register. Today, we will spend our time focusing on the requirements of the Hospital Price Transparency Final Rule.

## Who Must Comply? Definition of 'Hospital'

I'm now on slide 5. So, first, who must comply with these requirements? The final rule defines "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.

So, for purposes of our final rule in these requirements, we defined a state to include each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. This definition includes all Medicare-enrolled institutions that are licensed as hospitals or approved as meeting licensing requirements, as well as any non-Medicare-enrolled institutions that are licensed as a hospital by the state or approved as meeting licensing requirements for the state.

We note that federally owned or operated hospitals – for example, hospitals operated by the Indian Health Program, the U.S. Department of Veterans Affairs, or the U.S. Department of Defense – are regarded as being in compliance already with the requirements for making public their standard charges.

## What Are Hospital 'Standard Charges'?

Slide 6. Hospital standard charges – as I mentioned previously, starting in January 1, 2019, hospitals were required to make public their chargemaster rates, that is, their gross or list prices, online in a machine-readable format.

We received feedback from many of you, including hospitals and patient advocacy organizations, who indicated that gross charges as reflected in the hospital chargemaster may only apply to a small subset of consumers, for example, those who are self-pay or being asked to pay the chargemaster rate because the hospital is not included in the patient's insurance network.

You also noted to us that the charges listed in the hospital chargemaster are typically not the amounts that hospitals actually charge to consumers who have health care because, for insured populations, the hospital charge amounts reflect discounts to the chargemaster rates that the hospital has negotiated with third-party payers. Further, you all pointed out to us that some hospitals will charge lower amounts when a patient pays in cash.

Therefore, in response to your comment, we identified several types of standard charges that would apply to different groups of patients. These include the following. First, the gross charge, the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.

Second, the discounted cash price. This is the charge that applies to an individual who pays in cash or cash equivalent for a hospital item or service. Third, a payer-specific negotiated charge. This is the charge that a hospital has negotiated with a third-party payer for an item or service.

Fourth, the de-identified minimum negotiated charge. This is the lowest charge that a hospital has negotiated across all third-party payers for an item or service. And, finally, the de-identified maximum negotiated charge, which would be the highest charge that a hospital has negotiated with across all their third-party payers for an item or service.

A few notes on this. First, gross charges. We noted in the final rule that this type of standard charge is the same as the charges that are referenced in the CMS' Provider Reimbursement Manual and that hospitals use to create cost reports for Medicare purposes. Additionally, we noted in the final rule that gross charges may also sometimes be referred to as billed charges or billed amounts and appear on a patient's explanation of benefits as the first charge listed.

Regarding payer-specific negotiated charges, we finalized this type of standard charge related to negotiated rates because most consumers – over 90 percent, in fact – rely on a third-party payer to cover a portion or all of the cost of health care items and services, including a portion or all of the cost of items and services provided by hospitals in accordance with the terms and conditions of the third-party payer's contract agreement with that consumer.

Some third-party payers – for example, fee-for-service Medicare or fee-for-service Medicaid – currently make public the maximum rate they pay for a hospital item or service. However, many third-party payers do not reveal their negotiated rates even to the individuals on behalf of whom they pay.

Because consumers are not generally part of the negotiations or privy to the resulting negotiated rate, consumers often find it difficult to learn in advance of receiving a health care service the rate that their third-party payers may pay and, subsequently, what the individual portion of that cost might be.

Having insight into the charges negotiated on one's behalf is necessary for insured health care consumers to determine and compare their potential out-of-pocket obligations prior to receipt of a – of a health care service. For example, if a health care consumer knows that he or she will be responsible for a co-pay of 20 percent of the charges for a hospital service, he or she could compare the charges that their third party negotiated – their third-party payer negotiated with hospital A and with hospital B. And from that, the consumer could determine his or her expected out-of-pocket cost that would apply if the consumer went to hospital A versus hospital B.

This contracted rate is sometimes called the negotiated rate, the in-network amount, allowed charges, or negotiated discount. And it can be significantly lower than what a hospital would charge an individual who did not have an insurance company negotiating discounts on his or her behalf.

This contracted rate is reflected as the second charge in a patient's explanation of benefits after the health care service has been provided. By making both gross and payer-specific negotiated charges available, consumers could have the information necessary to create what could be considered an explanation of benefits in advance of the service rather than having to wait months after services were rendered to understand the extent of their health care cost obligations.

## Which Hospital 'Items and Services' Are Included?

Let's go to slide 7. Which hospital items and services are included? We finalized our proposal to define hospital "items and services" to mean all items and services that a hospital provides including individual items and services, as well as 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 charge.

Examples of hospital items and services include, but are not limited to, supplies and procedures, room and board, use of the facility, and other items – often, these are called facility fees – services of employed physicians and employed non-physician practitioners generally reflected as professional charges, and any other items or services for which a hospital has established a standard charge as we define them.

## Two Ways for Making Public Standard Charges

Slide 8. Under the final rule, hospitals are required to make their standard charges public in two ways. The first way is a comprehensive machine-readable file. This is a single machine-readable file that contains all five types of standard charges for all the items and services provided by the hospital.

Based on public comment, we believe this information and 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 for use at the point of care.

The second way hospitals are required to make public their standard charges, and also in response to comments indicating that a machine-readable file is not directly useful to many consumers – we are requiring that hospitals make public consumer-friendly shoppable services; that is, hospitals would be required to make public a consumer-friendly of some type of standard charges for a limited set of shoppable services, which would include 70 CMS-specified shoppable services and 230 hospital-selected shoppable services that are provided by the hospital.

In the final rule, we defined “shoppable service” as a service that could be scheduled by a health care consumer in advance. We believe that these requirements will allow health care consumers to directly make apples-to-apples comparisons of common shoppable hospital services across hospital settings.

## Requirements for Making Public All Standard Charges in a Machine-Readable Format

Slide 9. For the next couple of slides, we are going to go into more detail with the requirements of the first type of benefit for hospitals to make public their standard charges, that is, how they make public their – all standard chargers for all items and services in a machine-readable format.

So, each hospital location operating under a single hospital license that has a different set of standard charges would separately make public the standard charges that are applicable to that location. The data elements that are required to appear in this machine-readable file are a description of each item or service – this could be a short description – all standard charges, that is, all five types – the gross charges, payer-specific negotiated charges, discounted cash prices, minimum and maximum negotiated charges – that apply to each of those items or services that are listed when provided in, as applicable, the inpatient or outpatient department setting. A third type of required element is any code used by the hospital for purposes of accounting or billing for the item or service – for example, HCPCS codes, DRG codes, national drug codes, or other common payer identifiers.

Slide 10. The format that hospitals are required to make public all standard charges for all items and services in a machine-readable file is that the information must be published in a single digital file that is machine readable. And we define machine readable to mean a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, XML, JSON, and CSV.

As far as location and accessibility of this file, the file must be displayed by the hospital prominently, and it must clearly identify the hospital patient with which the standard charges information is associated. It must be posted on a publicly available website, and it must use a CMS-specified naming convention.

The hospital must also ensure the data is easily accessible without barriers, including ensuring the data is accessible free of charge, does not require the user to establish an account or a password or submit Personal Identifying Information, and is digitally searchable. The data must also be updated by the hospital at least annually and clearly indicate the date that it was last updated. Hospitals can do this by either putting the dates of the last update within the file itself or, otherwise, clearly associating that date with the file on its website.

## Comprehensive Machine-Readable File: Sample Display of Gross Charges

Slide 11. In the final rule, we provided an example of a comprehensive machine-readable file, sample display for gross charges. Again, this is just one of the five types of standard charges. So, this sample display illustrates how gross charges could be posted. And you see at the top it's got the clearly-identified hospital with which the charges are associated.

It's got the date that the prices were posted. Hospitals could include notes – any clarifying notes they feel are necessary. The first column has a short description of the item or service. There, we have included a number of different types of items and services based on your comments to the – to the rule.

So, you can see here there are inpatient services or outpatient services. There are services that are based on time. There are services that have – the different medications that are provided by the hospital, services that could be provided by employed practitioners.

The second column is the list of codes – common billing codes, and the third column national drug codes and, then, the price – the gross charge that applies in the outpatient or inpatient setting is different – and then, finally, additional columns that can be used to identify the quantity, for example, for prescription charge quantity.

## Requirements for Displaying Shoppable Services in a Consumer-Friendly Manner

Slide 12. The next couple of slides, we are going to go over requirements for displaying shoppable services, that second way that hospitals are required to make public their standard charges in a consumer-friendly manner. So, hospitals must display payer-specific negotiated charges, the de-identified minimum or maximum negotiated charges, and the discounted cash prices for at least 300 shoppable services, which would include 70 CMS-specified shoppable services and 230 hospital-selected shoppable services. Note here that for this requirement, hospitals are not required to post – to display their gross standard charges.

If a hospital does not provide one or more of the CMS-specified shoppable services, the hospital must indicate that the service is not offered by the hospital and select additional shoppable services such that the total number of shoppable services is at least 300. If a shoppable – if a hospital provides less than 300 shoppable services, the hospital must list as many shoppable services as it provides.

And the shoppable services selected for display by the hospital should be commonly provided to the hospital patient population. And remember the definition that we finalized. A shoppable service means that the service could be – could be scheduled in advance by the – by the patient.

Slide 13. For each shoppable service displayed, the hospital must do the following. They must include a plain-language description of each shoppable service, and any primary code used by the hospital for purposes of accounting and billing. They must group that primary shoppable service with any ancillary services that the hospital customarily provides in conjunction with that primary shoppable service.

Well, the idea here and in response to comments we received on the rule is that the service would be provided in the way that the patient experiences it. Oftentimes, the way that services are billed are not the way that the patient has experienced the service. So, the idea here is that the shoppable service would be grouped together with the ancillary services that are customarily provided in conjunction with that shoppable service.

The hospital must also indicate the location at which the shoppable service is provided and whether the standard 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.

We've provided flexibility for hospitals to choose an appropriate format for making public this consumer-friendly information. As far as location and accessibility, the hospital must display this information prominently on a publicly available Internet location that clearly identifies the hospital location with which the data is associated.

The information must also be easily accessible without barriers, including ensuring the data is accessible free of charge, does not require users to register or establish an account or password or submit Personal Identifying Information. It must also be searchable by service description, billing code, and payer. The hospital must also update this information annually and clearly indicate the date of the last update.

Slide 14. In the final rule, we finalized the policy that CMS will deem a hospital as having met the requirements for the second way of making public standard charges, that is, for making public their 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.

The requirements are that the tool provides 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.

The tool must also allow health care consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay for the shoppable service. The tool must also be prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password.

Note that we did not include a requirement that it be accessible to the public without submitting Personal Identifying Information. We are aware that there are tools that hospitals already offer that require individuals to submit, for example, Personal Identifying Information such as their insurance number. This would be acceptable.

## Sample Display of Shoppable Services

Slide 15. Here, in the final rule, we created a sample display of how some shoppable services might be posted by a hospital. In this example, we used – we used XML. And you can see at the top that the hospital – the charges are clearly identified with the hospital and its location, that the date that the prices were posted is there. There is space for hospitals to include any additional clarifying notes or disclaimers.

And, then, for these three shoppable services, we show how each shoppable service can be grouped together with its ancillary services, how the common billing codes can be associated, as well as the standard charges in this case for a particular plan. This would be the negotiated rates for plan X.

Note here that in the interest of being consumer friendly, in this example we have included a note for some services that are not provided by the hospital but may be billed to the consumer separately. This is not a requirement. However, we feel that it's patient friendly, consumer friendly, and we encourage hospitals to consider including that information.

In the second shoppable service, a simple office visit, there are no additional ancillary services to group. Therefore, it is posted by itself with a single HCPCS code and a single payer-specific negotiated charge. Now, we'll move to slide 16, and I'll turn things over to Heather Grimsley.

## Monitoring and Enforcement

Heather Grimsley: Thanks, Terri. I will talk briefly about the monitoring and enforcement provisions of this regulation. We will monitor and assess hospital compliance with these requirements in ways such as evaluating complaints received by individuals or entities to CMS, reviewing individual's or entities' analysis of noncompliance, and auditing hospitals' websites.

If CMS concludes the hospital is noncompliant with one or more of the requirements to make public standard charges for all items and services or displaying shoppable services in a consumer-friendly manner, CMS may take compliance actions generally in the following order.

First, providing a written warning notice to the hospital of the specific violation; second, requesting a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements; and, third, imposing a civil monetary penalty on the hospital and publicizing the penalty on the CMS website.

If the hospital fails to respond CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan, CMS may impose a civil monetary penalty on the hospital not to exceed $300 per day. CMS may also issue subsequent notices of imposition of a CMP where investigation reveals that there is continuing justification that results from the same instances of noncompliance.

The rule also establishes an appeals process for hospitals to request a hearing before an Administrative Law Judge of the civil monetary penalty. And the Administrator of CMS, at his or her discretion, may review in full or in part the Administrative Law Judge's decision.

On slide 17, as Terri mentioned earlier, based on stakeholder feedback through the rulemaking process, we extended the effective date to January 1st, 2021, to provide additional time for hospitals to become compliant with these regulations.

The next four slides, slides 18 through 21, include the list of 70 CMS-specified shoppable services and the categories of evaluation and management services, laboratory and pathology services, radiology services, and medicine and surgery services. I'll now turn this call back to Leah for the question-and-answer session.

## Question & Answer Session

Leah Nguyen: Thank you, Heather. We will now take your questions. As a reminder, this event is being recorded and transcribed. In an effort to get to as many questions as possible, each caller is limited to one question. To allow more participants the opportunity to ask questions, please send questions specific to your organization to the resource mailbox on slide 23 so our staff can do more research.

Preference will be given to general questions applicable to a larger audience. We will be mindful of the time spent on each question. Also, this call did not cover the proposed rule on transparency and coverage. We cannot address questions on this topic. All right, Dorothy, we are ready for our first caller.

Operator: To ask a question, press "star" followed by the number "1" on your touch-tone phone. To remove yourself from the queue, press the "pound" key. Remember to pick up your handset before asking your question to ensure clarity. Once your line is open, state your name and organization.

Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. If you have more than one question, press "star" "1" to get back into the queue. And we will address additional questions as time permits. Please hold while we compile the Q&A roster. Please hold while we compile Q&A roster.

Your first question comes from the line of Valerie Wrinkle.

Valerie Wrinkle: Hello. I am referring to your slide 14 and the exception for hospitals that can make their shoppable services estimates available through a tool, an online tool. On the slide, you indicate that the estimate of the amount that will be obligated to pay for the shoppable services.

And I wanted to be sure that this is still an estimate and that there is no requirement that hospitals would honor the estimate should circumstances change – in other words, that it is a fixed estimate that the patients would only solely have to pay that amount based on what the tool presents.

Dr. Terri Postma: Hi. This is Terri. Yes. The idea is that the online tool would provide an out-of-pocket estimate. Many of these estimates are tools that are already in use, are fairly specific, and do provide good faith estimates. Nothing, however, in this rule would prohibit a hospital from making any caveats or otherwise

explaining that if things were to change with the care, that there may be things that happen during the course of care that could change the estimate.

Valerie Wrinkle: Okay.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Diane Moore.

Diane Moore: Hello. This is Diane Moore from Memorial Medical Center in Port Lavaca, Texas. So, on slide 15 where you have this sample of the shoppable services, I just wanted to clarify – because I'm a little confused here – on the standard charge for the insurance. For example, we have four different Blue Cross contracts. So, would we have to show four different prices for each Blue Cross contract? Or how does that work?

Dr. Terri Postma: Yes. Thank you for the question. This is Terri again. Yes. This sample just shows the prices for one payer and one plan. So, you would have to post each payer and each payer's plan if those charges are different. And you could do that as separate files, or you could do that as different columns. We left it very flexible for you to determine how best to create that display in a way that's consumer friendly.

Leah Nguyen: Thank you.

Diane Moore: Okay. Thank you.

Operator: Your next question comes from the line of Jeff Lyle.

Jeff Lyle: Hi. This is Jeff Lyle from Falls Community Hospital. She just asked the same question. If I have 20 commercial payers, am I going to have to have 20 payer-specific negotiated charge examples?

Dr. Terri Postma: Yes. And this is Terri. The answer to that would be yes.

Jeff Lyle: Thank you.

Operator: Your next question comes from the line of Lee Shoots.

Lee Shoots: Hi. This is Lee from Jupiter Medical Center. I am just totally confused about this whole rule, to be honest with you. My background is not insurance. But I am looking at our managed care stuff and we have 30 different payers on the sheet and everybody is different for how the plan is set up for inpatient, whether it's a tiering of charges or CPTs or revenue codes or whatever.

How do you – has anybody on your team actually worked through this and had this work? And that might be a grandiose idea. But, to make it work, to make facilities able to do what you are asking, have you even thought about how we would do this? It's an incredible amount of stuff. I don't even know how to start.

Dr. Terri Postma: Yes. Thanks for the question. This is Terri. It is a large amount of data. We addressed many of those questions, comments, and concerns that came in for the proposed rule in the final rule. And, so, that's

one of the reasons why we are making samples available and things like that and also created a lot of flexibility in terms of format, particularly for the shoppable services, to present it in a way that's consumer friendly.

So, yes, we do recognize that it's a great deal of data. But it's all data that hospitals have either within the chargemaster itself or within its revenue billing cycle, in its contracts with third-party payers – the rate sheets, for example, that have the lists of items and services, codes, and the negotiated rates. So, I--

Lee Shoots: And when you say negotiated rates, do you mean …

Dr. Terri Postma: Yes.

Lee Shoots: I mean you used one term like "gross charge" for a hospital. That's our list charge. I get it. But, then, you switched, and you say, "payer-specific negotiated charge" and, then, you go to "cash price" and it's all – it's all over the place, to be honest. So, I'm not – I don't even have a handle on what kind of figure you are looking for for payers like we don't negotiate a charge as a facility. We charge what we charge. What they pay us is negotiated. So, the charge is the wrong word, I think. I don't think it's clear.

Dr. Terri Postma: I would encourage you to go to the final rule and read our section …

Lee Shoots: I've read it a couple of times.

Dr. Terri Postma: Okay. Great. So, then, you saw that we explained what those negotiated charges are and the payer-specific negotiated charges and where hospitals can find them within their billing and revenue cycle systems.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Dee Monty.

Dee Monty: Hi. Yes. On slide – on slide 12 in your first sentence, you used two terms, de-identified minimum and maximum. Can you – what do you mean by de-identified?

Dr. Terri Postma: Hi. This is Terri. So, the de-identified minimum/maximum – you would identify what those minimums and maximums are across all payers. So, if you have, let's say, 20 different payers. Each of those payers has a different rate for a particular item and service. And you would select the highest and the lowest for that item or service.

And, then, you could choose to put that into a column, have the minimum identified rate and the maximum rate in two different columns, listing those side by side for each item or service that the hospital provides. That would be in contrast to listing out the payer-specific negotiated rates, which are an identifiable list or identifiable to a specific payer and a specific plan.

Female on participant line: We only have (inaudible).

Dr. Terri Postma: Does that help?

Dee Monty: I – OK. Let's just – I'm sorry. It helps a little bit, I think. But, there's more questions. So, if you, for example, are coming in for an office visit and that we know what that payer-specific negotiated charge is – $45 – our list is 100 – what is the de-identified minimum and maximum related to that? It's still just $45. Right?

Dr. Terri Postma: So, again, if you have, let's say, 20 different payers, each of them has a different specific …

Dee Monty: So, all payers.

Dr. Terri Postma: Yes. It would be the minimum across all payers.

Dee Monty: Okay.

Dr. Terri Postma: De-identified.

Dee Monty: Got it. OK. So, then – OK. Interesting. So, on that payer sheet, we would say – we would say the minimum and maximum – it would be 20 to 75, for example, in this example.

Dr. Terri Postma: Yes. Correct.

Dee Monty: Yes.

Dr. Terri Postma: And remember, that is just across the payers with whom you negotiate. That would not include non-negotiated rates like the rates that fee-for-service Medicare sets, for example. That would not be included.

Dee Monty: Okay. Thank you.

Leah Nguyen: Thank you.

Dr. Terri Postma: Sure.

Operator: As a – as a reminder, if your question has been answered, please press the pound key. Your next question comes from the line of Bob Sterns.

Bob Sterns: Yes. One of the things that you said earlier about identifying specific and personal data, the – many providers already use a shoppable tool such as one with a vendor-based tool for – someone can enter their insurance information with an individual specific information – identifying information. I think you said on slide 14 that you are allowed to use a tool that does ask for personal information and that would meet the rule. Is that correct?

Dr. Terri Postma: Yes, it's correct. Thanks for the opportunity to clarify. We intentionally did not include that into this requirement on slide 14 because we do recognize that a number of tools that are existing or already out there require an individual to put in some personally identifying information like their insurance number, for

example, in order to be able to get that out-of-pocket estimate. So, we intentionally did not include that as a disqualifier for the tool.

We do, however, still require that the tool be accessible to consumers without charge and without having to register or establish a user account. So, for example, it has to be right up front on the hospital's webpage and can't require the individual to first establish a password or a login to an account to access.

Bob Sterns: Like you said, does that mean – thank you very much. Does that mean that if we have that kind of tool available, that we don't have to have the other machine-readable type stuff that – or searchable type stuff – that we don't have to have let's say we have 70 different insurance contracts. So, we don't have to list 70 specific – right – that that would suffice because we are saying that that is a negotiated rate per payer?

Dr. Terri Postma: If your hospital already has this type of tool that allows an individual to get a very consumer-friendly out of pocket, then we would deem you as having met the requirements for that second way of making public your standard charges, that is, it replaces the requirement for making public certain standard charges for the 300 shoppable services in a consumer-friendly manner. Your hospital would still have to post the comprehensive machine-readable file with all the standard charges and all the items and services. So, this tool would just replace that second way.

Bob Sterns: Okay. And, so, I understand that. Now, so, has CMS addressed the cost of incurring – the providers are going to incur to do this kind of thing?

Dr. Terri Postma: Yes, we did. That was one thing that we heard in our proposed rule open door forum. And we encouraged – and that we are required to do as part of any rule is to estimate the burden. And, so, we have a whole section in the final rule that draws from the comments that we got – very helpful comments, by the way, that we got from hospital systems and other organizations that submitted what they believe to be more reasonable estimates and then what we had estimated in the proposed.

And we increased the estimate from the proposed to the final to be approximately $12,000 per hospital for the first year of implementation. And I think it was like somewhere between 3,000 and 5,000 for subsequent years. So, if you want more details on those estimates, you can look at the burden estimate in the final rule.

Leah Nguyen: Thank you. As a reminder, if you have more than one question, you can press "star" "1" to get back into the queue, and we will address additional questions as time permits. Dorothy, can we take our next question?

Operator: Your next question comes from the line of Kim McDonnell.

Kim McDonnell: Hello. This is Kim McDonnell at Rutland Regional Medical Center in Rutland, Vermont. Is there a minimum threshold for a payer-negotiated rate, a minimum volume or a minimum dollar amount?

Dr. Terri Postma: No, we didn't finalize any minimums. It would be any payer-specific negotiated rate for all items and services provided by the hospital.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Mary Ann Elbadaro. Mary Ann, your line is open. There is no response…

Female: We needed to….

Operator: Your next question comes from the line of Jill Barber.

Jill Barber: Yes. I believe you answered part of my question. But I'm curious on line 14 if – I believe what you said is – yes, if we are able to do this on our patient estimator tool, we don't have to comply with the format similar to slide 15. However, I want to make sure that we could still require, based on slide 13, for a patient to submit their insurance information as part of that estimator tool. That really helps the patient because we are able to check eligibility and provide them specific patient out-of-pocket information specific to their particular plan design. So, I'm wondering if that would violate the PII that you have listed here.

Dr. Terri Postma: So, thanks for the question. This is Terri. Again, slide 14 – this alternative way that CMS can deem a hospital as having met requirements for making public standard charges for 300 shoppable services in a consumer-friendly manner does not have the disqualifying requirement of patient PII.

So, you are correct that this tool could ask a patient to insert their specific insurance information so that they can get an out-of-pocket – individualized out-of-pocket estimate. And that would be fine because the tool itself is being – we are deeming that as having met the prior requirements for the shoppable services in a consumer-friendly manner.

In other words, the things listed on slide 14 replaced the things that are listed on slide 12 and 13. So, if you are – if you don't have a tool, look at slide 12 and 13. And those are the requirements that need to be met. If you do have a tool, look at slide 14.

Leah Nguyen: Thank you.

Jill Barber: And, then, slide 14 would also replace 15?

Dr. Terri Postma: Yes. 15 is just an example …

Jill Barber: Great. Thank you very much.

Dr. Terri Postma: … and not a requirement. I just want to make that clear. The sample displays are not requirements. But these sample displays do adhere to the requirements that we – that we have finalized.

Leah Nguyen: Thank you.

Jill Barber: Great. Thank you.

Operator: Your next question comes from the line of Jinny McConville.

Sean Wolfe: Yes. This is Sean Wolfe from Community Hospital in McCook. And our question here is are Medicare and Medicaid rates required to be disclosed as third-party payers?

Dr. Terri Postma: Yes. Thanks for the question. We had specifically talked about this in the final rule that rates that are not negotiated with third-party payers such as fee-for-service Medicare or fee-for-service Medicaid are not included. These are already publicly available, publicly posted. And, so, we are not requiring hospitals to repost or re-release that information. We are focusing here on rates that are negotiated between the hospital and a third-party payer.

Leah Nguyen: Thank you.

Sean Wolfe: All right. Thank you very much.

Operator: Your next question comes from the line of Aaron Richards.

Aaron Richards: Hello. My name is Aaron Richards. And I was just curious as to what is the goal of the de-identified minimum and maximum rates?

Dr. Terri Postma: Thanks for the question. So, we think that the de-identified minimum and maximum rates are important for consumers that maybe don't know what their insurance plans are or can help, for example, employers who are looking at what that range might be. We think it's really important to have both minimum and maximum, as we explained in the final rule, because it does give a range that we think is quite useful to consumers.

Leah Nguyen: Thank you.

Aaron Richards: Okay. Thank you.

Operator: As a reminder, if your question has been answered, you may press the pound key to remove yourself from the queue. Your next question comes from the line of Sarah Campman.

Sarah Campman: Hi. Yes. This is Sarah Campman from Trinity Regional Medical Center in Fort Dodge. I'm just wanting to clarify that this rule will become effective, it looks like on slide 17, January 1, 2021?

Dr. Terri Postma: Yes. So, that's correct. January 1st, 2021. So, we heard from you all in the proposed rule that having it be effective by January 1, 2020, was just too short a timeframe for you to ensure that you could gather all the information and particularly for displaying the shoppable services, ensuring that it was presented in a consumer-friendly fashion. So, we finalized a date that gives you over a year to be able to put that information together and to do it well.

Leah Nguyen: Thank you.

Sarah Campman: Great. Thank you so much.

Operator: Your next question comes from the line of Fred Stocolak.

Fred Stocolak: Yes. Hi. This is Fred Stocolak from Panacea Healthcare Solutions. My question relates to the shoppable display. Where we have a case rate, let's say a hip replacement, and where that case rate includes ancillary services, diagnostic services, are you looking for us to display the typical ancillary services included in that case rate? Or, instead, is your definition of ancillary related to, such as in your example, those services not included in the case rate?

Dr. Terri Postma: So, the case rate as displayed – we feel that the shoppable services – when you display those in a consumer-friendly fashion, really think about it from the perspective of the patient. What is the patient going to want to know about that service? What's important for them to know? And especially when they are comparing that service from hospital site to hospital site, what's important? So, there are service packages or case rates that are already inclusive of primary diagnostic procedure that would normally have an individual HCPCS or CPT code associated with it. But, they may – you may have already negotiated your rate that's inclusive of other typical and ancillary services.

In that case, you would display the case rate and the common billing code that you are using, whether that'd be an APC or DRG or something else. And for the purposes of ensuring that it's consumer friendly, you wouldn't be required to, but I think that you would probably think about doing it to be consumer friendly – it would be to explain to the consumer what's included or what isn't included.

And so, again, not a requirement. The requirement is only to post the primary procedure along with the common billing code and the case rate that you've negotiated for that procedure along with any individual or ancillary services that aren't included in that rate. But, in order to be consumer friendly and in order to make sure that the consumer is understanding of what's included, you might want to strongly consider explaining what is included or not included in that charge.

Leah Nguyen: Thank you.

Fred Stocolak: Great. That's good advice. Thank you.

Operator: Your next question comes from the line of Dana Nunez.

Dana Nunez: Hi there. This is Dana Nunez from AHIP from Washington, D.C. I had several questions come in from our members of how they – how they display capitated rates if they don't have any fee-for-service rates to display. We didn't find anything in the rule.

Dr. Terri Postma: Yes. That's a great question. We recognize that there are a number of capitated negotiations that go on between hospitals and insurers. There are often fee-for-service rates associated with that underlying that appear on EOBs before the capitation is met. You might consider posting that information.

But it's not required because those underlying fee-for-service rates are not negotiated. So, a capitated rate is – you meet that over the course of time, over the course of services furnished, not for any individual or particular

item or service. So, that would not – a capitated rate would not be considered a negotiated rate for an item or service.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Brian Hall.

Brian Hall: Yes. I am just a little bit concerned. I want to make sure I understood. Are we saying that that will be a maximum and minimum price for each of the commercial payers, but those commercial payers will not be identified on the charts or on the listing? And if that's the case, has anybody put any thought in the competitive aspect of that?

I live in a state here in Alabama where one commercial payer dominates the landscape. And, obviously, after this is implemented, they will be able to go online and see what the other payers are willing to accept. And I can see that – them leveraging them that down that hurting the hospitals.

Dr. Terri Postma: If you have the slides in front of you and go to slide 6, you will see that we finalized five types of standard charges that the hospitals made public. Those include the gross charge as found in the chargemaster, the discounted cash price, a payer-specific negotiated charge – that's for each payer and each payer's plan for each item and service – as well as the de-identified minimum and maximum negotiated charges that are across all of payer-specific negotiated charges. So, the hospitals would be required to post both the payer-specific negotiated charge as well as the de-identified minimum and maximum.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Felisha Murray.

Felisha Murray: Hello. My name is Felisha Murray, and I'm with Brooks Rehabilitation. We are based in Jacksonville, Florida. And my question – it does refer to page – or slide 6 where we talked about the standard charges. A lot of our contracts are just going to be a per-diem rate. And, so, I guess we can outline, "This is our gross charge, and this is our daily rate for cash."

But what's the expectation when it comes to these per-diem rates that we have negotiated with our payers in comparison to a patient is going to see this long list of all these charges? And what is the expectation for us to explain that to the patient or potential patient, I should say?

Dr. Terri Postma: Yes. Thanks for the question. So, when you are listing out the negotiated rate for a payer and payer plan, then, if there is only one line item for inpatient services, a per diem, then you would list the charge for that – for that per diem that you negotiated.

If there are other – if there's other explanatory information that you feel would benefit the individual, the consumer, the patient, please, by all means, we encourage any additional education or verbiage that you feel is important to communicate to that individual in advance of getting a service.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Molik Shaha.

Molik Shaha: This is Molik Shaha from University of Utah. A clarifying question from slide 14. Let's assume that the hospital has an Internet-based tool that meets your requirement and let's assume that there are 5,000 services or items that are provided by the hospital. And out of those 5,000 services, 1,000 of them are listed on the Internet-based tool including the 300 shoppable services.

Do you expect the rest of the 4,000 services to be listed out in the machine-readable format? Or does that – having the Internet-based tool waive that requirement?

Dr. Terri Postma: So, these are two different requirements. So, the – going back to slide – take a look at slide 8. The final rule finalizes two ways that the hospital must make public their standard charges. One is this comprehensive machine-readable file. That includes all your standard charges for all your items and services. Okay. So, everyone has to do that. Set that aside.

The second way is the consumer-friendly shoppable services. And, so, the tool would satisfy – if you have a tool that meets the requirements that are listed on slide 14, that would satisfy the requirements for making public your standard charges for shoppable services in a consumer-friendly manner. It would satisfy the second requirement.

I also just want to take the opportunity to clarify that a lot of these tools provide out-of-pocket estimates. A lot of tools that are existing provide out-of-pocket estimates for many, many more than 300 shoppable services. But we started with 300 to – for a few reasons.

First, we know that there are – we've talked to many hospitals, CEOs, and other folks that are – have been doing this for a while. And they – many of them told us that when they began their tools, they were able to begin with about 350 shoppable services or so and expand from there, so – to provide good-faith estimates. So, that's a requirement. You just have to – you just have to be able to – the tools just has to be able to provide an individualized out of pocket.

So, that's why we started with about 300 shoppable services in the – in the tool and – this Internet-based price estimator tool. And within those 300 – so, it's not limited to 300 is what I'm saying. It could have a lot more than 300. But, at minimum, it's got to have 300 and it's got to have as many as CMS – 70 CMS-specified shoppable services that are provided by the hospital. So, that's the basic requirement for the shoppable services that are in the tool.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Laura Martucci.

Laura Martucci: Hi. This is Laura Martucci from Summa Health System. And I have the question regarding the sample display of gross charges on page 11. With respect to the pharmacy charges that are listed here, what is the requirement since, obviously, patients receive different amounts of pharmaceutical items – should the price reflect one unit for the HCPCS description?

Dr. Terri Postma: Thanks for the question. This is Terri again. So, we have suggested a way that the hospital can list the gross charge for each of those items and services. So, for example, you will see at the far right there is a charge quantity. So, oftentimes, hospitals will have this information listed in this way in their chargemasters.

So, this is one way that you could do it or that your chargemaster might do it. Your chargemaster might do it in a different way by – I don't know – use a different method for creating a charge for a medication that's provided to a patient. But this is one way that's often – that's fairly common.

Leah Nguyen: Thank you.

Operator: As a reminder, if you question has been answered, to remove yourself from the queue, press the pound key. Your next – your next question comes from the line of Tanya Parton.

Tanya Parton: Good afternoon. My name is Tanya Parton. I'm from UnityPoint Health in Des Moines, Iowa. I just wanted a clarification. In the proposed rule, there was the requirement – the proposed requirement to include employee physician services with your list of shoppable services. Has that been removed?

Dr. Terri Postma: Hi. This is Terri. If you go back to slide 7 where we talked about hospital item services and what's included, we finalized our proposed definition of a hospital item with services to mean all items and services including things like supplies and procedures, room and board, facility fees, and the services of employed physicians and employed non-physician practitioners and any other items and services for which the hospital has established a standard charge. So, no, that was not removed from the final. We, in fact, finalized the definition of hospital items and services as proposed.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Amy Gendran.

Amy Gendran: Hi. Thank you for taking my question. As part of this CMS 70 shoppable services, there are included five different DRGs, which make up a very extensive plethora of services. And the final rule specifically excludes using average charges for that because it's not part of the standard charges definition. Do you plan on providing an example, as you did for some of the less complex services, for that? Or can you elaborate on how you expect us to do that and comply?

Dr. Terri Postma: Yes. Thanks for the question. So, we explained in the final rule that there are – just setting your specific question about those five aside for a moment, let's talk about service packages that hospitals – that hospitals offer. Many hospitals will negotiate a charge for a service package with providers.

A lot of payers will use DRGs. So, for Medicare, we use MS-DRGs. Right? The Medicare DRGs. But, in the private sector, a lot of payers will follow suit and hospitals and payers will negotiate a base rate for service packages that are identified by a APR-DRGs, for example, or other standard billing codes that that payer will use – it may be a payer-specific billing code – for a – for a service package.

So, that's really what we are talking about. When we are talking about hospital items and services, the hospital chargemasters have a list of individualized or itemized items and services. But, your payer contracts, the ones that you – the charges that you negotiate with payers, may be service packages. For example, somebody earlier brought up a per diem. That would be a service package. Or you might use the APR-DRGs, for example, as a service package. That has a base rate associated with it. So, that's what we are talking about here.

So, when you are making public your – let's go back to the 70 specified shoppable services. And we did provide in that list of 70 – there are five services under medicine and surgery services that have been identified by MS-DRG. And thank you for whoever sent in the comments about that being potentially confusing.

We did not intend that to be potentially confusing because, as you noted, though, MS-DRGs are specific to Medicare. And what we are talking about here in providing the base rates for payer-specific negotiated charges for those shoppable service packages is not posting an average. It's not posting the Medicare rate. You will be posting the base rate that you have negotiated for that service package with your payers.

So, we said in the final rule that you could substitute those specific DRG numbers with the – with an appropriate payer-specific billing code. So, for example, with an APR-DRG, that would be applicable. I hope that helps.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Angie Labadie.

Angie Labadie: Hi. This is Angie Labadie from UC Irvine Health. With respect to slide 15, if we go with the option of displaying in a format of Excel or a spreadsheet the services for the 300 shoppable services, did you – did you indicate that gross standard charges are not required to be part of that list?

Dr. Terri Postma: Yes. That's correct. So, for the list of shoppable services, the – if you go back to slide 12, the hospitals must display payer-specific negotiated charges, the de-identified minimum or maximum negotiated charges, and the discounted cash prices for the 300 shoppable services. So, what's excluded here is that fifth type of standard charge, the gross charge.

Leah Nguyen: Thank you.

Angie Labadie: Okay.

Operator: Your next question comes from the line of Pam Livingston.

Pam Livingston: Hello. This is Pam Livingston from Health Care Solutions. And I've got actually a follow-up question regarding slide number 11. You just indicated – and I think we talked about how these service packages can be shown on slide 14. Can you expand and provide an example of how services packages – either via per diem or an MS-DRG – how can they be shown on slide 11, which – 11 is the itemized – the CDM itemized line items. And it looks like the example I have only shows the gross charge. Can you give us an example of what that would look like expanded out for the other four standard charge types?

Dr. Terri Postma: Yes. Thanks for the question. This is Terri. So, one way – this is – it's not a requirement, but one way that a hospital could include that information in its comprehensive machine-readable file would be to create a separate tab for a specific payer, so – and, then, using your rate sheet for that payer, listing out the items and services along with the common billing codes, along with the inpatient and outpatient charge for that item or service, if different.

And, so, that's one way. You could do it instead of having to list – try to list all itemized individual services and all service packages on one tab. You choose to create separate tabs within the same file.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of William Roberts.

William Roberts: Hello. My name is William Roberts – excuse me – and I work with Memorial Healthcare System in Hollywood, Florida. And we had published our chargemaster online for the last couple of years because it's a state requirement.

But we received notification either from CMS or from our MAC not to display CPT codes because they are copyrighted by the AMA. And I know this in your presentation. You were showing CPT codes on the charges. And I understand that Medicare owns the HCPCS codes. But, have we – has Medicare made a deal with AMA to display CPT codes?

Dr. Terri Postma: Hi. Thank you for the question. This is Terri. So, you can display the HCPCS codes. At least as of the beginning of last year when hospitals were required to post their chargemasters online, the AMA had a statement on their website, so – answering some of those questions.

So, you might go back to the AMA and talk to them about that. And – but, we do not believe it's a problem because the requirement was in place starting January 1 and the AMA had actually put out a public statement saying that it was okay to post CPTs for purposes of complying with the CMS guidance.

William Roberts: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jillian Keckler.

Jillian Keckler: Hi. I have a question regarding slide 11 for the machine-readable file. When you go through …

Leah Nguyen: Are you still there?

Jillian Keckler: Are you still there?

Leah Nguyen: Yes.

Dr. Terri Postma: Yes. Go ahead.

Jillian Keckler: OK. I'm so sorry. When you go through – and similar to some of the other examples that people have referenced to – so, you may be paid, I get it, at an MS-DRG level or the DRG level. When you are trying to parse that out onto this comprehensive machine-readable file, do you all have any recommendations on how to do that so that it is consumer friendly and that it actually would be somewhat accurate?

I mean mathematically you can try to say that you're going to be paid $1,000 and these are the five normal things that would go into that particular DRG and you can just kind of mathematically assign an amount. But, that's kind of forcing the issue. So, have you guys thought through that or have any recommendations on that?

Dr. Terri Postma: So, just to repeat back what I think I heard – so, the comprehensive machine-readable file is one thing. Right? But I think you are asking about the consumer-friendly way of displaying that information. So

Jillian Keckler: No. I actually am asking about the machine-readable file. So …

Dr. Terri Postma: Okay. So (inaudible) two different things.

Jillian Keckler: Yes. So – yes. Because with the example that you have – so, like you have room and bed charges. On slide 11, you have a surgery charge, you have some meds that are on here. So, if this was an inpatient stay and the negotiated rate was based off of a DRG – right – and, so, I would be paid $1,000 – how do you then distribute that on each of those line items?

Because you are charging more than just the DRG. You are charging the room and bed for day one, the room and bed for day two, the surgery that was done on day one, the medications that were given on day one and day two. Have you guys thought through how – recommendation for us to be able to do that?

Dr. Terri Postma: So, again, when you've negotiated a service package with a payer – let's just – for ease of discussion, let's talk about that as an APR-DRG. You know what that base rate it for that DRG. Right? So, if you have that payer, let's say you create a separate tab. This is – this is gross charges that are displayed on slide 11 that represent the charges in your chargemaster.

Let's say you create a separate tab for payer X and you have a number of different service packages that you have negotiated a rate for. All you would do would be to list the description of that service package along with the APR-DRG along with the base rate. That – you don't have to list out all the individualized items and services that could be contained within that DRG or within that per diem. That's not what we are ….

Jillian Keckler: Okay. That's very helpful. Because that's one of the things that several of us have been talking kind of back and forth between some of the different health systems and that we are struggling and we are trying to figure out how to display that in the way that you have requested.

Dr. Terri Postma: Yes. I know. We understand that would be a challenge. But, it's a single – it's a single negotiated charge for a service package. What goes into that package can vary from patient to patient and whatever. But all we are asking you to do is provide the description of that service package along with its code, along with its base rate that you have negotiated.

Jillian Keckler: Okay. Thank you.

Leah Nguyen: Thank you. Dorothy, we have time for one final question.

Operator: Your final question comes from the line of Austin Kaval.

Austin Kaval: Hi, there. In terms of posting charges for employed physicians, my question is more in regards to that definition of an employed physician. Would that include associated physician groups as well or just employees actually employed by the hospital itself?

Dr. Terri Postma: Yes. There are a lot of different arrangements that hospitals have. They might own the clinic but the practitioners themselves are contracted, not employed. In that instance, we are not talking about posting the charges for those contracted practitioners. We are specifically talking about practitioners that have been employed by the hospitals and the charges that are negotiated by the hospitals for those services.

Austin Kaval: Yes. I understand that. But, if the physician group is owned by the hospital, is that considered an employee of the hospital itself and, therefore, need to post those charges?

Dr. Terri Postma: It depends on your arrangement with the practitioners. If they are employed – if the practitioners themselves are employed by the hospital, then you would include those charges. If there are – if there are some other arrangement like a contracted arrangement, not an employment arrangement, then you would not include those charges.

Leah Nguyen: Thank you.

Austin Kaval: Okay.

## Additional Information

Leah Nguyen: Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 23. We hope you will take a few moments to evaluate your experience. See slide 24 for more information. An audio recording and transcript will be available in about two weeks at go.cms.gov/npc.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on Hospital Price Transparency. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.