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CY24 OPPS FINAL RULE (CMS-1786-FC) FOR UPDATES TO HOSPITAL PRICE TRANSPARENCY REQUIREMENTS – SUMMARY OF UPDATES

Provided by: Cleverley + Associates

BACKGROUND

The CY24 OPPS Final Rule contains additional information and requirements regarding hospital price transparency. The changes build on transparency requirements previously established through the following rules:

1) **FY19 IPPS Final Rule**:
    a. The FY19 IPPS Final Rule initiated requirements in order for hospitals to comply with language in the Affordable Care Act. The rule 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, or more often as appropriate. This could be in the form of the chargemaster itself or another form of the hospital's choice, as long as the information is in machine readable format."
2) **CY20 OPPS Final Rule on Transparency**:
    a. As a continuation of the FY19 IPPS Final Rule, the CY20 OPPS Final Rule on Transparency introduced additional clarification and requirements for hospitals. These requirements became effective on January 1, 2021 and included the following key elements:
        i. A definition of "hospital" that requires nearly all hospitals to comply with the rule,
        ii. Definitions for five types of "standard charges" to be disclosed by hospitals (gross charge, discounted cash price, payer specific negotiated charge, and the deidentified minimum and maximum negotiated charge)
        iii. A definition of hospital "items and services" that include all items and services (including individual items, services, service packages, and employed professional fees) provided by the hospital to a patient in connection with an inpatient admission or an outpatient department visit;
        iv. Requirements for making public a machine-readable file that contains all definitions of standard charges for all items and services and service packages provided by the hospital;
        v. Requirements for making certain standard charges public for select hospital-provided items and services that are "shoppable" and that are displayed in a consumer-friendly manner – either through a file or a web-based patient estimation tool;
        vi. Non-compliance monitoring, actions, civil monetary penalties, and appeal process.
3) **CY22 OPPS Final Rule**:
    a. The key updates for hospitals in the CY22 OPPS Final Rule were a significant increasing of the monetary penalties for non-compliance and the prohibition of barriers to automatic download of the machine-readable file on a hospital's website.

In the following pages, we will outline the key changes contained within the CY24 OPPS Final Rule.

CY24 OPPS FINAL RULE SUMMARY FOR UPDATES TO TRANSPARENCY REQUIREMENTS

There are five key updates provided in the final rule, as follows:

1) Definitions for several terms
2) A requirement that hospitals make a good faith effort to ensure standard charge information is true, accurate, and complete, and to include a statement affirming this in the MRF
3) Establishing new data elements that hospitals must include in their MRFs, as well a requirement that hospitals encode standard charge information in a CMS template layout
4) A requirement that hospitals include a .txt file in the root folder that includes a direct link to the MRF and a link in the footer on its website that links directly to the publicly available webpage that hosts the link to the MRF
5) Changes to the enforcement process by updating the methods to assess hospital compliance, requiring hospitals to acknowledge receipt of warning notices, working with health system officials to address noncompliance issues in one or more hospitals that are part of a health system, and publicizing more information about CMS enforcement activities related to individual hospital compliance.

All of the above elements have a phased timeline for implementation ranging from January 1, 2024 to January 1, 2025. We now summarize the key areas above.

1) DEFINING NEW TERMS

The most significant update to the Hospital Price Transparency (HPT) requirements contained in the CY24 OPPS Final Rule is a new mandate for hospitals to disclose information in the single, comprehensive machine-readable file (MRF) through a new CMS template. In November 2022, CMS released a voluntary sample format that hospitals could utilize to display the contents of the MRF. That sample format, with some additional changes described later, is now required beginning July 1, 2024. In order to accomplish the requirement for a template, CMS needed to codify new terms and approaches within the federal regulations. As a result, CMS has codified the following terms, as follows:

1) **"CMS template"** means "a CSV format or JSON schema that CMS makes available for purposes of compliance with the requirements of § 180.40(a)."
2) **"Estimated allowed amount"** *(previously Consumer Friendly Expected Allowed Amount in the proposed rule)* means "the average dollar amount that the hospital has historically received from a third party payer for an item or service." **Note that in the proposed rule, CMS proposed this field would relate to "expected" payment – not historical payment. This new field will be described in more detail in a forthcoming section.*
3) **"Encode"** means "converting hospital standard charge information into a machine-readable format that complies with § 180.50(c)(2)."
4) **"Machine-readable file"** means "a single digital file that is in a machine-readable format."

2) GOOD FAITH EFFORT & MRF ATTESTATION

In this section CMS explains the need for hospital leadership to affirm the completeness of the content within the MRF. Specifically, CMS finalizes two actions:

1) **Beginning July 1, 2024, the hospital must affirm in its MRF that, to the best of its knowledge and belief, the hospital has included all applicable standard charge information in its MRF, in accordance with the requirements of § 180.50, and that the information encoded is true, accurate, and complete as of the date indicated in the MRF.**
2) Beginning January 1, 2024, each hospital must make a good faith effort to ensure that the standard charge information encoded in the MRF is true, accurate, and complete as of the date indicated in the MRF.

Hopefully, all hospitals are already complying with item #2 and will simply need to use the bolded language above to insert into their MRF beginning July 1, 2024 as part of the new CMS MRF template.

3) STANDARDIZING THE MRF FORMAT AND DATA ELEMENTS

In the CY22 OPPS Proposed Rule, CMS sought comment for standardizing the format and data contained in the MRF. The outcome of that feedback and a technical expert panel combined to produce the recommendations for a voluntary sample format that was released in November 2022. The CY24 OPPS final rule builds on that voluntary sample to create a new required file format and data elements.

First, we'll discuss the additional data elements that will now be part of the required template. Keep in mind that these new data elements will supplement the already required elements relating to the five types of standard charge for all items, services, and service packages. No previously required element is being eliminated, only new elements are being added.

NEW GENERAL DATA ELEMENTS:

1) **Hospital name(s), license number, and location name(s) and address(es)** under the single hospital license to which the list of standard charges apply. Location name(s) and address(es) must include, at minimum, all inpatient facilities and stand-alone emergency departments.
    a. *CMS modified the proposal for ALL hospital related addresses to be shown. The following text explains: "To reduce burden, we will therefore finalize a modification to the requirement. Specifically, we will require that hospitals encode the name(s) and address(es) of each hospital inpatient location and each standalone emergency department in the MRF. While strongly encouraged, it will not be required to encode all outpatient locations. We note, however, that even though we are making this practical accommodation, hospitals must still include all standard charge information in the MRF, including standard charge information for outpatient locations not encoded for this data element."*
2) The **version number of the CMS template and the date of the most recent update** to the standard charge information in the machine-readable file.

NEW REQUIRED DATA ELEMENTS RELATING TO TYPES OF STANDARD CHARGES:

1) **Setting** - specifically, whether the item or service is provided in connection with an inpatient admission, outpatient department visit, or both
2) **Payer and plan** – CMS is creating a technical revision for payer and plan to be separate data elements in the MRF. In addition, CMS provides that plan(s) may be indicated as categories (such as ''all PPO plans'') when the established payer-specific negotiated charges are applicable to each plan in the indicated category.

3) **Standard charge methodology** – CMS is creating this data element to describe the type of contracting method used to establish the payer specific negotiated standard charge. There is a list of valid values below. Please note that "Other" is an option which will likely be best when the payer specific negotiated charge is represented as an algorithm (more information to come).

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.

4) **Standard charge value interpretation** – 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 believes that "most if not all payer-specific negotiated charges will fall into one of three categories, depending on how a hospital has established them: (1) standard dollar amount, (2) standard algorithm or percentage, or (3) hybrid where a standard dollar amount can be identified but the final allowed amount is dependent on additional variables."

   CMS is finalizing that "the hospital will be required to indicate in its MRF whether the standard charge indicated 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. 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." CMS does, however, "agree with commenters that having to display a detailed algorithm within an MRF would be unwieldy and burdensome." Inasmuch, CMS clarifies that the hospital should "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."

5) **Estimated Allowed Amount** *(originally proposed as Consumer friendly expected allowed amount)* – One of the more significant additions to the MRF template is the "Estimated Allowed Amount." The element is defined as "the average dollar amount that the hospital has historically received from a third party payer for an item or service." However, this new data element only needs to be populated for payer-specific negotiated charges where the standard charge value is interpreted as either a percentage or algorithm (described in the point above). This data element has a required date on January 1, 2025, as opposed to July 1, 2024 when nearly all others are required.

    a. CMS provides the following use case, as an example:
    Patients X and Y are under the same payer's plan. They both go to a hospital for the same procedure. The hospital submits a claim to the payer for the total gross charges associated with itemized items and services provided to each patient. The payer analyzes the claims and assigns the same DRG code. The gross charges (that is, the charges billed on the claim to the payer) for each itemized item and service provided by the hospital for Patient X's procedure total $1500, while Patient Y's gross charges for each itemized item and service provided by the hospital total $2000. The hospital and payer have negotiated a payerspecific negotiated charge that is calculated as an amount equal to 50 percent off the total gross (or billed) charges for the procedure identified by the DRG code. The resulting charge (in dollars) for Patient X would be $750 while resulting charge (in dollars) for Patient Y would be $1000. In this example, the payer-specific negotiated charge (as an algorithm) is the same for each patient in the payer's plan for the procedure, but it is possible that each patient covered under this payer's plan would have a different resulting charge, in dollars, for the same procedure. In other words, in this example, there is no single dollar amount that would be appropriate for the hospital to post in its MRF as the payer-specific negotiated charge. Instead, the only payer-specific negotiated charge that applies to the group is the algorithm used to calculate the individualized dollar amount (in this example, the algorithm would be "50 percent of the total gross charges" that are billed on the claim for the procedure).

As proposed, this data element was called Consumer friendly expected allowed amount and represented the "the amount, on average, that the hospital estimates it will be paid for the item or service based on the contract with the third party payer." However, this prospective view was revised for the final rule. As finalized, it represents the "average reimbursement in dollars that it (the hospital) has received from the payer in the past, that is, what some might call an 'historical allowed amount.'" As such, "to avoid confusion, we (CMS) will modify the definition to refer to the average amount 'historically received' (rather than 'expects to be paid', and also rename the data element "estimated allowed amount.""

CMS preserves the flexibility for how the hospital should derive this value, but, does specifically share that "using information from the EDI 835 electronic remittance advice (ERA) transaction, the electronic transaction that provides claim payment information, including any adjustments made to the claim, such as denials, reductions, or increases in payment, 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."

CMS does provide guidance on value suppression for this data element, namely, that values derived from patient claims experience representing less than 11 patients could be excluded. This is only guidance and meant for consideration in development of the MRF. One point to consider, however, is that if the "less than 11" exclusion criteria is followed, many hospitals would struggle to provide information at the payer/plan level for many items, services, or service packages. This might create situations where the MRF is viewed negatively by consumer advocacy groups and/or CMS. Because volume counts aren't required, it's highly unlikely – even impossible – for any patient identifiable information to be obtained through the MRF.

NEW REQUIRED DATA ELEMENTS RELATED TO HOSPITAL ITEMS & SERVICES
CMS finalizes the addition of:

1) **General description of the item or service**
2) **Whether the item or service is provided in connection with an inpatient admission or an outpatient department visit (or both)**
3) And, beginning January 1, 2025, for drugs, the **drug unit and type of measurement**

The last two items described in #3 could be more challenging for hospitals to work through. CMS provides the following description for why these fields are being added. "As example, if a hospital establishes a gross charge of $2 for an item or service it describes as 'aspirin 81mg chewable tablet – each,' the hospital would be required to input data for each of the required separate data elements, which would look something like this in the MRF, based on the current technical specifications in the data dictionary that accompanies the currently available sample templates: gross charge: 2; description: aspirin 81mg chewable tablet; unit of measurement: 1; type of measurement: UN."

CMS shared that more technical guidance is coming, but, does offer the following valid values:

VALID VALUES FOR DRUG TYPE

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

REQUIRED DATA ELEMENTS RELATED TO ITEM OR SERVICE BILLING
CMS is codifying new fields relating to code types – including modifiers. There are two new fields in the MRF as a result.

1) **Code & Code Type:** The first relates to "any code(s) used by the hospital for purposes of accounting or billing for the item or service at new; and corresponding code type(s)." Current valid values are listed in the table below. Note that this represents a list of *possible* values, not meant to imply an expectation that all hospitals will have need to use all of them.

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

2) **Modifier**: In addition, beginning January 1, 2025, "the hospital must encode 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 would change the standard charge." Note that the hospital is only required to include modifiers when "they are necessary to provide the additional context needed for the standard charges the hospital has established." CMS agrees "it is unnecessary to include modifiers that do not impact or change the standard charges established by the hospital." This point is important as there are many modifiers used that have no impact on standard charges.

CMS TEMPLATE

All of the existing and new data elements, described above, will be contained in a CMS template. 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 – such as XML were permitted, but, the new CMS templates would only be permitted in the above formats. This likely won't pose much of an issue to hospitals as these two formats are currently widely used for the MRF delivery.

Technical guidance for the template and data elements can be found here:
https://github.com/CMSgov/hospital-price-transparency

Please note that 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.

MACHINE READABLE FILE TEMPLATE DATA ELEMENTS:
The table below presents the current CMS version 2.0 data elements with corresponding definition and date for inclusion. Note that the new template will not be in effect until July 1, 2024 with some additional elements being required on January 1, 2025. This will mean that hospitals posting on July 1, 2024 will need to include the January 1, 2025 fields, or, be ready to update the MRF again on January 1, 2025 with those data elements.

Name	Definition	Requirement Date
Hospital Name	The legal business name of the licensee.	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)	July 1, 2024
CMS Template Version	The version of the CMS Template used.	July 1, 2024
Hospital Location(s)	The unique name of the hospital location absent any acronyms.	July 1, 2024
Hospital Address(es)	The geographic address of the corresponding hospital location.	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.	July 1, 2024
Affirmation Statement	Required affirmation statement. Valid values: true and false. See additional affirmation notes for more details.	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.	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.	July 1, 2024
Code Type(s)	The corresponding coding type for the code data element. There is a list of the valid values.	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".	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.	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.	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.	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.	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.	July 1, 2024
Plan Name	The name of the payer's specific plan associated with the standard charge.	July 1, 2024
Modifier(s)	Include any modifier(s) that may change the standard charge that corresponds to hospital items or services.	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.	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.	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.	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.	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.	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.	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."	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.	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.	July 1, 2024

Optional Data Elements		
Name	Definition	Requirement Date
Hospital Financial Aid Policy	The hospital's financial aid policy. See additional financial aid policy notes for more details.	Optional
Billing Class	The type of billing for the item/service at the established standard charge. The valid values are "professional", "facility", and "both".	Optional

4) REQUIREMENTS TO IMPROVE ACCESS TO HOSPITAL MRFs

CMS finalized two key elements with regard to MRF accessibility:

1) That a hospital ensures the public website includes a .txt file in the root folder that includes a standardized set of fields including the hospital location name that corresponds to the MRF, the source page URL that hosts the MRF, a direct link to the MRF (the MRF URL), and hospital point of contact information.
2) That the hospital ensure its public website includes a link in the footer, including but not limited to the homepage, that is labeled "Price Transparency" (instead of "Hospital Price Transparency") and links directly to the publicly available web page that hosts the link to the MRF.

5) REQUIREMENTS TO IMPROVE & ENHANCE ENFORCEMENT

Assessment Activities

CMS currently has the authority to monitor and assess a hospital's compliance position. However, the regulatory language for allowed activities provides more ability to monitor as opposed to assess and CMS is seeking to strengthen the regulatory language as it relates to assessment activities. To do so, three primary actions are finalized:

- To revise existing rule language to "indicate that CMS may conduct a comprehensive compliance review of a hospital's standard charge information posted on a publicly available website, in addition to the use of audits which will be retained."
- To add language, "we will require, upon our request, an authorized hospital official to submit to CMS a certification to the accuracy and completeness of the standard charge information posted in the MRF."
- To add language, "we will require submission to us, upon our request, additional documentation as may be necessary to make a determination of hospital compliance."

Requiring hospitals acknowledge receipt of warning notices

CMS also proposed and is finalizing that hospitals "submit an acknowledgement of receipt of the warning notice in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital."

Addressing noncompliance within hospital systems

If a hospital found to be noncompliant is part of a health system, CMS includes language that would permit CMS to "notify the health system leadership of the action and may work with hospital system leadership to address similar deficiencies for hospitals across the health system."

Publicizing compliance actions and outcomes

Finally, 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."

CONCLUSION

We hope this summary of the CY24 OPPS Final Rule Hospital Price Transparency Updates has been helpful. We recognize that there is a significant amount of change specified in the rule and welcome any questions you may have as you develop your MRF compliance plan.