Cleverley + Associates

A RESPONSE TO THE CY24 OPPS PROPOSED RULE (CMS-1786-P) FOR UPDATES TO HOSPITAL PRICE TRANSPARENCY REQUIREMENTS

Provided by: Cleverley + Associates

BACKGROUND

The CY24 OPPS Proposed Rule contains additional information and requirements regarding hospital price transparency. The proposed changes would 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 proposals contained within the CY24 OPPS Proposed Rule with feedback to consider when responding to CMS in the comment window which ends on September 11, 2023.

CY24 OPPS PROPOSED RULE SUMMARY FOR UPDATES TO TRANSPARENCY REQUIREMENTS

There are three primary components pertaining to hospital price transparency contained in the CY24 OPPS Proposed Rule:

1) Proposal to modify the requirements for making public hospital standard charges
2) Proposals to improve and enhance enforcement
3) Seeking comment on consumer-friendly displays and alignment with Transparency in Coverage and No Surprises Act

We now summarize the key areas above with feedback to be considered by hospitals in their comments to the CMS.

1) MODIFYING CURRENT TRANSPARENCY REQUIREMENTS

The most significant proposal in the CY24 OPPS Proposed Rule that would alter the way hospitals disclose information in their single, comprehensive machine-readable file (MRF) is the use of a CMS template to display the transparency data. In November 2022, CMS released a voluntary sample format that hospitals could utilize to display the contents of the MRF. We assumed that at some point in the future this "voluntary" sample would transition to a requirement. If finalized, that voluntary format – with some additional modifications contained in the proposed rule – would be required beginning January 1, 2024. In order to accomplish the requirement for a template, CMS must first codify new terms and approaches within the federal regulations. This section explains those necessary proposed updates:

DEFINING NEW TERMS

CMS would codify definitions for 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) **"Consumer-friendly expected allowed amount"** means the average dollar amount that the hospital estimates it will be paid by a third party payer for an item or service.
3) **"Encode"** means to enter data items into the fields of the CMS template.
4) **"Machine-readable file"** means a single digital file that is in a machine-readable format.

Most notable among these definitions is for the term "Consumer-friendly expected allowed amount." CMS has recognized that there are numerous instances where the payer-specific negotiated charge amounts cannot be listed as a dollar amount as the establishment of the charge is based on an algorithm that is dependent on patient utilization to determine. We completely agree with this assessment and would further say that virtually all payer specific negotiated charges are determined by an algorithm and require patient specific utilization to determine values. Beyond percentage of charge contracts, fixed contracts have a multitude of custom carveout, lesser-of, and stoploss provisions that impact the patient's standard charges. The consumer-friendly expected allowed amount is essentially the average expected payment across a set of payer claims that would be listed when a payer specific negotiated charge is not able to be provided. We will explain more on this field later and how it might connect with additional new fields, however, we do agree that this data element should be added but with a modified definition. We present our proposed comments to CMS regarding this section below:

Cleverley + Associates Comment to CMS:
Given the proposed changes to utilize a CMS template for disclosing the contents of the machine-readable file, we understand and agree with the addition of the definitions. However, we would suggest modifying the definition of "Consumer-friendly expected allowed amount" to read: **"the average dollar amount that the hospital estimates it will be paid by a third party payer for patient claims that include items, services, or service packages."**

We believe it's important to emphasize the term "patient claim" within the definition because that is the only level where hospitals would calculate or store this data element. We also feel that adding "service packages" into the definition will provide consistency with the definition of standard charge and permit appropriate disclosure of these claim-driven values as they would be grouped at the service package level.

REQUIRING HOSPITALS TO AFFIRM THE ACCURACY/COMPLETENESS OF THE MRF CONTENT
In this section CMS explains the need for hospital leadership to affirm the completeness of the content within the MRF. Specifically, CMS would add language that would "require that, in its MRF, each hospital add a statement affirming 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 displayed is true, accurate, and complete as of the date indicated in the file."

This idea of an attestation has been discussed previously and was not a surprise to see in the rule. Given other hospital reporting documents that have similar provisions, we do not see this as a significant concern but would recommend that CMS add this to the template as it is currently not contained in the available sample.

Cleverley + Associates Comment to CMS:
We believe this is a reasonable addition to the MRF. We note that this field is not currently contained in the available V1.1 HPT sample and might suggest that if/when the field is added to the template that sample language be provided. Also, our reading of this particular attestation language in the rule is that it pertains to the "organization" only and not any single individual. Essentially, that the organization is attesting to the completeness and accuracy of the data through a statement on the MRF. We are aware, however, of some potential confusion with this attestation and later language in the enforcement proposal for an individual to attest to the file's contents. We might suggest that if this first attestation for the MRF is approved for the final rule that some additional confirmation of this point could be useful to avoid confusion.

STANDARDIZING THE MRF'S 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 current proposed rule would leverage that sample with some additional modifications in the following ways:

First, CMS would 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.

The data elements contained in the template are contained in the table below:

MACHINE READABLE FILE TEMPLATE DATA ELEMENTS:

DATA ELEMENT	DESCRIPTION
hospital_name	The legal business name of the hospital associated with the file
last_updated_on	The date the file was last updated on
version	The CMS template version being used (currently V1.1 is latest available)
hospital_location	If the MRF contains identical standard charges for multiple hospital locations, list each location
hospital_address	Physical address associated with the hospital MRF file
financial_aid_policy	*Optional* text field describing the hospital's financial aid policy
license_number | [state]	The hospital license number and the licensing state or territory's two-letter abbreviation for the hospital location(s)
description	Description of the item, service, or service package
code | [i]	Any alphanumeric code used by the hospital for purposes of accounting or billing for the item or service
code | [i] | type	Associated code type for the alphanumeric code (CDM, HCPCS, MSDRG, etc)
billing_class	*Optional* value describing setting of Professional or Facility
setting	Inpatient, Outpatient, or Both designation
drug_unit_of_measurement	The unit value that corresponds to the established standard charge for drugs
drug_type_of_measurement	The measurement type that corresponds to the established standard charge for drugs
modifiers	Applicable modifiers used for billing purposes
standard_charge | gross	The CDM gross charges
standard_charge | discounted_cash	Any discounted cash price that has been established - this is not a requirement for a hospital to have established
payer_name	Name of the payer associated with the payer specific negotiated charges
plan_name	Plan name (PPO, HMO, etc)
standard_charge | negotiated_dollar	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.
standard_charge | negotiated_percent	This field should be used only when the payer-specific negotiated charge cannot otherwise be displayed as a single dollar amount.
standard_charge | min	De-identified minimum negotiated charge is the lowest that a hospital has negotiated with all third-party payers
standard_charge | max	De-identified maximum negotiated charge is defined as the highest charge that a hospital has negotiated with all third-party payers
consumer_friendly_expected_allowed_amount	The average expected payment for the applicable payer for that service
standard_charge | contracting_method	The type of contracting method utilized by the payer
additional_generic_notes	A free text data element to help explain any of the data including standard charges based on algorithms, blank values due to no applicable data, or other contextual information that aids in the comprehension of the standard charges
additional_payer_notes	A free text data element to help explain any of the data in the file that is related to a payer-specific negotiated charge. If a payer-specific negotiated charge can only be expressed as an algorithm, the algorithm should be indicated here.

While many of the above data elements are already required fields or may not represent a significant challenge for hospitals to add, we do offer the following points for consideration in our comments to CMS listed below.

Cleverley + Associates Comment to CMS:
We appreciate the development of a standardized template for hospitals to utilize in the creation of their machine-readable files. We also believe that the inclusion of some of the additional data elements will help with the identification and utilization of the included data. We do offer the following considerations for certain data elements that we believe could be useful for the final rule.

1) File format – we are generally agreeable with the file schemas developed for the JSON and CSV templates and appreciate allowing hospitals some flexibility in choosing which method will be most appropriate for them.
2) Data elements – while many data elements are already required or should require little additional effort to include, we do offer some specific feedback for the following:
    a. **Drug Unit & Type of Measurement** – we understand the need for transparency in drug charges. These fields, however, are not always established separately or in readily accessible databases for many hospitals. Some hospitals develop their own code descriptions that contain this information and some leverage HCPCS-related dosing descriptions. The effort to establish an electronic database with these fields could be a very significant undertaking for many hospitals. We would propose making these fields optional with potentially a later date for requirement.
    b. **Standard Charge – Gross (*TYPE*)** – we would like to suggest the addition of another field called "Standard Charge – Gross Type" that would allow hospitals to indicate any specialty pricing schedules they maintain. These schedules go beyond patient type and can include special lab, imaging, or clinic prices as examples. Our firm currently discloses these prices in separate "columns" side-by-side with standard/default gross charge data. We would continue to include them with clarifying information in the "Additional Generic Notes" field, however, we believe that these schedules are so common that it could warrant an additional data element for "Standard Gross Charge – Type." Because other clarifying notes could be contained in the "Additional Generic Notes" field we wanted to offer a suggestion to account for these common pricing structures.
    c. **Contracting Method & Consumer Friendly Expected Allowed Amount** – we are very encouraged by the addition of these fields into the MRF template. In the end, all contracting methods and negotiated rates established between hospitals and payers exist to derive this expected payment amount that will be dependent on the items, services, and service packages utilized during the healthcare encounter. Our firm has partnered with hundreds of hospitals annually for over twenty years to evaluate charge positions. In these studies, we have modeled thousands of hospital contracts and would submit that **all hospital payment is based on an algorithm** and that is why we are pleased to see it represented. Inasmuch, we contend that the only way to complete the MRF will be to list "algorithm" in the "contracting method" field as we do not see examples where the other options exist on their own. In each of the other available options (case rate, fee schedule, percent of total billed charges, per diem), we see exceptions for item or service carveouts with different payment terms, claim-level

lesser-of and stop-loss provisions, percent of charges minimum and not to exceed clauses, and length-of-stay dependent reimbursement differences to provide only a few examples. As described in the proposed rule, our firm would plan to note that these situations exist in the additional payer notes field and then provide the consumer-friendly expected allowed amount. We caution, however, that the multitude of algorithm logic is impossible to contain within a text field in the additional payer notes. That logic would include elements, as follows:

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

As seen, the logic elements are complex and the corresponding lists of hundreds or thousands of different types of codes and values make a note containing this level of detail impossible. Our firm and others have created data algorithm systems to house these conditions and codes and "price" each claim uniquely. We do not see a way to list that logic in a cell but plan to provide the following note in the additional payer notes filed: "*Conditional payment logic at the claim level including numerous contracting methods, hierarchical applications, and service utilization requirements. Standard charge provided accounts for these structural rates, conditions, and utilization.*"

We believe this will provide context to the algorithm in fulfilling the proposed rule's language. Further, we don't believe that the absence of the myriad data points contained in algorithm logic is problematic as the intended result of providing it would be to calculate the expected payment amount. Meaning, if all of the immense detail behind the hospital/payer logic were provided (which would be impossible in a single cell - or even multiple cells - given the constraints discussed), technology developers would still need to infuse patient claim experience to calculate a field that would represent the contents of the Consumer Friendly Expected Allowed Amount. Further, the value they would calculate would not be specific to the typical treatment course utilized by the hospital's patients as they would likely not have that hospital's patient claims detail.

In sum:

1. We completely agree that "Contracting Method" be included in the MRF template with the option of "algorithm" for a method as we believe that all hospital payment is based on an algorithm.

2. We completely agree that a "Consumer Friendly Expected Allowed Amount" be included in the MRF template as that is the field that is most important to patients and would be the desired outcome of any developer-led initiative to take the contents of the MRFs to calculate.
3. We completely agree that a statement be provided in the additional payer notes to footnote that the contents of the Consumer Friendly Expected Allowed Amount is built using an algorithm that encompasses a multitude of factors. We caution, however, against any expectation that the multitude of those factors that includes code lists, values, conditions, and hierarchies which are built into a claims processing system be expected to be provided within that single "additional notes" cell.

TIMING & ENFORCMENT

The proposed rule also contains some key provisions for timing and enforcement. First, the new format and data elements described previously would be required beginning January 1, 2024 with a 60-day grace period for enforcement. We believe this timing is much too soon given that many hospitals have already or will be finalized with their files when the final rule is published. We provide the following comments for consideration as it relates to timing.

Cleverley + Associates Comment to CMS:

As it relates to timing, we believe that January 1, 2024 with a 60-day grace period for enforcement is unreasonable for hospitals to meet. The current rule specifies that the data provided in the MRF be updated at least annually. To meet that provision, many hospitals that have a July 1 fiscal year beginning and make charge updates on that date have already invested and produced their files for their FY2024. In addition, for others that would plan to update on January 1, 2024, the final rule would likely be released within 45-60 days of the date. We have many clients that will have already produced their files given current guidelines before that date as they prepare for implementing FY24 pricing. Most hospitals budget time and monetary resources to the production of the MRF files and this date will burden them to duplicate the expenditure of those resources within their current budget year. We strongly believe that the new format and data element requirements should be effective January 1, 2025. That will give all hospitals the ability to incorporate the changes into their next MRF regardless of their fiscal year budgeting cycle. Another option could be that files marked posted/effective before March 1, 2024 (the 60-day grace period) would be considered compliant given the current requirements. This would also allow hospitals that have invested time and monetary resources to meet the current requirements the ability to leverage those investments for the full year they were anticipating and planning for in their financial and operational budgets. In the end, we believe it will be less confusing to simply have January 1, 2025 be the beginning date for utilizing the new CMS template and data elements.

ACCESSIBILITY

CMS also proposes two key elements with regard to MRF accessibility:

1) That a hospital ensures that the public website it uses to host the MRF include 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, and hospital point of contact.

2) That the hospital ensure the public website includes a link in the footer on its website, including but not limited to the homepage, that is labeled ''Hospital Price Transparency'' and links directly to the publicly available web page that hosts the link to the MRF.

Cleverley + Associates Comment to CMS:
As for the accessibility proposals, we do not see substantial technical difficulty with implementing either the .txt file or "Hospital Price Transparency" homepage footer link. We do believe that the .txt file is largely duplicative, though, as the proposed MRF template fields would contain hospital location information and the proposed homepage footer link would address the URL issue. The only remaining item could be "contact" information and we wonder if that could be added to the MRF? However, it would be important to reference a department phone number or email, however, as individuals might transition to new roles. Contact information might also be addressed by many organizations as often hospitals list a resource to contact for additional information on their transparency pages. In sum, we believe the homepage footer could be useful to enhance transparency tool accessibility but do not believe the .txt file has much additional value given the points above.

2) ENFORCEMENT PROPOSALS

CMS has also included proposals for some key changes to enforcement authority. We outline these proposed changes below.

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, four primary proposals are made:

- To revise existing rule language to indicate that "CMS may conduct a comprehensive compliance review of a hospital's standard charges information posted on a publicly available website."
- To add language, "requiring an authorized hospital official to submit to CMS a certification to the accuracy and completeness of the standard charges information posted in the MRF at any stage of the monitoring, assessment, or compliance phase."
- To add language, "requiring submission to CMS of additional documentation as may be necessary to assess hospital compliance. Such documentation may include contracting documentation to validate the standard charges the hospital displays, and verification of the hospital's licensure status or license number, in the event that information was not provided in the MRF."
- To revise existing language to read ''Monitoring and Assessment'' and amending 180.90 by revising paragraph (b)(2)(ii)(C) to remove the phrase ''resulting from monitoring activities'' and adding in its place the phrase ''resulting from monitoring and assessment activities.''

Cleverley + Associates Comment to CMS:
We understand the need for the public to believe that posted hospital transparency information is accurate. We believe the MRF attestation will help address this concern and appreciate CMS including it in this proposed rule. We are concerned about some of the additional "assessment" components, however.

1) First, how will the "comprehensive compliance reviews" be initiated and what would they entail? Meaning what issues will CMS use as a basis for initiating a comprehensive compliance review? The example issues provided in the proposed rule for requiring this review involve data completeness questions (some deficiency in reporting a required field or questions around discount cash pricing) and/or a question from the public (presumably regarding the same). CMS writes "We expect that many of these issues would be resolved if the proposed improvements to standardizing display of hospital standard charges (as discussed in section XVIII.B.3 of this proposed rule) are finalized as proposed." If so, is this additional language necessary? If this language is to be considered, we would recommend the criteria for a comprehensive review be established and included in proposed rule language before finalized so hospitals can have an opportunity to understand and provide appropriate comment.
2) We also question the availability of assessment activities within the reviews to require "submission to CMS of additional documentation as may be necessary to assess hospital compliance. Such documentation may include contracting documentation to validate the standard charges the hospital displays, and verification of the hospital's licensure status or license number, in the event that information was not provided in the MRF." While the license number is not an issue, the potential magnitude of time and documentation inherent in this short sentence is profound. Coupled with the uncertainty of when a comprehensive compliance review can be initiated as described in the first point, hospitals would be very concerned about the potential investment of resources involved in pulling and supporting this activity.

We believe, however, that CMS has proposed this language to be able to validate transparency disclosure data when reasonable questions arise. We do understand this need and would propose alternative language that would involve the following steps:

1) CMS determines reasonable issue(s) that disclosed transparency data is inaccurate. This finding would be different from a clear violation of HPT requirements, such as not providing required field data. In those cases, a noncompliance letter would immediately be issued.
2) CMS sends a "Request for Discussion" letter with the identified issue(s) described and a request for a web conference call to discuss with hospital administrators. The purpose of the call will be for CMS to convey the specifics of the issue(s). Hospital administrators can, at that time, address them or schedule a follow-up call within a determined amount of time to discuss. Should the outcome be a satisfactory explanation that the contents of the disclosure are accurate then the matter would be considered resolved.
3) If CMS and/or the hospital determine that the file's contents were displayed inaccurately, CMS can issue a formal noncompliance letter and have the hospital work through the noncompliance/CAP process as described in existing language.

We believe the exploratory conversations will help the hospital and CMS create an efficient process to address reasonable concerns. If a hospital is noncompliant, then there would be an existing process to work through.

Finally, we do disagree with including the provision for "requiring an authorized hospital official to submit to CMS a certification to the accuracy and completeness of the standard charges information posted in the MRF at any stage of the monitoring, assessment, or compliance phase." We believe no one person can certify all the contents of the MRF as it involves so many different individuals and teams. We agree with the proposed organization attestation in the MRF but believe this individual attestation is not appropriate and could introduce personal liability that will create challenges. We also believe that

the request for a primary point of contact for MRF questions contained in the "acknowledgement of warning notices" language is reasonable and should address this issue.

Requiring hospitals acknowledge receipt of warning notices
CMS also proposes 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. As part of the confirmation of receipt, we may request contact information from the hospital to streamline further communications."

Cleverley + Associates Comment to CMS:
We believe this is reasonable and should negate the need for an individual attestation as it would provide a primary point of contact at the hospital to work through any compliance questions.

Addressing noncompliance within hospital systems
If a hospital found to be noncompliant is part of a health system, CMS includes proposed 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."

Cleverley + Associates Comment to CMS:
We believe this is a reasonable addition and could help health system leadership have confidence that all system hospitals would be well positioned for compliance after resolving any questions or concerns with the identified hospital(s).

Publicizing compliance actions and outcomes
CMS proposes that it "may publicize on its website information related to CMS' assessment of a hospital's compliance, any compliance actions taken against a hospital, the status of such compliance action(s), and the outcome of such compliance action(s). Additionally, we propose…that CMS may publicize on its website information related to notifications that CMS may send to health system leadership."

Cleverley + Associates Comment to CMS:
We understand the need for compliance accountability and using website posting to encourage growth in compliance. We also understand the need to communicate with the public in situations where compliance questions have been raised. We believe the following should be considered for final rule adoption for each of the situations currently raised:

1) **Any compliance action, status of such compliance action(s), and outcome of such compliance action(s)**

   In response to this proposal, we note the following language in the proposed rule:
   "As of June 27, 2023, CMS had issued approximately 906 warning notices and 371 requests for CAPs since the initial regulation went into effect in January 2021. Approximately 301 hospitals were determined by CMS after a comprehensive compliance review to not require any compliance action and approximately 457 hospitals received a closure notice from CMS after having addressed deficiencies indicated in a prior warning notice or a request for a CAP following an initial comprehensive compliance review. We have imposed CMPs on four hospitals and publicized those CMP impositions on our website. Every other hospital that we have identified as being noncompliant has either corrected its deficiencies or is cooperating with CMS

to work towards correcting its deficiencies."

From this text, we believe this proposed stance to include posting any compliance action will have the following negative effects:

a. Hospitals ultimately found to be compliant will receive negative public attention: CMS states that 301 of the 906 hospitals that were issued letters were found not to require any additional action. Meaning, approximately one-third of hospitals that received noncompliance notices were ultimately found to be compliant after further discussions. We have no issue with hospitals needing to answer questions regarding their files, however, had this authority for web posting any compliance action been in effect, these 301 hospitals would have faced unfair and undue public/media attention.

b. The proposed action will take away from positive communication and collaboration: CMS notes that outside of four facilities, every other hospital that received a noncompliance notice was either ultimately found to be compliant or addressed (or is actively addressing) file deficiencies. This statistic shows collaborative work toward compliance. Undoing this positive momentum with punitive communication would be truly discouraging. We also note that CMS believes "that many of these issues would be resolved if the proposed improvements to standardizing display of hospital standard charges (as discussed in section XVIII.B.3 of this proposed rule) are finalized as proposed." We agree with this, as well, and would encourage seeing this through before including this language.

   However, we do understand the need for CMS to address the concerns of the public that hospitals – potentially some that have been requested to be reviewed – are being evaluated. To address this need, we suggest that CMS could display the following language and table:

   HOSPITAL PRICE TRANSPARENCY MONITORING POSTING
   CMS regularly monitors the compliance of hospitals regarding the Hospital Price Transparency requirements. The table below presents the status of these reviews. A hospital that is currently being reviewed does not necessarily imply noncompliance but rather that it is being evaluated as part of our ongoing monitoring.

Hospital Name	Review Status	Review Complete Date	Compliance Position
Other location fields could be added to assist in identifying facilities	**In Process** (when a hospital is being reviewed or in discussion on a potential compliance issue) – or – **Complete** (when the review is closed)	This field would be empty until the review finalizes	**Compliant** (if a hospital was ultimately found to be compliant or successfully completed a CAP) – or – **Noncompliant/ CMP imposed** The field would be empty until the review finalizes

2) **Notifications sent to health system leadership**

Similar to the discussion above, we do not believe collaborative conversation with health system leaders should be publicly posted. We do, however, believe that the hospital within the health system that is being reviewed could be presented in the sample table we have provided.

3) ADDITIONAL COMMENTS

As it relates to the various transparency rules, including the hospital, payer, and No Surprises Act, CMS seeks comment on the following questions:

- How, if at all, and consistent with its underlying legal authority, could the HPT consumer-friendly requirements at § 180.60 be revised to align with other price transparency initiatives?
- How aware are consumers about healthcare pricing information available from hospitals? We solicit recommendations on raising consumer awareness.
- What elements of health pricing information do you think consumers find most valuable in advance of receiving care? How do consumers currently access this pricing information? What are consumers' preferences for accessing this price information?
- Given the new requirements and authorities through TIC final rules and the NSA, respectively, is there still benefit to requiring hospitals to display their standard charges in a ''consumer friendly'' manner under the HPT regulations?
- Within the contours of the statutory authority conferred by section 2718(e) of the PHS Act, should information in the hospital consumer-friendly display (including the information displayed in online price estimator tools) be revised to enhance alignment with price information provided under the TIC final rules and NSA regulations? If so, which data should be revised and how?
- How effective are hospital price estimator tools in providing consumers with actionable and personalized information? What is the minimum amount of personalized information that a consumer must provide for a price estimator tool to produce a personalized out-of-pocket estimate?
- How are third parties using MRF data to develop consumer-friendly pricing tools? What additional information is added by third parties to make standard charges consumer friendly?
- Should we consider additional consumer-friendly requirements for future rulemaking, and to the extent our authorities permit? For example, what types of pricing information might give consumers the ability to compare the cost of healthcare services across healthcare providers? Is there an industry standard set of healthcare services or service packages that healthcare providers could use as a benchmark when establishing prices for consumers?

Cleverley + Associates Comment to CMS:

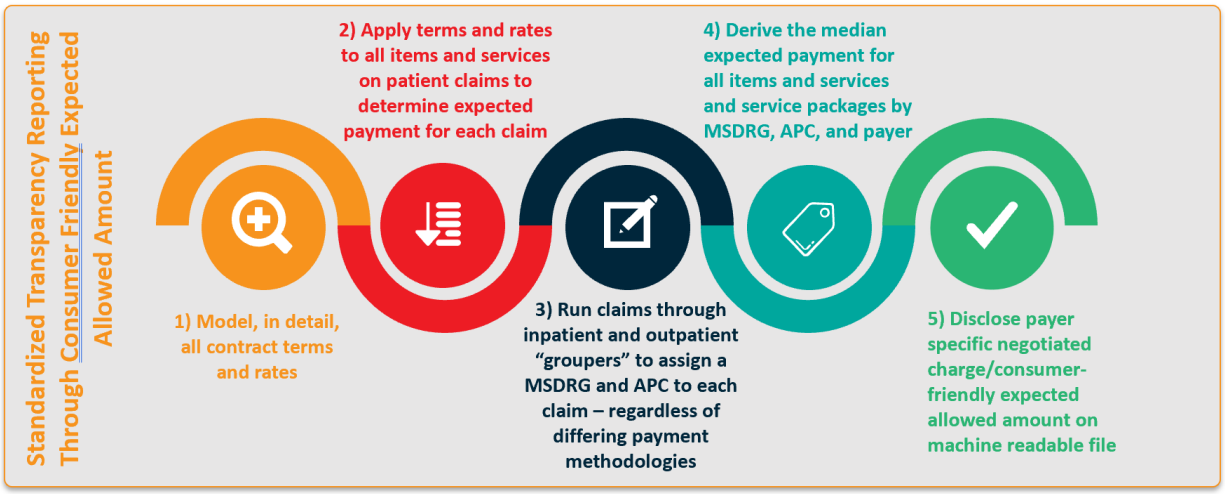
We are encouraged by the increasing levels of data available to consumers. However, these increases come with different sources and can produce differing results while still conforming to current applicable requirements. An example would be the way hospitals and payers create and display negotiated rates. We believe these duplicative efforts produce inefficiencies and economic burdens in addition to consumer confusion. For this, we would recommend future rule-making consider creating single ownership for relevant fields, as follows:

1) Hospital Price Transparency – Responsible for providing standard gross charge only

2) Payer Transparency – Responsible for providing payer negotiated rates and consumer-friendly tools for members leveraging up-to-date member YTD expense tracking

Having hospitals disclose standard gross charge information would allow focus on the primary area that hospitals have direct ownership. Payment disclosure would then be the responsibility of payers as they typically direct the form of methodology/algorithm used in the negotiated rate.

We also believe that future rule making should include language for payers to produce the Consumer Friendly Expected Allowed amount and to report in a consistent inpatient (MSDRG) or outpatient (primary APC) methodology. This would allow comparison across all hospitals and payers. Until this is achieved, there will always be questions regarding source data construction that will render disclosed data relatively meaningless. In the graphic below we illustrate the steps any hospital or payer could take to produce this field and report it in the same manner. Not only would this achieve comparability of results, it also could dramatically improve payer transparency file size.



We hope that this information has been useful to summarize the numerous proposed disclosure requirements and provide some commentary on the challenges with many of the components. Given these concerns, we highly encourage hospitals to submit feedback to CMS within the comment window which ends on September 11, 2023.

RESPONDING TO CMS

The following information provides direction from the OPPS proposed rule for commenting:

DATES: To be assured consideration, comments on this proposed rule must be received at one of the addresses provided in the ADDRESSES section **by September 11, 2023.**

ADDRESSES: In commenting, please refer to file code CMS-1786-P. Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1) Electronically. You may submit electronic comments on this regulation to https://www.regulations.gov. Follow the "Submit a comment" instructions.

Search for CMS-1786-P (Look for the result that shows comments due Sep 11, 2023 and select "Comment"

2) By regular mail. You may mail written comments to the following address ONLY:
Centers for Medicare & Medicaid Services, Department of Health and Human Services,
Attention: CMS-1786-P,
P.O. Box 8010,
Baltimore, MD 21244-1810.

   Please allow sufficient time for mailed comments to be received before the close of the comment period.

3) By express or overnight mail. You may send written comments to the following address ONLY:
Centers for Medicare & Medicaid Services, Department of Health and Human Services,
Attention: CMS-1786-P,
Mail Stop C4-26-05,
7500 Security Boulevard, Baltimore, MD 21244-1850.