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Summary of Key Provisions in the Price Transparency Rule

Here is a description of some of the major requirements in CMS's final regulation on hospital price transparency. This was prepared by McDermott Will & Emery. View the full chart at http://bit.ly/2rde4xz.

	PROPOSED RULE	FINAL RULE
Items and Services	"Items and services" defined as all items and services, including individual items and services and "service packages," that could be provided by a hospital to a patient in connection with an inpatient admission or outpatient department visit for which the hospital had established a standard charge. Items and services would also include services furnished by physicians and non-physician practitioners who were employed by the hospital, but not practitioners who were not employed by the hospital but provided services at a hospital location. "Service packages" would mean an aggregation of individual items and services into a single service with a single charge.	"Items and services" and "Service packages" finalized without modification, but the Final Rule also finalized a technical change to include examples of "items and services" in the regulation, including: • supplies and procedures; • room and board; • use of the facility and other items; • services of employed physicians and non-physician practitioners; and • any other items or services for which a hospital has established a "standard charge."
Standard Charges	"Standard charges" defined as including two sets of charges: (1) "gross charges" (2) "payer-specific negotiated rates."	The Final Rule adopted the proposed definition of "standard charges" as including gross charges and "payer-specific negotiated rates," but it also added three additional types of "standard charges" that must be disclosed: (1) discounted cash prices (2) de-identified minimum negotiated charges (3) de-identified maximum negotiated charges.
Gross Charges	"Gross charges" were defined as the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.	Finalized without modification.

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Payer-Specific Negotiated Charges	"Payer-specific negotiated charges" were defined as the charge that the hospital negotiated with a third-party payer for an item or service. "Third-party payer" would include an entity that is, by statute, contract or agreement, legally responsible for payment of a claim for a healthcare item or service (including Medicare Advantage plans).	Finalized without modification.
Discounted Cash Price	The Proposed Rule considered defining a type of "standard charge" as the "discounted cash price," defined as the price the hospital would charge individuals who pay cash (or cash equivalent) for an individual item or service or service package.	The Final Rule finalized the definition of "discounted cash price" to mean the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service. The Final Rule clarified that the "discounted cash price" would reflect the discounted rate published by the hospital, unrelated to any charity care or bill forgiveness that a hospital may choose or be required to apply to a particular individual's bill.
De-Identified Minimum and Maximum Negotiated Charges	CMS considered in the Proposed Rule defining as types of "standard charge" the minimum and maximum negotiated charges of the distribution of all negotiated charges across all third-party payer plans and products.	The Final Rule finalized "de-identified minimum negotiated charge" to mean the lowest charge that a hospital has negotiated with all third-party payers for an item or service, and "de-identified maximum negotiated charge" to mean the highest charge that a hospital has negotiated with all third-party payers for an item or service.
Requirements for Disclosure		

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Standardized Elements	Hospitals would be required to disclose the following elements: Description of each item or service Gross charge for each individual item or service when provided in, as applicable, inpatient and outpatient settings Payer-specific negotiated charge when provided in, as applicable, inpatient and outpatient settings Code used by the hospital for accounting or billing for the item or service (e.g., CPT code, HCPCS code, DRG, NDC); Revenue code, as applicable	The list of items finalized in the Final Rule include the proposed standardized elements and added two additional elements: • De-identified minimum and maximum negotiated charges that apply to each item or service when provided in, as applicable, inpatient and outpatient settings • Discounted cash price that applies to each item or service when provided in, as applicable, inpatient and outpatient settings
Proposed Definitions	"Shoppable services" was defined as a "service package" that could be scheduled by a healthcare consumer in advance. These are typically routinely provided in non-urgent situations that do not require immediate action or attention to the patient, thus allowing patients to price shop and schedule a service at a time that is convenient for them. Hospitals would need to make public the payer-specific negotiated charge for a shoppable service that is grouped together with charges for associated ancillary services. An "ancillary service" would be defined as an item or service a hospital customarily provides as part of or in conjunction with a shoppable primary service, including laboratory, radiology, drugs, delivery room, operating room, therapy services, hospital fees, room and board charges, and charges for employed professional services. "Ancillary services" may also include other special items or services for which charges are customarily made in addition to a routine service charge. To the extent a hospital customarily provides (and bills for) such services as part of or in conjunction with the primary service, the hospital would need to group the service charge along with the other payer-specific negotiated charges that were displayed for the shoppable service.	The Final Rule finalized the definition of "shoppable services" and related definitions as proposed, with the exception that it modified its definition of "shoppable services" to remove reference to a "service package," because not every shoppable service will be a "service package." CMS emphasized that it was still finalizing its requirement that hospitals display ancillary services along with each primary shoppable service, as applicable.

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Selected Shoppable Services	Hospitals required to make public a list of their payer-specific negotiated charges for as many of the 70 shoppable services CMS identified in the Proposed Rule that are provided by the hospital, and hospitals would be allowed to select as many additional shoppable services as necessary for the combined total of at least 300 shoppable services. CMS proposed that hospitals select such services based on the utilization or billing rate of the services in the past year.	The Final Rule generally finalized the rule as proposed, but created an exception for some small or specialty hospitals that do not offer 300 services that could be scheduled by consumers in advance, who must display as many of the services it provides that could be scheduled by patients in advance.
Data Elements	Hospital would be required to make available online to the public the following elements: i. Plain language description of each shoppable service ii. Payer-specific negotiated charge applicable to the shoppable service iii. A list of all of the associated ancillary items and services the hospital provides with the shoppable service, including the payer-specific negotiated rate for each ancillary item or service iv. The location at which each shoppable service is provided in the hospital v. Any primary code used by the hospital for accounting or billing for the shoppable service (e.g., CPT, HCPCS, DRG)	The Final Rule makes a variety of modifications to the list of data elements necessary to be disclosed, to include: i. Plain language description of each shoppable service ii. Payer-specific negotiated charge, discounted cash price, deidentified minimum and maximum negotiated charge applicable to the shoppable service (and corresponding ancillary services, as applicable) iii. The location at which each shoppable service is provided in the hospital, including whether the shoppable service applies to the inpatient setting, outpatient setting or both (and if the standard charge for the shoppable service varies based on location or whether the hospital provides the shoppable service in the inpatient versus the outpatient setting, the hospital would be required to identify each set of standard charges) iv. Any primary code used by the hospital for accounting or billing for the shoppable service (e.g., CPT, HCPCS, DRG)

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Internet-Based Price Estimator Tool	Silent	The Final Rule created a new option for hospitals to meet the otherwise applicable requirements for displaying shoppable services in a consumer-friendly manner if the tool: i. 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 ii. Allows healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service iii. Is 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

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