Pricing Transparency Guide

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Use of this Resource

This Small Rural Hospital Improvement Program (SHIP) Pricing Transparency Guide (herein referred to as the SHIP Pricing Transparency Guide) aims to support SHIP Coordinators, along with their hospitals and local partners, navigate the Price Transparency Rule of November 15, 2019. The Final Rule was published in the November 27, 2019 Federal Register and requires hospitals operating in the United States to provide clear, accessible pricing information online about the items and services they provide in two ways. The SHIP Pricing Transparency Guide supports hospitals as they implement the various components of the rule to ensure compliance by the effective date of January 1, 2021. This guide may be shared with hospitals as a reference tool as part of their implementation. Hyperlinks to the legislation and detailed information are provided. Pricing transparency is an allowable SHIP activity in the adaptation to changing payment systems through investments in hardware, software and related trainings.

The SHIP Pricing Transparency Guide includes an overview of the basics and history of the Price Transparency Rulings, key terms, eligibility, exemptions and key components followed by a hospital readiness workplan, and penalties for non-compliance. This guide also includes resources, a list of shoppable services, and a template work plan for implementation.

The SHIP Pricing Transparency guide is intended as a reference guide. It does not seek to provide legal counsel or financial advice. It is not intended to cover any individual situation or concern, as the contents are intended for general information purposes only. Users are urged not to act upon the information contained in the guide without first consulting legal, accounting, or other professional advice regarding implications of a factual situation. All eligibility, usage of funds, and reporting requirements are at the sole discretion of the awarding agency and all questions should be directed to the awarding agency to provide clarification.

Acronyms

ACA – Affordable Care Act

APC – Ambulatory Payment Classification

APG – Ambulatory Patient Group

CAH – Critical Access Hospital

CMS – Centers for Medicare and Medicaid Services

CPT – Current Procedural Terminology

CY – Calendar Year

DRG – Diagnosis Related Group

EAPG – Enhanced Ambulatory Patient Grouping

EO – Executive Order

FAQ – Frequently Asked Questions

FR – Federal Register

HCPCS – Healthcare Common Procedure Coding System

HHS – U.S. Department of Health and Human Services

IPPS – Inpatient Prospective Payment System

MS-DRG – Medicare Severity-Diagnosis Related Group

ONC – Office of the National Coordinator for Health Information Technology

OPPS – Outpatient Prospective Payment System

PPS – Prospective Payment System

SCH – Sole Community Hospital

Introduction

Disclaimer

The material in this guide has been prepared by Eide Bailly LLP in agreement with the National Rural Health Resource Center and is general information regarding the Centers for Medicare and Medicaid Services (CMS) Price Transparency Rule implementation. This information does not purport to be complete. The information is current as of the date of the Guide and may become outdated at any time. As of the date of publication, the rule is anticipated to be effective on January 1, 2021

COVID Statement

This rule was published prior to the COVID-19 Public Health Emergency, however, there were a few items related to price transparency and the rules published throughout the pandemic. The FAQ located at the CMS COVID-19 resources page discusses the specific requirements.

Timeline for Implementation

Hospitals are required to meet the price transparency rule by January 1, 2021. In order to comply, hospitals need to post a machine-readable file and a list of shoppable services or price estimator tool on their website in accordance with the requirements defined in the Final Rule. The following steps help hospitals meet the deadline (additional details for these steps and corresponding tools are provided in Section III of this guide.

- Define Price Transparency Governance
- Identify Departmental Responsibility/Roles and Create a Charter
- Populate the Work Plan
- Chargemaster
- Contracts
- Information Systems
- Shoppable Services/Price Estimation Tool
- Create Spreadsheet of Prices

- Create Shoppable Services or Work with Vendor on Price Estimator
- Populate Website and Proof/Test
- Publish Machine Readable File and Shoppable Services/Price Estimation Tool on Hospital's Website by January 1, 2021

SECTION I: Basics and History of Price Transparency

Price Transparency: The Basics

Price transparency is the ability of the health care consumer to access provider-specific information on the price of health care services — including out-of-pocket costs — regardless of the setting in which they are delivered. The intent of the rule by CMS is to provide information making it easier for consumers to shop and compare prices across hospitals and estimate the cost of care before going to the hospital.

Hospital prices and charge structures are complicated. They have evolved from a combination of coding and billing rules which apply to the services provided by a hospital. Prices and charges can be based on cost plus a markup, a percentile of market within a hospital's defined peer market, or a markup of the highest reimbursement negotiated with a health plan for a service. In some cases, prices on specific services are re-evaluated based on patient inquiries and/or complaints. There are tools available to assist a patient in getting a price estimate. However, there can be differences in total costs due to the complexity of the patient's treatment plan, the payer (i.e., private insurer, Medicare or Medicaid) who will be paying the hospital for the health care services delivered to that patient, the length of time spent in the hospital, additional tests or procedures needed, or any other unforeseen conditions or circumstances that arise during care or recovery.

CMS believes consumers should be able to know, long before they open a medical bill, roughly how much a hospital will charge for items and services it provides. Once hospital price transparency goes into effect on January 1, 2021, hospitals' standard charges, including the rates they negotiate with insurance companies and the discounted price a hospital is willing to accept directly from a patient if paid in cash, must be publicly available, free of charge, and presented in a consumer-friendly display.

History and Relevant Rulings

Requirements for hospital price transparency began in 2010 and ten years later, the final guidelines have been established (Figure 1). This was after proposed rules, comment periods, and several key rulings published in the federal register which have had price transparency requirements.

2010 Patient Protection and Affordable Care Act

Price Transparency at the federal level dates back to the Patient Protection and Affordable Care Act (ACA) of March 23, 2010. The Act states "each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital".

2015 Inpatient Prospective Payment System (IPPS) Final Rule

Noting slow implementation of the ACA, CMS decreed via a rule for hospital price transparency. The Federal Fiscal Year 2015 Inpatient Prospective Payment System (IPPS) Final Rule included general language regarding price transparency. This rule stated a hospital could meet compliance requirements by providing a link on its website to their state hospital association website with charges posted for common procedures.

2019 Inpatient Prospective Payment System (IPPS) Final Rule

The Inpatient Prospective Payment System (IPPS) Final Rule (see page 41686), provided hospitals with additional specific requirements:

- Hospital must post standard charges on their website

- Standard charges must be in machine readable format (i.e., no pdf files)
- Standard charges must be updated at least annually
- Prospective Payment System (PPS) hospitals are required to publish a list of prices by the Medicare Severity-Diagnosis Related Group (MS-DRG)
- Effective date: January 1, 2019.

Hospitals were provided a fair amount of leeway to comply with the January 1, 2019 requirement. The postings varied widely from cryptic extractions from a hospital's chargemaster with no coding identifying information to that which not only provided the charge detail, but also attempted to provide information to assist patients in understanding how to utilize the information as well as its limitations.

Proposed Rules and Executive Orders

2019 Office of the National Coordinator for Health Information Technology (ONC) Rule

In February of 2019, the Office of the National Coordinator for Health Information Technology (ONC) issued a proposed rule related to pricing transparency. In this proposed rule, the ONC requested comments on whether it should require pricing information as part of mandated electronic health information. They also sought comments on potential penalties for noncompliance. The final item relating to price transparency within this proposed rule discussed seeking comments on whether negotiated rates should be made public.

2019 Executive Order (EO) on Improving Price and Quality Transparency in American Health to Put Patients First

On June 24, 2019, acknowledging this as a Bi-Partisan issue and further noting continued challenges to the patient consumer, President Trump issued an *Executive Order (EO) on Improving Price and Quality Transparency in American Health to Put Patients First*. The EO directed the U.S. Department of Health and Human Services (HHS) to issue regulations requiring hospitals to post charge information. "It is the policy of the Federal Government to increase the availability of meaningful price and quality information for patients." Specifically, it discussed reporting of charges, negotiated rates, and shoppable items and services. The EO directed the Secretary of HHS to propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information. This order was the foundation for CMS's Final Rule on Price Transparency of November 15, 2019 with an effective date of January 1, 2021.

Other Related Rules

2019 Transparency in Coverage Proposed Rule

On November 15, 2019, as part of the larger effort to improve price transparency, CMS released the Transparency in Coverage proposed rule that would require insurers to post prices which could help hospitals to compare rates.

2021 Inpatient Prospective Payment System (IPPS) Final Rule

The FY 2021 Final Inpatient Prospective Payment rule requires hospitals to report on the Medicare cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organizations (also referred to as MA organizations) payers, by MS-DRG, beginning with cost reporting periods ending January 1, 2021. The market-based rate information they are finalizing for collection on the Medicare cost report would be the median of the payer-specific negotiated charges by MS-DRG, as described

previously, for a hospital's MA organization payers. The payer-specific negotiated charges used by hospitals to calculate these medians would be the payer-specific negotiated charges for service packages that hospitals are required to make public under the requirements finalized in the Hospital Price Transparency Final Rule (84 FR 65524) that can be cross-walked to an MS-DRG." Note that Critical Access Hospitals (CAHs) are exempt from this related reporting rule.

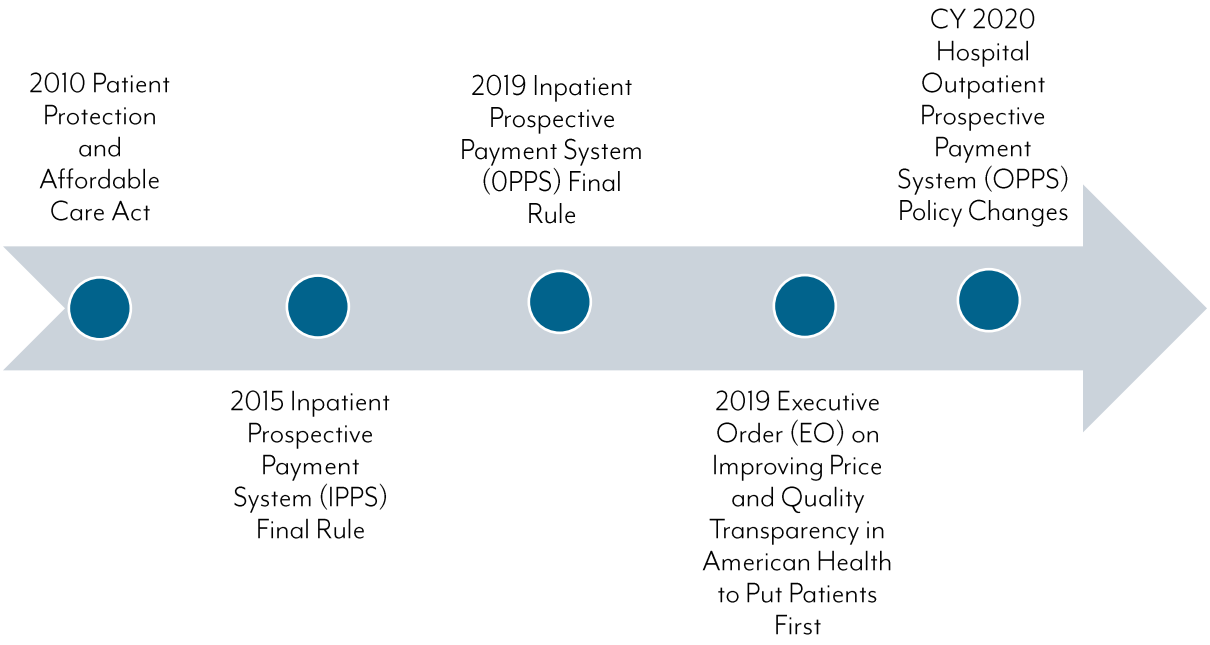
Price Transparency Final Rule

CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes

The calendar year (CY) 2020 Hospital OPPS rule was supplemented to include "Price Transparency Requirements for Hospitals To Make Standard Charges Public" which implements Section 2718(e) of the Public Health Services Act. CMS notes that it improves upon prior agency guidance that required hospitals to make public their standard charges from the hospital's chargemaster upon request starting in 2015 (79 FR 50146). This rule subsequently indicated the standard charges be posted online in a machine-readable format starting in 2019 (83 FR 41144).

Section 2718(e) requires each hospital operating within the United States to establish, annually update, and make public a yearly list of the hospital's standard charges for items and services provided by the hospital, including diagnosis-related groups (DRG) charges established under section 1886(d)(4) of the Social Security Act.

Figure 1: Timeline of Key Price Transparency Rulings



SECTION II: Price Transparency Key Terms, Eligibility, and Exemptions

Final Rule Definitions

Price Transparency

The final rule with the supplement (CY 2020 OPPS) for price transparency establishes the hospital requirements to annually create and make public a list of hospital standard charges for the items and services provided. The goal of CMS is to promote price transparency in health care and provide public access to hospital standard charges. With more information provided to the public (patients, providers, employers and other third parties), price transparency is intended to make health care more affordable for all patients.

Required Four Components

- Standard Charges- each hospital to establish and make public a yearly list of the hospital's standard charges for items and services provided by the hospital.
- Machine Readable- CMS required the information be in specific file formats for accessibility
- Frequency of Update- each hospital is required to annually update information
- Shoppable Items and Services - The final rule also codified the definition of "shoppable items and services"

Hospital

The final rule codified the definition of a hospital (45 CFR 180.30(c). If an entity is licensed as a hospital, then it is a hospital for the application of the price transparency rule. This means that regardless of how Medicare pays for services provided to their beneficiaries (i.e., DRGs, APCs, Cost, etc.), if an organization is licensed as a hospital, the facility is a hospital.

Location

Facilities located in each of the 50 states that are licensed as hospitals must comply with the price transparency rule. In addition, this rule applies to hospitals located in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and Northern Mariana Islands

Single License/Multiple Locations

With respect to licensing, if an organization has a single hospital license, but has multiple locations, then this rule applies to all locations.

Federal Exemptions

Federally owned or operated facilities, such as Veterans Affairs (VA) Hospitals and Indian Health Services, are exempt from this rule. This exemption is made as these facilities are public and thus their information is already readily available.

Standard Charges

Annually hospitals are required to create and make public a list of hospital standard charges for the items and services provided (sample display in Appendix D). CMS codified the definition of 'standard charges' to include the following:

- Gross charge: The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.
- Discounted cash price: The charge that applies to an individual who pays cash, or a cash equivalent, for a hospital item or service.
- Payer-specific negotiated charge: The charge that a hospital has negotiated with a third-party payer (typically an insurance company) for each individual item or service. This includes charges for both individual items and services as well as service packages provided in both the inpatient and outpatient setting.
- De-identified negotiated charges: The lowest charge that a hospital has negotiated with

all third-party payers for an item or service.

- De-identified maximum negotiated charges: The highest charge that a hospital has negotiated with all third-party payers for an item or service.

Negotiated Payer rates are further defined as requiring the inclusion of:

- Rates by payer by product.
- Rates for individual items and/or service packages (i.e., Diagnosis Related Group (DRG), Ambulatory Payment Classification (APC), Enhanced Ambulatory Patient Grouping (EAPG), All Payer Refined Diagnosis Related Group (APR-DRG), etc.).
- Negotiated rates including commercial payers, Medicare Advantage, Managed Medicaid plans.
- Traditional fee-for-service Medicare and Medicaid rates are excluded as these are already publicly displayed.

NOTE: Hospitals that are paid on an Enhanced Ambulatory Patient Grouping (EAPG) and/or Ambulatory Patient Group (APG) basis will likely find challenges in providing this level of information due to the complexity and proprietary nature of the calculation used in arriving at the actual payment.

Cash discounted price is further defined as having greater applicability to self-pay, out of network, exceeded coverage limits, high deductible health plans, and Health Savings Accounts. In other words, the price the hospital would charge individuals who pay cash or cash equivalent.

Machine Readable Format

The final rule provided specifics on format. CMS required the information be in specific file formats for accessibility

CMS has defined the file formats, accessibility and additional data element requirements for the posted price transparency information, see below.

- The information must be easily accessible, without barriers, including ensuring the data is:

    - Accessible and free of charge, does not require a user to register for a portal, establish an account or a password or submit Personal Identifiable Information, and is
    - searchable by service description, billing code, and payer.
- The File format needs to be machine-readable.
- Examples of acceptable machine-readable file formats include:
    - .XML
    - .JSON
    - .CVS
    - *PDF is not an acceptable file format*
- The File needs to be prominently displayed (i.e., easy to find). It cannot be buried within the website.
- The File requires the inclusion of any codes used for accounting or billing of items and/or services such as Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS), Revenue Codes, etc.
- The file needs to be easily searchable by service description, payer and billing code.

Frequency of Updates

The transparency file must be updated at least annually. The date of the most recent update should be clearly denoted on the file posted on the hospital website

Shoppable Items and Services

Hospitals must post standard charges for the items and services provided referred to as "shoppable items and services". (See Appendix A for sample display provided by CMS). Seventy specific services are required and an additional 230 for a total of 300. The definition is an additional requirement of price transparency posting.

Shoppable Items and Services are those services that can be scheduled in advance. CMS has mandated 70 services that need to be posted (See Appendix B). If a hospital does not provide one or more of the 70 CMS-specified shoppable services, the hospital must indicate that the service is not offered by the hospital and select additional shoppable services such that there are

at least 300 shoppable services in total. If the hospital provides less than 300 total shoppable services, this should be noted.

Hospitals can have discretion to choose a format for making public consumer-friendly information. Specific posting requirements include:

- The shoppable services selected for display by the hospital should be commonly provided to the hospital's patient population.
- Plain language description.
- A list of associated ancillary items and services provided by the hospital with the shoppable service.
- Standard charge.
- Payer specific negotiated charge.
- Discounted cash price.
- De-identified minimum rate across all payers.
- De-identified maximum across all payers.
- Location where shoppable service is provided.
- Primary code used for billing or accounting purposes (i.e., CPT, HCPCS, DRG).
- Includes charges for employed physicians and nonphysician practitioners.

The shoppable services need to be grouped by the payer-specific negotiated charge for the primary service with the charges for associated ancillary services. This is intended to provide consumers with an accessible means to shop for healthcare service(s) price information. Items or

services that could be considered as shoppable services to include as part of the 230 shoppable services are listed in Appendix B.

If a hospital has an online price estimation tool that includes the 70 CMS required plus 230 additional shoppable services, the hospital will have met the requirement to display charges for shoppable services. The estimator *must* provide an estimate of what the consumer will have to pay the hospital for the shoppable service based on their insurance which can vary from patient to patient. In addition, the price transparency rule requires reporting of charges, which are not consumer costs. The estimator tool is a way for consumers to know their costs, thus going beyond the posting of charges.

The hospital is still required to make public all standard charges of all items and services in a machine-readable format as stated in the Final Rule at 84 FR 65579.

SECTION III: Hospital Readiness

This section outlines the steps for implementation of price transparency to guide the process for compliance. This information does not purport to be complete. The information is current as of the date of the Guide and may become outdated at any time. As of the date of publication, the rule is anticipated to be effective on January 1, 2021. The following steps help hospitals meet the deadline, however based on the initiation of the work plan, the milestone dates must be set by the hospital.

Step 1: Establish a Team

A governance structure for hospital price transparency is recommended. This clearly identifies those within the organization who are responsible for pricing and price transparency. A charter or agreement is suggested to establish defined roles and responsibilities, resources, and communication for price transparency implementation. An implementation team, working under the charter should include an executive sponsor (hospital leader), project manager, and work group members to execute work plan activities towards implementation. The project manager oversees task reporting, team meetings, reassignment of resources, change, and quality. Generally, the work group members for price transparency will representation from: finance, information technology, revenue cycle management, legal, and compliance. See Appendix C for charter template.

Step 2: Populate the Work Plan

In order to meet the deadline and gather all information, the suggested work plan tasks are recommended for hospitals. The team inserts them into the work plan based on the required data elements and format described in the Final Rule. Responsible hospital team members are

assigned along with due dates, actions, and status of implementation (See Appendix D for Work plan sample).

Tasks to consider for inclusion in work plan

- Chargemaster review
    1. Determination of when last performed
    2. Identification of review purpose
    3. Review for plain language definitions
    4. Consideration of opportunities to bundle charges
        a. Coordinate efforts with finance department to address budget neutrality
- Chargemaster updates:
    1. Completion of annual Current Procedural Terminology (CPT) code updates
    2. Adjustments discussion with finance department on charge amounts for changed codes
- Charge/Pricing Strategy and Policy
    1. Documentation of strategy and formalize policy
    2. If organization has a strategy and policy, review for adequacy and revisions
- Charge market analysis comparison
    1. Determine when last performed
    2. Confirm confidence in alignment with organization's price setting strategy
    3. Address annual price increase
        a. Budget considerations
        b. Payer contracting notification
        c. Medicare cost report cost to charge ratios reviewed for potential pricing issues
        d. Identification of any payments at 100% of billed charges for additional investigation
        e. Clinical department input
        f. History of patient complaints on charges
- Information Systems
    1. Determination of machine-readable format
    2. Create strategy for system data extraction
    3. Identify and confirm searchable capabilities
    4. Determine process for website upload and export capabilities

5. Determination of location of transparency data files on website

- Contracts
    1. Obtain inventory of negotiated payer contracts, plans, products
    2. Confirm availability of rate schedules
    3. Plan to obtain missing rate schedules
    4. Confirmation of payer matrix in place
    5. Identification of the five types of charges (required listings)
        a. Gross charges – standard charges from chargemaster
        b. Negotiated payer specific rates/charges
        c. Cash discounted price
        d. De-identified negotiated charge
        e. De-identified maximum negotiated charge
- Determination of any state requirements
- Shoppable Services
    - Gather data for 70 CMS and 230 Other shoppable services with five types of charges.

    Or

    - Evaluate utilization of a Price Estimator Tool.
        - Review the hospital cost and benefit of contacting for price estimator (Note: This is a product available through some software vendors. The intent is to provide procedure-specific benefit validation to provide out of pocket estimates to patients.)

Step 3: Implement the Plan

Successful implementation of price transparency requirements requires the completion of the work plan components above. A hospital team with clear roles and the resources, gathers data from contracts and payers. This is critical to keep the process moving towards milestones in the work plan. CMS has estimated the total burden for hospitals to review and post their standard charges for the first year to be 150 hours per hospital at **$11,898.60 per hospital** in the Final Rule. As with any next project, identification and approval of resources for hospital staff time and contractors if needed is important at the onset. Also, the determination if a price estimator tool is the best solution, the hospital will need to seek proposals and select a vendor. Finally, the information technology team is needed to prepare the two information files for posting online and perhaps communication or marketing representatives. The CMS Hospital Price Transparency FAQ is a recommended resource.

SECTION IV: Civil Monetary Penalties

In the case that a hospital does not meet the requirements of price transparency by January 1, the Final Rule also codified Civil Monetary Penalties for non-compliance. CMS has stated that it will monitor compliance. If an organization is reviewed and findings of noncompliance are noted, the hospital will receive a written notice of noncompliance and will be required to file a Corrective Action Plan with CMS. Failure to comply in any aspect of this rule be it no implementation, failure to submit a Corrective Action Plan, etc., will result in a $300 maximum daily dollar civil monetary penalty.

CMS provided an email to report noncompliance: PriceTransparencyHospitalCharges@cms.hhs.gov.

Resources for Price Transparency

The following references provide additional guidance on price transparency:

- CMS Price Transparency Fact Sheet
- CMS Webinar on December 3, 2019 on Price Transparency
- CMS Clarification to Webinar on December 3, 2019 on Price Transparency
- CMS Newsroom Press Release
- Executive Order
- The final rule (CMS-1717-F2)
- CMS website on Hospital Price Transparency (includes checklist, FAQs, Machine readable file, and shoppable services reference documents)
    - Hospital Price Transparency Website
    - Quick Reference Checklist
    - Frequently Asked Questions
    - Machine Readable File
    - Shoppable Services

Appendix A

Table 1. Sample of Display of Shoppable Services provided by CMS

Hospital XYZ Medical Center			
Prices Posted and Effective [month/day/year]			
Notes: [insert any clarifying notes or disclaimers]			
Shoppable service	**Primary service and ancillary services**	**CPT/HCPCS code**	**[Standard charge for Plan X]**
Colonoscopy	primary diagnostic procedure	45378	$750
	anesthesia (medication only)	[code(s)]	$122
	physician services	Not provided by hospital (may be billed separately)	
	pathology/interpretation of results	Not provided by hospital (may be billed separately)	
	facility fee	[code(s)]	$500
Office Visit	New patient outpatient visit, 30 min	99203	$54
Vaginal Delivery	primary procedure	59400	[$]
	hospital services	[code(s)]	[$]

Hospital XYZ Medical Center			
	physician services	Not provided by hospital (may be billed separately)	
	general anesthesia	Not provided by hospital (may be billed separately)	
	pain control	Not provided by hospital (may be billed separately)	
	two day hospital stay	[code(s)]	[$]

Source: Sample Display of Shoppable Services. Hospital Price Transparency, 84 Federal Register 65567.

Appendix B

CMS Required Shoppable Services (70 items)

Below is the CMS listing of the 70 shoppable services required to be posted on the hospital's website or be included as part of an organization's price estimation tool. Source: Hospital Price Transparency Final Rule Quick Reference Checklists, CMS, October, 2020.

Evaluation and Management Services

1. Psychotherapy, 30 minutes (90832)
2. Psychotherapy, 45 minutes (90834)
3. Psychotherapy, 60 minutes (90837)
4. Family psychotherapy, not including patient, 50 minutes (90846)
5. Family psychotherapy, including patient, 50 min (90847)
6. Group psychotherapy (90853)
7. New patient office or other outpatient visit, typically 30 min (99203)
8. New patient office or other outpatient visit, typically 45 min (99204)
9. New patient office or other outpatient visit, typically 60 min (99205)
10. Patient office consultation, typically 40 min (99243)
11. Patient office consultation, typically 60 min (99244)
12. Initial new patient preventive medicine evaluation, for those ages 18 to 39 (99385)
13. Initial new patient preventive medicine evaluation, for those ages 40 to 64 (99386)

Laboratory and Pathology Services

14. Basic metabolic panel (80048)
15. Blood test, comprehensive group of blood chemicals (80053)
16. Obstetric blood test panel (80055)
17. Blood test, lipids (80061)
18. Kidney function panel test (80069)
19. Liver function blood test panel (80076)

20. Manual urinalysis test with examination using microscope (81000 or 81001)
21. Automated urinalysis test (81002 or 81003)
22. Prostate specific antigen (84153 or 84154)
23. Blood test, thyroid stimulating hormone (84443)
24. Complete blood cell count, with differential white blood cells, automated (85025)
25. Complete blood count, automated (85027)
26. Blood test, clotting time (85610)
27. Coagulation assessment blood test (85730)

Radiology Services

28. CT scan, head or brain, without contrast (70450)
29. MRI scan of brain before and after contrast (70553)
30. X-Ray, lower back, minimum four views (72110)
31. MRI scan of lower spinal canal (72148)
32. CT scan, pelvis, with contrast (72193)
33. MRI scan of leg joint (73721)
34. CT scan of abdomen and pelvis with contrast (74177)
35. Ultrasound of abdomen (76700)
36. Abdominal ultrasound of pregnant uterus, greater or equal to 14 weeks 0 days, single or first fetus (76805)
37. Ultrasound pelvis through vagina (76830)
38. Mammography of one breast (77065)
39. Mammography of both breasts (77066)
40. Mammography, screening, bilateral (77067)

Medicine and Surgery Services (* denotes DRG vs. CPT)

41. Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities (216)*
42. Spinal fusion except cervical without major comorbid conditions or complications (460)*
43. Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (470)*
44. Cervical spinal fusion without comorbid conditions or major comorbid conditions or complications (473)*
45. Uterine and adnexa procedures for non-malignancy without comorbid conditions or major comorbid

conditions or complications (743)*

46. Removal of 1 or more breast growth, open procedure (19120)

47. Shaving of shoulder bone using an endoscope (29826)

48. Removal of one knee cartilage using an endoscope (29881)

49. Removal of tonsils and adenoid glands patient younger than age 12 (42820)

50. Diagnostic examination of esophagus, stomach, and/or upper small bowel using an endoscope (43235)

51. Biopsy of the esophagus, stomach, and/or upper small bowel using an endoscope (43239)

52. Diagnostic examination of large bowel using an endoscope (45378)

53. Biopsy of large bowel using an endoscope (45380)

54. Removal of polyps or growths of large bowel using an endoscope (45385)

55. Ultrasound examination of lower large bowel using an endoscope (45391)

56. Removal of gallbladder using an endoscope (47562)

57. Repair of groin hernia patient age 5 or older (49505)

58. Biopsy of prostate gland (55700)

59. Surgical removal of prostate and surrounding lymph nodes using an endoscope (55866)

60. Routine obstetric care for vaginal delivery, including pre-and post-delivery care (59400) DRG 807

61. Routine obstetric care for cesarean delivery, including pre-and post-delivery care (59510) DRG 788

62. Routine obstetric care for vaginal delivery after prior cesarean delivery including pre-and post-delivery care (59610) DRG 807

63. Injection of substance into spinal canal of lower back or sacrum using imaging guidance (62322 or 62323)

64. Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance (64483)

65. Removal of recurring cataract in lens capsule using laser (66821)

66. Removal of cataract with insertion of lens (66984)

67. Electrocardiogram, routine, with interpretation and report (93000)

68. Insertion of catheter into left heart for diagnosis (93452)

69. Sleep study (95810)

70. Physical therapy, therapeutic exercise (97110)

Appendix B

Examples of Additional Shoppable Services (230 items)

CMS has stated that in addition to the required 70 shoppable services, a hospital also needs to **report** an additional 230 services to equal 300 services in total. Below are some examples of additional shoppable services for consideration to be included as part of the requirement whether posted on the website or included in the price estimation tool.

Evaluation and Management Services

1. Psychiatric diagnostic evaluation (90791)
2. Office or other outpatient visit established patient (low complexity) (99212)
3. Office or other outpatient visit established patient (expanded focus) (99213)
4. Office or other outpatient visit established patient (moderate complexity) (99214)
5. Office or other outpatient visit established patient (high complexity) (99215)

Laboratory

1. Ammonia (82140)
2. Amylase (blood) (82150)
3. Albumin, serum (82040)
4. Adenovirus (87260)
5. Bilirubin-total (82247)
6. Blood culture (87040)
7. Blood gases (82803)
8. Blood, occult, qualitive, feces (82270)
9. Blood urea nitrogen (84520)
10. BNP (83880)
11. C-Reactive Protein (86140)
12. Calcium (82310)
13. CEA (82378)
14. Cholesterol (82465)

15. Clostridium difficile (87449)
16. Clotting, factor V (85220)
17. Creatinine (blood) (82565
18. D-Dimer Qualitative (85378)
19. Electrolyte Panel (80051)
20. Ferritin (82728)
21. Fibrinogen (85384)
22. Folic Acid (82746)
23. Glucose Tolerance (3 specimen) (82951)
24. Glucose, quantitative (82947)
25. Glycosated Hemoglobin (Hemoglobin A1C) (83036)
26. Hemoglobin (85018)
27. HIV (86694)
28. Helicobacter Pylori antigen (87339)
29. IGA/IGG (82784)
30. Influenza A/B (87804)
31. Immunoassay for tumor antigen, each (CA-125) (86316)
32. Iron-Total Iron Binding Capacity (83550)
33. Lactic Acid (83605)
34. LD, LDH (83615)
35. Magnesium (83735)
36. Parainfluenza (87279)
37. Parathyroid hormone (83970)
38. Potassium (84132)
39. Progesterone (84144)
40. RAST (per allergen) (86003)
41. Rheumatoid factor (86431)
42. RSV (87807)
43. Sedimentation Rate, automated) (85652)
44. T-4 Assay Free (84439)
45. T-3 (total) (84480)
46. Testosterone (84402)
47. Thromboplastin time (PTT) (85730)
48. TSH (84443)
49. Uric Acid (84550)
50. Urine Culture (87086)
51. Vitamin B12 (82607)

Radiology

1. Abdomen 2 views (74019)
2. Abdomen 3 or more views (74021)
3. Bone and joint imaging, limited area (78300)
4. Bone and joint imaging, multiple areas (78305)
5. Carotid ultrasound (93880)
6. Cervical spine, complete (72050)
7. Chest 2 views (71046)
8. Cholecystography, oral contrast (74290)
9. Cholangiography, intraoperative (74300)
10. Colon (barium enema) (74270)
11. CT angiography, abdominal aorta with extremity runoff (75635)
12. CT Lung Cancer screening (G0297)
13. CT Maxillary Sinus (70488)
14. CTA Chest (71275)
15. CT lower extremity without contrast (73700)
16. CT lower extremity with contrast (73701)
17. CT lower extremity with and without contrast) 73702
18. CT upper extremity without contras (73200)
19. CT upper extremity with contrast (73201)
20. CT upper extremity with and without contrast (73202)
21. Dexa Scan Hips, pelvis, spine (77080)
22. Duplex scan of extremity veins, complete bilateral (93970)
23. Echocardiogram (99306)
24. Electromyelography (96002)
25. Hip two view (73502)
26. Knee 3 views (73562)
27. Lumbar spine x-ray, 2 views (72100)
28. MRI any joint lower extremity with and without contrast (73723)
29. MRI any joint lower extremity without contrast (73721)
30. MRI any joint lower extremity with contrast (73722)
31. MRI Chest with and without contrast (71552)
32. MRI Abdomen with and without contrast (74183)
33. MRI Pelvis (with and without contrast) (72197
34. PET scan myocardial imaging (78459)
35. PET scan whole body (78816)
36. Shoulder minimum 2 views (73030)

37. SPECT (myocardial perfusion study) (78452)
38. Swallowing function radiography (74230)
39. Thoracolumbar spine 2 views (72080)
40. Thyroid uptake (78012)
41. Thyroid imaging (78013)
42. Ultrasound, abdominal aorta (76706)
43. Ultrasound, abdominal (76700)
44. Ultrasound lower extremities (76881)
45. Ultrasound upper extremities (76882)
46. Urography, retrograde (74420)
47. US spine (76800)
48. US transvaginal OB (76817)
49. US Pelvic, limited bladder (76857)
50. US transrectal (76872)
51. Ultrasound, breast, unilateral (76441)
52. Ultrasound, retroperitoneal (urinary organs) (76770)
53. Venography, extremity, bilateral (75822)

Surgery

1. Adenoidectomy, only (12 years or over) (42831)
2. Benign Skin lesion removal trunk/arms/legs 1-2 cm (11402)
3. Benign Skin lesion removal trunk/arms/legs 2-3 cm (11403)
4. Benign Skin lesion removal trunk/arms/leg 3-4 cm (11404)
5. Benign Skin lesion removal scalp/head/neck 0.5 cm or less (11420)
6. Benign Skin lesion removal scalp/head/neck 0.5 – 1 cm (11421)
7. Benign Skin lesion removal scalp/head/neck 1-2 cm (11422)
8. Benign Skin lesion removal scalp/head/neck 2-3 cm (11423)
9. Benign Skin lesion removal scalp/head/neck 3-4 cm (11424)
10. Biopsy soft tissue back (21920)
11. Biopsy thigh soft tissue (27550)
12. Biopsy Lymph node (38500
13. Bone marrow biopsy (38221)
14. Bone marrow aspiration (38220)
15. Breast biopsy, incisional (19101)
16. Breast biopsy, needle (19100)
17. Breast biopsy with placement imaging device (19083)
18. Circumcision, non-newborn (54150)
19. Circumcision newborn (54160)
20. Cystoscopy (52000)
21. Cystoscopy with biopsy (52204)
22. Cystoscopy with treatment (52234)
23. Cystoscopy with treatment (52281)
24. Cystoscopy with stent removal (51310)
25. Colectomy, partial (44140)
26. Excision Malignant lesion trunk;0.5CM (11600)
27. Excision malignant lesion trunk/arms/legs 0.6CM-1.0CM (11601)
28. Excision malignant lesion trunk/arms/legs 1.1 to 2 cm (11602)
29. Excision malignant lesion trunk/arms/legs 2-3 cm (11603)
30. Excision malignant lesion trunk/arms/leg 3-4 cm (11604)
31. Excision malignant lesion scalp/neck/hands/feet/genitalia 0.5-1 cm (11620)
32. Excision malignant lesion scalp/neck/hands/feet/genitalia 0.6-1 cm (11621)
33. Excision malignant lesion scalp/neck/hands/feet/genitalia 1 cm-2 cm (11622)
34. Excision malignant lesion scalp/neck/hands/feet/genitalia 2-3 cm (11623)
35. Excision malignant lesion scalp/neck/hands/feet/genitalia 3-4 cm (11624)
36. Excision malignant lesion face/,ears/eyelid/,nose/ lips 0.5 or less (11640)

37. Excision malignant lesion face/,ears/eyelid/,nose/ lips 1.6-1 cm (11641)
38. Excision malignant lesion face/,ears/eyelid/,nose/ lips 1-2 cm (11642)
39. Excision malignant lesion face/,ears/eyelid/,nose/ lips 2-3 cm (11643)
40. Excision malignant lesion face/,ears/eyelid/,nose/ lips 3-4 cm (11644)
41. Excision malignant lesion face/,ears/eyelid/,nose/ lips over 4 cm (11645)
42. Excision mouth lesion (40812)
43. Fallopian tube ligation, laparoscopic (58670)
44. Hemorrhoidectomy, external (46320)
45. Hemorrhoidectomy, external two or more (46250)
46. Hernia repair, inguinal, laparoscopic (49650)
47. Hernia repair, inguinal, open (49505)
48. Hernia repair, umbilical, laparoscopic (49652)
49. Hernia repair, umbilical, open (49587)
50. Hydrocelectomy (55040)
51. Incision and drainage mouth lesion (41000)
52. Incision and drainage of pilonidal cyst, simple (10080)
53. Incision and drainage of pilonidal cyst, complex (10081)
54. Injection single tendon sheath (20550)
55. Incision and drainage soft tissue arm/elbow (23931)
56. Intranasal biopsy (30100)
57. Insertion PICC line (36568)
58. Insertion central venous catheter (36569)
59. Kyphoplasty (22899)
60. Laryngoscopy, diagnostic (31575)
61. Mastectomy (Outpatient) (19307)
62. Mastectomy (Inpatient) 583*
63. Mastoidectomy (69502)
64. Nasal endoscopy diagnostic (31231)
65. Nasal endoscopy with maxillary antrostomy (31256)
66. Placement single lead pacemaker (33216)
67. Placement dual lead pacemaker (33217)
68. Removal of gallbladder, open (47600) 263*
69. Repair nail bed (11760)
70. Skin lesion removal trunk/arms/legs less than 0.5 cm (11400)
71. Skin lesion removal trunk/arms/leg 0.5 -1 cm (11401)
72. Thoracentesis without imaging (32554)
73. Thoracentesis with imaging (32555)
74. Tonsillectomy and adenoidectomy (42821)

75. Tonsillectomy only (42826)
76. Tympanostomy, bilateral (general anesthesia) (69436)
77. Wedge excision nail fold (11765)

Medical Procedures

1. Cardiac Rehab (per session) (93797)
2. Chemotherapy infusion, up to 1 hour (96413)
3. Chemotherapy infusion, each additional hour (96415)
4. Chemotherapy injection (96409)
5. Diabetes self-management, individual (G0108)
6. Diabetes self-management, group (G0109)
7. Dialysis (hemodialysis) (90935)
8. Dialysis (peritoneal (90945)
9. EKG without interpretation (93005)
10. EEG 20 to 40 minutes, awake and drowsy (95816)
11. EEG (awake and asleep) (95189)
12. Evoked otoacoustic screening (hearing) (92558)
13. Hearing aid check (92592)
14. Hepatitis B vaccine (90747)
15. HPV vaccination, quadrivalent, 3 dose – (90649)
16. Hydration (96360)
17. Influenza intradermal vaccine (18-64 years) (90630)
18. Influenza HD vaccine (65 & up) (90662)
19. Infusion therapeutic substance, initial (96365)
20. Infusion therapeutic substance, additional hour (96366)
21. Injection, therapeutic, initial (96374)
22. Injection, therapeutic, subsequent (96375)
23. Interrogation pacemaker (93288)
24. Interrogation ICD (93289)
25. Medical Nutrition therapy, individual (97803)
26. MMRII vaccine (90707)
27. Observation (G0378)
28. Occupational Therapy Evaluation, moderate (97166)
29. Physical Therapy Evaluation, moderate (97162)
30. Physical Therapy gait training (97116)
31. Physical Therapy, ultrasound (97035)

32. Physical Therapy/Occupational Therapy therapeutic activities (97530)
33. Programming pacemaker single lead (93279)
34. Programming pacer dual lead (93283)
35. Pulmonary Function Test (94010)
36. Removal impacted cerumen, irrigation/lavage, unilateral (69209)
37. Removal impacted cerumen, instrumentation, unilateral (69210)
38. RSV vaccination (90378)
39. Stress Test (94621)
40. Speech Therapy Evaluation, speech therapy (92521)
41. Speech Therapy Evaluation, voice analysis (92524)
42. Tdap Injection 10 & older (90715)
43. Transfusion blood components (36430)
44. Wound care, non-selective debridement (97602)
45. Wound vacuum (97605)
46. Zoster shingles vaccine administration (90471)
47. Zostavax (varicella) vaccine (90736)

Appendix C

Sample Charter Template

Below is an example of a charter template that can be used by hospitals in outlining the purpose and governance of price transparency for their organization. The identified team leader initiates the Charter development and upon approval by hospital executive sponsor (leadership) shares it with the team and uses it as a guide for the project.

Price Transparency Committee Charter

Price Transparency Committee Purpose

Executive Sponsorship

Committee Membership

Duties and Responsibilities

Reporting and Communications

Meeting Frequency

Appendix D

Sample Work Plan

Below is an example of a work plan hospitals can use to outline the steps and track the status of implementation and compliance with the Price Transparency Final Rule. Complete downloadable Excel version for customization available on SHIP website.

	A	B	C	D	E	F	G	H	I
1	**Hospital Name**								
2	**Hospital Location**						**Today**		
3	**Price Transparency 2021 Work Plan**						**8/20/2020**		
4	**Category**	**Task**	**Department**	**Responsible Party**	**Anticipated Completion Date**	**Revised/Actual Completion Date**	**Days to Complete**	**Status**	**Actions**
5	***High level task category***	*Specific task or work item required to be completed*	*Department Responsible for completion of task or reporting on the completion*	*Individual Responsible for completion of task or reporting on the completion*	*Target date for task completion*	*New date due to early completion or extended deadline*	*G= >5 days Y= 0-5 days R= Past Due*	*Any comments or note to explain revised expectation or delays*	*Use to document decisions made*
6	**Example Price Transparency Work Group**	**Populate the work plan**	**Price Transparency Work Group**	**Price Transparency Lead**	**8/15/2020**	**8/31/2020**	**11**	**push date out due to vacations**	**Work Group established - members include:???, Charter established**
7	Charges for Hospital Employed Physicians					8/1/2020	-19		
10	Standard Charges								
11	Negotiated payer specific charges/rates						-43430		
12	Cash Discounted Rates						-43430		
13	De-identified Minimum								
14	De-identified Maximum								

Appendix E

Sample Display of CMS Gross Charges

Comprehensive Machine-Readable File: Sample Display of Gross Charges[1]

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes]

Description	CPT/HCPCS Code	NDC	OP/Default Gross Charge	IP/ER Gross Charge	ERx Charge Quantity
HB IV INFUS HYDRATION 31-60 MIN	96360		$1,000.13	$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		$251.13	$383.97	
HB IV INFUSION THERAPY 1ST HR	96365		$1,061.85	$1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				$2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				$2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				$2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				$2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			$3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			$1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			$6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	$251.13	$383.97	12 Each
PHENYLEPHRINE HCL 10 % OP DROP		17478020605	$926.40	$1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	$0.00	$0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		$185.00		
GENETIC COUNSEL 15 MINS	S0265		$94.00		
DIALYSIS TRAINING/COMPLETE	90989		$988.00		
ANESTH, PROCEDURE ON MOUTH	170		$87.00		

[1] Note that this example shows only one type of standard charge (specifically the gross charges) that a hospital would be required to make public in the comprehensive machine-readable file. Hospitals must also make public the payer-specific negotiated charges, the de-identified minimum negotiated charges, the de-identified maximum negotiated charges, and the discounted cash prices for all items and services.

National Rural Health Resource Center

References

Documents referenced and linked in the Pricing Transparency Guide.

"CMS Statement on Extended Comment Period for Transparency in Coverage Proposed Rule (CMS-9915-P)." Centers for Medicare and Medicaid, December 27, 2019.

"Executive Order (EO) on Improving Price and Quality Transparency in American Health to Put Patients First." Executive Order. No. 13877, June 24, 2019.

"HHS Proposes New Rules to Improve the Interoperability of Electronic Health Information." U.S. Department of Health and Human Services (HHS), 11 Feb. 2019.

"Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates." Federal Register 85:32460 (May 29, 2020)

"Hospital Price Transparency 101: Understanding the Basics." The Center for Health Affairs.

"Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency

Requirements for Hospitals To Make Standard Charges Public." Federal Register Vol. 84, No. 229, November 27, 2019.

"Patient Protection and Affordable Care Act of 2010," Pub. L. No. 111–148, 124 Stat. 119 (2010), Codified as Amended 42 U.S.C. § 18001.

"Price Transparency Frequently Asked Questions for Consumers." North Carolina Healthcare Association (2019).

"Proposed Changes to Hospital Outpatient Prospective Payment System (OPPS) Final Rule." Federal Register 84:39398 (August 9, 2019).

"Price Transparency Fact Sheet." Centers for Medicare and Medicaid Services, 2020.

"Price Transparency: Requirements Price Transparency: Requirements for Providers to Make Public Cash Prices for COVID-19 Diagnostic Testing." Centers for Medicare and Medicaid Services, 2020.