

Hospital Price Transparency Frequently Asked Questions (FAQs)

This document is designed as a resource for Hospital Price Transparency frequently asked questions (FAQs).

All FAQs presented in this document are current as of September 30, 2020.

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General Provisions

Where can I find the final rule establishing the hospital price transparency regulations?

CMS finalized new hospital price transparency requirements under section 2718(e) of the Public Health Service Act, as well as a regulatory scheme under section 2718(b)(3) that enables CMS to enforce those requirements, in the Calendar Year 2020 Outpatient Prospective Payment System (OPPS) 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 (CMS-1717-F2) final rule (Hospital Price Transparency final rule). The Hospital Price Transparency final rule was published in the Federal Register on November 27, 2019 (84 FR 65524) and is available at

<https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and>

What are hospitals required to do under the hospital price transparency regulations? When do hospitals have to comply with these requirements?

By January 1, 2021, each hospital operating in the United States is required to provide clear, accessible pricing information about the items and services they provide in two ways:

1. Comprehensive machine-readable file with all items and services.
2. Display of shoppable services in a consumer-friendly format.

What requirements do hospitals have to comply with before January 1, 2021?

Existing CMS guidance requires that all hospitals in the United States make public their list of their current standard charges (whether in the form of a “chargemaster” or another form of the hospital’s choice) online in a machine-readable format and to update this information annually. There are no hospitals operating within the United States with exemptions from this requirement under the current policy. Please refer to the FAQs for FY 2019 IPPS/LTCH PPS final rule (83 FR 41144) <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FAQs-Req-Hospital-Public-List-Standard-Charges.pdf> and the following additional FAQs <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspectivePaymentGen/Downloads/Additional-Frequently-Asked-Questions-Regarding-Requirements-for-Hospitals-To-Make-Public-a-List-of-Their-Standard-Charges-via-the-Internet.pdf> for existing guidance. This guidance remains in effect until December 31, 2020.

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How do the hospital price transparency regulations fit into CMS' Price Transparency strategic initiative?

The CMS Price Transparency Initiative is one of 16 CMS strategic initiatives designed to deliver better value and results for patients through competition and innovation. We believe that by ensuring accessibility to all hospital standard charge data for all items and services, these data will be available for use by the public in price transparency tools, to be integrated into EHRs for purposes of clinical decision-making and referrals, or to be used by researchers and policy officials to help bring more value to healthcare. Additionally, the ability to price shop across settings and calculate and compare of out-of-pocket costs requires data from both providers and payers. Because the Hospital Price Transparency Final Rule focuses on charge data that is controlled by providers, specifically hospitals, we view these policies as a first step in ensuring that pricing data necessary to determine out-of-pocket costs is available to consumers. We continue to encourage hospitals to go further in helping individuals understand their financial obligations in advance of receiving a health care service by, for example, creating consumer-friendly price transparency tools and lookups that provide consumer-specific out-of-pocket price estimates. You can read more about the Price Transparency strategic initiative: <https://www.cms.gov/About-CMS/Story-Page/Price-transparency-fact-sheet.pdf> and the proposed Transparency in Coverage proposed rule: <https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-proposed-rule-cms-9915-p>.

Definitions

How is hospital defined under the Hospital Price Transparency Final Rule? Does the rule apply to Critical Access Hospitals, other small or rural hospitals, state owned/operated institutions, and non-acute hospitals such as inpatient psychiatric hospitals and inpatient rehabilitation facilities (IRFs)?

Hospital means an institution, in any State in which State or applicable local law provides for the licensing of hospitals, which is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. For purposes of this definition, a State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. All hospital location(s) operating under the same hospital license (or approval), such as a hospital's outpatient department located at an off-campus location (from the main hospital location) operating under the hospital's license, are subject to the requirements in this rule. This definition includes all Medicare-enrolled institutions that are licensed as hospitals (or approved as meeting licensing requirements) as well as any non-Medicare enrolled institutions that are licensed as a hospital (or approved as meeting licensing

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requirements). Given this definition, this rule applies to every institution that meets the definition of 'hospital' established by the Hospital Price Transparency Final Rule including institutions such as critical access hospitals, specialty hospitals, and state owned or operated facilities. Please refer to 45 CFR [§ 180.20](#).

Federally owned or operated hospitals (for example, hospitals operated by an Indian Health Program, the U.S. Department of Veterans Affairs, or the U.S. Department of Defense) that do not treat the general public, except for emergency services, and whose rates are not subject to negotiation, are deemed to be in compliance with the requirements for making public standard charges because their charges for hospital provided services are publicized to their patients in advance (for example, through the *Federal Register*). Please refer to 45 CFR [§180.30](#).

What standard charges must hospitals make public?

A standard charge means the regular rate established by the hospital for an item or service provided to a specific group of paying patients. For purposes of complying with the Hospital Price Transparency Final Rule, this includes five types of standard charges:

1. The gross charge (the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts).
2. The discounted cash price (the charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service).
3. The payer-specific negotiated charge (the charge that a hospital has negotiated with a third party payer for an item or service).
4. The de-identified minimum negotiated charge (the lowest charge that a hospital has negotiated with all third-party payers for an item or service).
5. The de-identified maximum negotiated charge (the highest charge that a hospital has negotiated with all third-party payers for an item or service).

Please refer to 45 CFR [§180.20](#).

What hospital "items and services" are included by the Hospital Price Transparency Final Rule? What is a "service package"?

For purposes of complying with the hospital price transparency requirements, items and services are 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 an outpatient department visit for which a hospital has established a standard charge. Examples include supplies and procedures, room and board, and use of the facility and other

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items (generally described as facility fees), services of employed physicians and non-physician practitioners (generally reflected as professional charges), and any other item or service for which a hospital has established a standard charge. Please refer to 45 CFR [§180.20](#).

A service package is an aggregation of individual items and services into a single service for which the hospital has a single standard charge. “Service packages” may have charges established on, for example, the basis of a common procedure or patient characteristic, or may have an established per diem rate that includes all individual items and services furnished during an inpatient stay. Please refer to 45 CFR [§180.20](#).

The definition of “items and services” includes services of employed physicians and non-physician practitioners. How does CMS define “employment”?

Given the variation and complexity in employment models and possible contracting relationships that may exist between hospitals and physicians, we believe it is important to preserve flexibility for hospitals to identify employed physicians or non-physician practitioners under their organizational structure, and, for this reason, we declined to codify a definition of “employment” in the Hospital Price Transparency Final Rule. Refer to 84 FR [65535](#). One resource that hospitals could consider reviewing for purposes of determining whether or not a physician or non-physician practitioner is employed by the hospital is: <https://www.irs.gov/newsroom/understanding-employee-vs-contractor-designation>.

Do these requirements apply to non-employed physicians and other practitioners who provide and bill for the same services at the hospital?

No. Services provided by physicians and non-physician practitioners who are not employed by the hospital are practitioners that are practicing independently, establish their own charges for services, and receive the payment for their services. Such services, therefore, are not services “provided by the hospital.”

Do these requirements apply to the services of employed practitioners whose charges are not found in the hospital chargemaster?

Yes. The Hospital Price Transparency Final Rule does not limit the requirements to only hospital standard charges that are found within the hospital chargemaster, including standard charges for items and services provided by practitioners employed by the hospital. The requirements apply to such charges that may be located elsewhere within the hospital accounting and billing system, or, in the case of payer-specific negotiated charges, in contracts and rate sheets that are specific to a particular third party payer. Please refer to 84 FR [65535](#).

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Public Disclosure Requirements

Can hospitals choose between displaying standard charges in a machine-readable format and displaying standard charges for shoppable services in a consumer-friendly format?

No. Hospitals must make public both of the following: (1) A machine-readable file containing a list of all standard charges for all items and services as provided in § 180.50 and (2) a consumer-friendly list of standard charges for a limited set of shoppable services as provided in § 180.60. Please note that CMS will deem a hospital as having met the second of these two requirements if the hospital maintains an internet-based price estimator tool which meets the requirements provided in § 180.60(a)(2).

Our hospital does not provide a discounted cash price for items and services. How should we reflect this in the display of standard charge information?

Some hospitals may not have determined a discounted cash price for self-pay consumers for the items and services it provides. In this case, the hospital must post the gross charge as reflected in the hospital chargemaster. Please refer to 84 FR [65553](#) for discussion on this topic.

Some of the hospital items or services we offer do not have an associated HCPCS or CPT code. Are we required to list such services? If so, what should be indicated next to the item or service?

Yes. The Hospital Price Transparency Final Rule requires hospitals to disclose the standard charges for each item or service it provides, therefore, all hospital items and services for which the hospital has established a standard charge must be listed regardless of whether or not all the required corresponding data elements are available. Corresponding common billing and accounting codes must be included, as applicable. When an item or service does not have a corresponding payment or diagnosis codes associated with an item or service, it is acceptable to leave the information blank. Alternatively, a hospital could choose its own indicator or other method to communicate to the public that there is no corresponding code. Please refer to [Table 1](#) (84 FR [65558](#)) for an example of a display of gross charges which includes this scenario.

Is there a limitation on the number of third party payers for which we have to make negotiated charges public? For example, does this requirement apply to contracts with our top payers only?

No. Hospitals are required to list their standard charges, as applicable, including all payer-specific standard charges, for all items and services. The Hospital Price Transparency Final Rule

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did not place limits on the number of third party payers for which a hospital would be required to make their standard charges public. Please refer to 84 FR [65567](#) for further discussion on this topic.

What is a “base rate” for a service package?

The base rate is the payer-specific charge the hospital has negotiated for a service package. Base rates for service packages are typically not found in the hospital chargemaster, but can be found in other parts of the hospital’s billing and accounting systems, or in what are known as ‘rate sheets’ found in hospital in-network contracts with their third party payers. The base rate is **not** the final payment or reimbursement rate for the service package received by the hospital for individual patients.

My hospital negotiates rates with third party payers in three ways: 1) as a percent discount off gross charges, 2) as a per diem, and 3) based on DRG. How should my hospital display these payer-specific negotiated charges?

For each third party payer with whom your hospital has negotiated charges, you should consult your contract and rate sheets to identify and collect the data elements that are required (as applicable) for display.

This simplified example demonstrates how a hospital might display its payer-specific negotiated charges for each of three categories: 1) as a discount off its gross charges, 2) as a per diem, and 3) as a DRG. The following assumptions apply:

- For sake of simplicity, the hospital provides only inpatient services and has contracts with three different payers that have only one plan each.
- With Payer 1, the hospital has negotiated a 50% discount off its gross charges for each individual item or service (in this example, a CT scan associated with a CPT or HCPCS billing code) found in its chargemaster.
- With Payer 2, the hospital has negotiated a daily service package rate for an inpatient stay (in this example, a per diem rate).
- With Payer 3, the hospital has negotiated a service package rate (in this example, a joint replacement surgery that is associated with a DRG billing code).

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Item/service description	Billing Code	Gross Charges	Payer 1 negotiated charge	Payer 2 negotiated charge	Payer 3 negotiated charge
CT scan	[if applicable, for example, CPT or HCPCS]	\$250	\$125	N/A	N/A
Hospital inpatient care – per diem (daily) rate	[if applicable]	N/A	N/A	\$500	N/A
Joint replacement	[if applicable, for example, DRG]	N/A	N/A	N/A	\$15,000

How should my hospital display charges for service packages that vary based on severity of illness?

Base rates for service packages are sometimes adjusted by a multiplier to address severity of illness (SOI) or adjustments for other factors. For example, a joint replacement may have a payer-specific negotiated base rate at \$2,000 with multipliers for various SOIs: intermediate complexity at \$3,000 (\$2,000 x 1.5); high complexity at \$4,000 (\$2,000 x 2); or very high complexity at \$5,000 (\$2,000 x 2.5). The Hospital Price Transparency Final Rule does not limit hospitals from displaying additional clarifying information for patients, for example, providing a base rate for each severity level within a DRG or other clarifying information to patients related to how a service package base rate may change depending on severity of illness (SOI). Please refer to 84 FR [65547](#) and [65551](#) for further discussion on this topic.

Should Medicaid plan rates be considered part of the de-identified minimum charge and payer-specific charge if a state is a fully managed Medicaid state?

Hospitals are required to make public the payer-specific negotiated charges that they have negotiated with third party payers, including charges negotiated by third party payer managed care plans such as Medicare Advantage plans, Medicaid MCOs, and other Medicaid managed care plans. Therefore, a state’s Medicaid managed care contracts may fall within this description, if such managed care contracts include rates negotiated with the hospital. Please refer to 84 FR [65551](#) where we finalized our definition of “third party payer” as an entity that, by statute, contract, or agreement, is legally responsible for payment of a claim for a healthcare item or service.

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We believe displaying payer-specific negotiated rates publicly would violate the confidentiality clause of the hospital’s contract with our third-party payers. Has CMS addressed this issue?

We recommend that hospital use the time before 1/1/2021 to review their contracts with third party payers and revise as they believe may be necessary to ensure hospital compliance with the Hospital Price Transparency Final Rule. Even if a contract between a hospital and a payer contained a provision prohibiting the public disclosure of its terms, it is our understanding that such contracts typically include exceptions where a particular disclosure is required by Federal law. Please refer to 84 FR [65544](#).

Can you give examples of how to determine the de-identified minimum and maximum negotiated charges for an item or service?

Once your hospital has listed each item and service it provides, along with the corresponding payer-specific negotiated charges the hospital has established for each one, you must identify the minimum and maximum amount. The following illustrations provide simple examples of how a hospital can determine the de-identified minimum and maximum negotiated charges for each item or service across all their payers.

Example 1: A hospital negotiates the following payer-specific charges with three payers for an individual item or service, for example, an imaging test identified by billing code ‘12345’.

Item/service description	Billing Code	Payer 1 negotiated charge	Payer 2 negotiated charge	Payer 3 negotiated charge	De-identified minimum negotiated charge	De-identified maximum negotiated charge
Imaging test	12345	\$125	\$300	\$550	\$125	\$550

Example 2: A hospital negotiates the following payer-specific charges with three payers for two different service packages. The hospital has negotiated a payer-specific charge with Payer 1 for a procedure based on an APR-DRG. With Payers 2 and 3, the hospital has negotiated a payer-specific charge based on the number of days the patient spends in the hospital, that is, a *per diem* charge.

Item/service description	Billing Code	Payer 1 negotiated charge	Payer 2 negotiated charge	Payer 3 negotiated charge	De-identified minimum negotiated charge	De-identified minimum negotiated charge
Procedure	999	\$1250	N/A	N/A	\$1250	\$1250
Per diem	xxx	N/A	\$500	\$450	\$450	\$500

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What are the similarities and differences of the requirements for the two ways that each hospital must make public a list of the hospital's standard charges for items and services it provides?¹

	Comprehensive Machine-readable File	Consumer-friendly display of Shoppable Services²
General requirement	Single comprehensive machine-readable file containing a list of standard charges, as applicable, for all items and services.	Some standard charge information, as applicable, for at least 300 shoppable services including 70 CMS-specified services presented in a consumer-friendly manner ³ . The primary shoppable service must be grouped with any ancillary services the hospital customarily provides as part of or in conjunction with the primary service.
Standard Charges	<ul style="list-style-type: none"> • Gross charge • Discounted cash price • Payer-specific negotiated charges • De-identified minimum negotiated charge • De-identified maximum negotiated charge 	<ul style="list-style-type: none"> • Discounted cash price (or gross charge, where the hospital has not established a discounted cash price) • Payer-specific negotiated charges • De-identified minimum negotiated charge • De-identified maximum negotiated charge

¹ A complete overview of requirements can be found at [Subpart B-Public Disclosure Requirements](#).

² A hospital is deemed by CMS to meet the requirements of this section if the hospital maintains an Internet-based price estimator tool which meets the following requirements:

- 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.
- 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.
- 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.

³ If a hospital does not provide 300 shoppable services, the hospital must make public its standard charges for as many shoppable services as it provides.

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	Comprehensive Machine-readable File	Consumer-friendly display of Shoppable Services²
Description of item or service and billing codes	A description of each item or service along with, as applicable, any code used by the hospital for purposes of accounting or billing for the item or service.	A <u>plain-language</u> description of each shoppable service along with, as applicable, any primary code used by the hospital for purposes of accounting or billing for the shoppable service.
Service not offered by hospital	No requirement	Use an indicator when one or more of the CMS-specified shoppable services are not offered by the hospital (for example, N/A).
Format	A single digital file that is machine-readable	No requirement
Naming Convention	Must adhere to the CMS naming convention: <ein>_<hospital-name>_standard charges.[json xml csv]	No requirement
Location of information	Displayed prominently on a publicly-available website and in a prominent manner that clearly identifies the hospital location with which the information is associated.	Displayed prominently on a publicly-available website and in a prominent manner that clearly identifies the hospital location with which the information is associated.
Access to information	Must be free of charge and may not require a log-in or password, other barriers, and/or the submission of any personal identifying information (PII).	Must be free of charge and may not require a log-in or password, other barriers, and/or the submission of any personal identifying information (PII).
Search Capability	Digitally searchable	Searchable by service description, billing code, and payer
Updates	Annually – with date of last update clearly indicated	Annually – with date of last update clearly indicated

Machine-Readable File

What is a ‘machine-readable’ file format?

A machine-readable file format is a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of this format include, but are not limited to, .XML, .JSON, and .CSV formats. Please refer to 45 CFR § 180.20.

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Must a hospital use a specific naming convention for the comprehensive machine-readable file? If so, what is the CMS-specified naming convention?

Yes. Hospitals must use the following naming convention specified by CMS for its comprehensive machine-readable file: <ein>_<hospital-name>_standardcharges.[json|xml|csv]. Please refer to 45 CFR [§180.50](#).

Consumer-friendly Display of Shoppable Services

What is a shoppable service? Are medications considered shoppable services?

A shoppable service means a service that can be scheduled by a healthcare consumer in advance. Procedures such as joint replacements and services such as physical therapy are examples of shoppable services. Hospital administration of a medication could be considered a shoppable service if it can be scheduled in advance. Examples of administration of a medication that could be considered a shoppable service are the administration of flu shots or medication infusions for chronic conditions. The definition of 'shoppable service' can be found at 45 CFR [§180.20](#).

What if a hospital does not provide one or more of the 70 CMS-specified shoppable services or provides less than 300 shoppable services in total? How can requirements of this regulation be met?

If a hospital does not provide one or more of the 70 CMS-specified shoppable services, the hospital must select additional shoppable services such that the total number of shoppable services is at least 300. If a hospital does not provide 300 shoppable services, the hospital must list as many shoppable services as they provide. The hospital must clearly indicate any CMS-specified shoppable service that it does not provide. The hospital may use "N/A" for the corresponding charge or use another appropriate indicator to communicate to the public that the shoppable service is not provided by the hospital. Please refer to 84 FR [65569](#) and [65574](#) for further discussion.

What is an 'ancillary item and service'?

Ancillary services are any item or service a hospital customarily provides as part of or in conjunction with a shoppable primary service and may include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including post-anesthesia and postoperative recovery rooms), therapy services (physical, speech, occupational), hospital fees, room and board charges, and charges for employed professional services. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. For example, an outpatient procedure may include many

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services that are provided by the hospital, for example, local and/or global anesthesia, services of employed professionals, supplies, facility and/or ancillary facility fees, imaging services, lab services and pre- and post-op follow up. To the extent that a hospital customarily provides (and bills for) such ancillary services as a part of or in conjunction with the primary service, the hospital should group the ancillary service charges along with the other standard charges that are displayed for the shoppable service. The definition of ancillary service can be found at 45 CFR [§180.20](#) and further discussion of ancillary services can be found at 84 FR [65564](#).

How should a hospital display charges for a shoppable service in a consumer-friendly manner when the hospital offers it as a service package or when the hospital already includes all ancillary services as part of the service package charge?

To the extent that the hospital includes in its public display a shoppable service that it commonly provides as a service package, the hospital must display the charge the hospital has established for the service package as a whole. In other words, if the hospital has established a standard charge for the service package, the hospital must display that standard charge as opposed to displaying a manufactured charge for each of the individual items and services that make up the service package. For example, when displaying the charge for a shoppable service identified by a DRG, the hospital would display the payer-specific negotiated charge (the “base rate”) negotiated with a third party payer for the DRG. To be consumer friendly, the hospital may elect to communicate what individual items and services are included in the standard charge for the service package, but this is not required under the Hospital Price Transparency Final Rule. However, the rule does require hospitals to list any additional ancillary services the hospital customarily provides with the shoppable service. In other words, if there are any items and services that are not already included in the service package but that would be customarily provided by the hospital in conjunction with the service package, the hospital must provide a description of the ancillary service along with its standard charge(s) and other required data elements, as applicable.

Can a price estimator tool be used to meet the requirement to display shoppable services in a consumer-friendly format? If yes, what requirements must the price estimator tool meet?

Yes. In the Hospital Price Transparency Final Rule, we stated that we had been persuaded by commenters’ suggestions that hospitals offering online price estimator tools that provide real-time individualized out-of-pocket cost estimates should receive consideration. Although we recognize that some hospital price estimator tools may not display consumer-friendly standard charge information in the precise ways we are requiring under the rule, they do

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appear to accomplish the goal and intent of ensuring such information is available in a consumer-friendly manner by allowing individuals to directly determine their specific out-of-pocket costs in advance of committing to a hospital service. We emphasize, however, that hospitals must still publish their standard charges for the items and services they provide in a comprehensive machine-readable file (refer to 45 CFR §180.50). In other words, offering a price estimator tool can satisfy the requirement to post shoppable service information in a consumer-friendly format but does not satisfy the requirement to display hospital standard charges in a comprehensive machine-readable file.

Further, if a hospital chooses to exercise this option, the hospital Internet-based price estimator tool must meet the following criteria to be deemed in compliance:

- Provide 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.
- Allow 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.
- 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.

Please refer to 84 FR [65577](#) for further discussion on this topic and to 45 CFR [§180.60\(a\)\(2\)](#) for the requirements.

Does CMS have an example of disclaimer language that a hospital could use on its price estimator tool?

No. Each hospital is unique and serves a unique patient population. We encourage, but do not require, hospitals to provide disclaimers as applicable and appropriate in their price estimator tools, including disclaimers acknowledging the limitation of the presented standard charge information and advising the user to consult, as applicable, with his or her health insurer to confirm individual payment responsibilities and remaining deductible balances. Similarly, we encourage, but do not require, that hospital standard charge information include the following:

- Notification of the availability of financial aid, multiple procedure discounts, payment plans, and assistance in enrolling for Medicaid or a state program.
- An indicator for the quality of care in the healthcare setting.
- Making the standard charge information available in languages other than English, such as Spanish and other languages that would meet the needs of the communities and populations the hospital serves.

We discussed the flexibility to provide disclaimers in hospital price estimator tools at 84 FR [65578-65579](#).

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Can CMS provide a list of internet-based price estimator tool vendors?

No, we do not have an available list of vendors who provide price estimator tool application software. Offering such tools is one way a hospital can choose to comply with requirements for displaying charges for shoppable services in a consumer-friendly manner, but this method of compliance is optional under the Hospital Price Transparency Final Rule.

Can hospitals provide additional consumer-friendly resources?

Yes. Hospitals are encouraged to embrace a patient-centered approach to care in all forms, including providing consumer-friendly resources related to cost of care that will empower patients with pricing information to help them make healthcare decisions that work best for them.

Do contracts with non-payer companies, i.e. local employers for drug screening, need to be included in the list of payer-specific negotiated rates?

The term “payer-specific negotiated charge” is defined as the charge that the hospital has negotiated with a third party payer for an item or service. The term “third party payer” is defined as an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service. Therefore, if a local company meets the definition of “third party payer” and your hospital has negotiated a payer-specific negotiated charge for an item or service with that company, then you must list the payer-specific negotiated charge for the item or service, along with the other required data elements, as applicable. These definitions can be found at 45 CFR § 180.20.

Monitoring and Penalties for Noncompliance

What happens if a hospital does not comply?

CMS has the authority to monitor hospital compliance with section 2718(e) of the Public Health Service Act, by evaluating complaints made by individuals or entities to CMS, reviewing individuals’ or entities’ analysis of noncompliance, and auditing hospitals’ websites. Should CMS conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may request a corrective action plan (CAP) from the hospital if its noncompliance constitutes a material violation of one or more requirements, and may assess on a hospital a civil monetary penalty not in excess of \$300 per day, and publicize the penalty on a CMS website, should the hospital fail to respond to CMS’ request to submit, or comply with the requirements, of a CAP. Please refer to Subpart C- Monitoring and Penalties for Noncompliance.

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Appeals of Civil Monetary Penalties

Can a hospital appeal a civil monetary penalty related to hospital price transparency?

Yes. A hospital upon which CMS has imposed a penalty may request a hearing before an Administrative Law Judge (ALJ) in accordance with [45 CFR part 180, subpart D](#). In deciding whether the amount of a civil monetary penalty is reasonable, the ALJ may only consider evidence of record related to the following: hospital's posting(s) of standard charges, if available; material the hospital timely previously submitted to CMS (including with respect to corrective actions and corrective action plans), and material CMS used to monitor and assess the hospital's compliance.

How long does a hospital have to request a hearing?

A hospital must request a hearing within 30 calendar days after the date of issuance of the notice of imposition of a civil monetary penalty. The "date of issuance" is no more than five (5) days after the filing date postmarked by the U.S. Postal Service, or deposited with a carrier for commercial delivery, unless there is a showing that the document was received earlier. Please refer to 45 CFR §§150.401, 150.405(a).

Can a hospital request an extension of time for filing a request for a hearing?

A request for an extension of time must be made promptly by written motion. The ALJ may extend the time for filing a request for hearing only if the ALJ finds that the hospital was prevented by events or circumstances beyond its control from filing its request within 30 calendar days after the date of issuance of the notice of imposition of a civil monetary penalty. Please refer to [45 CFR § 150.405\(b\)](#).

What happens if a hospital does not request a hearing according within the required timeframe?

If a hospital does not request a hearing within 30 calendar days of the issuance of the notice of imposition of a CMP, CMS may impose the CMP indicated in such notice and may impose additional penalties pursuant to continuing violations according to new 45 CFR 180.90(f) without right of appeal. According to 45 CFR §180.110(b), the hospital has no right to appeal a penalty with respect to which it has not requested a hearing in accordance with 45 CFR §150.405, unless the hospital can show good cause, as determined at §150.405(b), for failing to timely exercise its right to a hearing.

Hospital Price Transparency Frequently Asked Questions (FAQs)