

Supporting Statement – Part A

Requirements for Hospitals to Make Public a List of Their Standard Charges Effective January 1, 2021 (CMS-10707)

A. Background

The Centers for Medicare & Medicaid Services (CMS) finalized new rules, at 45 CFR part 180, authorized by section 2718 of the Public Health Service (PHS) Act. Section 2718(e) of the PHS Act requires each hospital operating within the United States for each year to 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, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act (the Act). The data collection includes establishing, updating, and making public via the internet in a single machine-readable file a list of standard charges (including gross charges, payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted cash prices) for all items and services. The data collection also includes hospitals making public via the internet standard charges (including payer-specific negotiated charges, discounted cash prices, de-identified minimum negotiated charges, de-identified maximum negotiated charges) in a consumer-friendly manner 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.

In the FY 2015 IPPS/LTCH PPS proposed and final rules (79 FR 28169 and 79 FR 50146, respectively), we reminded hospitals of their obligation to comply with the provisions of section 2718(e) of the PHS Act and provided guidelines for its implementation. At that time, we required hospitals to either make public a list of their standard charges or their policies for allowing the public to view a list of those charges in response to an inquiry. In addition, we stated that we expected hospitals to update the information at least annually, or more often as appropriate, to reflect current charges. We also encouraged hospitals to undertake efforts to engage in consumer-friendly communication of their charges to enable consumers to compare charges for similar services across hospitals and to help consumers understand what their potential financial liability might be for items and services they obtain at the hospital.

In the FY 2019 IPPS/LTCH PPS proposed and final rules (83 FR 20164 and 83 FR 41144, respectively), we again reminded hospitals of their obligation to comply with the provisions of section 2718(e) of the PHS Act and updated our guidelines for its implementation. The announced update to our guidelines became effective January 1, 2019, and took one step to further improve the public accessibility of standard charge information. Specifically, we updated our guidelines to require hospitals to make available a list of their current standard charges via the internet in a machine-readable format and to update this information at least annually, or more often as appropriate. We subsequently published two sets of Frequently Asked Questions (FAQs)¹ that provided additional guidance to hospitals, including a FAQ clarifying that while

¹Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FAQs-Req-Hospital-Public-List-Standard-Charges.pdf> and <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FAQs-Req-Hospital-Public-List-Standard-Charges.pdf>

hospitals could choose the format they would use to make public a list of their standard charges, the publicly posted information should represent their standard charges as reflected in their chargemaster. We also clarified that the requirement applies to all hospitals operating within the United States and to all items and services provided by the hospital.

B. Justification

1. Need and Legal Basis

Section 1001 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by section 10101 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), amended Title XXVII of the PHS Act, in part, by adding a new section 2718(e). Section 2718 of the PHS Act, entitled “Bringing Down the Cost of Health Care Coverage,” requires each hospital operating within the United States for each year to 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, including for diagnosis-related groups established under section 1886(d)(4) of the Act.

On June 24, 2019, the President signed Executive Order 13877 entitled “Improving Price and Quality Transparency in American Healthcare to Put Patients First” that directed the Secretary of HHS, within 60 days to “propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format using consensus-based data standards that will meaningfully inform patients’ decision making and allow patients to compare prices across hospitals. The regulation should require the posting of standard charge information for services, supplies, or fees billed by the hospital or provided by employees of the hospital. The regulation should also require hospitals to regularly update the posted information and establish a monitoring mechanism for the Secretary to ensure compliance with the posting requirement, as needed.”

Based on feedback from hospitals and consumers following the January 1, 2019 implementation of the revised guidelines, and in accordance with President’s Executive Order 13877, CMS proposed an expansion of hospital charge display requirements to include charges and information based on negotiated rates and for common shoppable items and services, in a manner that is consumer-friendly. The “Medicare Program; Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children’s Hospitals-Within-Hospitals” (84 FR 39398 through 39644), herein referred to as the “CY 2020 OPPS/ASC proposed rule,” was displayed in the Federal Register on July 29, 2019, with a comment period that ended on September 27, 2019.

[Service-Payment/ProposedMedicareFeeSvcPmtGen/Downloads/Additional-Frequently-Asked-Questions-Regarding-Requirements-for-Hospitals-To-Make-Public-a-List-of-Their-Standard-Charges-via-the-Internet.pdf](#)

On November 27, 2019, the final rule entitled “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” was published in the Federal Register. With this final rule, CMS finalized a new Part 180--Hospital Price Transparency to Title 45 of the Code of Federal Regulations (CFR) which contains regulations on price transparency for purposes of section 2718(e) of the PHS Act. These requirements build upon previous guidance that required hospitals to make public their standard charges upon request starting in 2015 (79 FR 50146) and subsequently online in a machine-readable format starting in 2019 (83 FR 41144), and consider public comments received on the proposals in the CY 2020 OPPTS/ASC proposed rule (84 FR 39398). The final rule includes information collections associated with the following: requirements specified in §180.50 for a “hospital” (as defined in §180.20) to make public a machine-readable file that contains a hospital’s gross charge, payer-specific negotiated charge, the de-identified minimum negotiated charge, the de-identified maximum negotiated charge, and discounted cash price for all “items and services” (as defined in §180.20) provided by the hospital; requirements specified in §180.60 for a hospital to make public payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted cash prices for at least 300 select hospital-provided items and services that are “shoppable” and that are displayed and packaged in a consumer-friendly manner.

Collection of this information is necessary for CMS to ensure pricing information is readily accessible and usable to consumers. Health care consumers continue to lack the meaningful pricing information they need to choose the healthcare services they want and need despite prior requirements for hospitals to make public their chargemaster rates online. The final rule requiring public release of hospital standard charge information is a necessary and important step in ensuring transparency in health care prices for consumers.

2. Information Users

Hospitals: Hospitals are the only respondents for the purpose of this information collection. This final rule applies to each hospital operating within the United States. As specified in §180.40, a hospital is required to 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.. CMS believes that these two different methods of making hospital standard charges public are necessary to ensure such data is available to consumers where and when it is needed (for example, via integration into price transparency tools, Electronic Health Records (EHRs), and consumer apps), and also directly available and useful to consumers that search for hospital-specific charge information without use of a developed price transparency tool. We believe that requiring hospitals to make public standard charges for shoppable services will increase consumer satisfaction and encourage price comparison, ultimately resulting in decreased out-of-pocket cost to the consumer.

Health Care Consumers: CMS intends for consumers to have easier access to health care pricing information, including gross charges, payer-specific negotiated charges, de-identified minimum

negotiated charges, de-identified maximum negotiated charges, and discounted cash prices for all hospital items and services as well as, payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted cash prices for shoppable services. Consumers will have a better ability to estimate their hospital bills prior to treatment.

Third party developers, researchers and employers: Third party developers will have access to all payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted cash prices for the first time, and may innovate and create new products, including Internet-based price estimator tools, or upgrade existing technologies to support hospitals in meeting these requirements and aiding consumers and healthcare providers in using data that is made public by hospitals. Researchers will have better information on regional and local health care costs which may lead to a better understanding of price dispersion and economic factors that result in artificially inflated costs. Other members of the public, such as employers, would be better informed to monitor insurer effectiveness and to help their employees shop for value.

Further, consumers (individuals) or entities may review the publicly available information and report to CMS findings that suggest a hospital's noncompliance with these finalized requirements.

3. Use of Information Technology

Generally, under the final rule, hospitals must make public information about their standard charges on the internet. While all data (list of standard charges) must be made available in a machine-readable format, a subset of the data (shoppable services) must be made available in a consumer-friendly format. CMS defines a machine-readable format as 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 machine readable formats include, but are not limited to, .XML, .JSON and .CSV formats. Requiring hospitals to post a list of their standard charges in a machine-readable format ensures that standard charge data can be accessible to the public, including third party developers who may use such data to create consumer-friendly price transparency tools.

4. Duplication of Efforts

We anticipate no duplication of efforts for hospitals. The required information collection is distinguishable from other federal efforts, and flexibility is afforded in the final rule to allow hospitals to use already existing platforms for making a list of standard charges public to avoid duplication of State and private sector efforts aimed to improve price transparency. As specified in the final rule, CMS will deem a hospital as having met the requirements for making public standard charges in a consumer friendly manner if the hospital maintains an internet-based price estimator tool which meets the requirements as specified in §180.60.

5. Small Businesses

The final rule applies to all hospitals, including small rural hospitals. However, we determined that the requirements included in the final rule will not have a significant impact on a substantial number of small entities.

6. Less Frequent Collection

Less frequent collection would not be an option because section 2718(e) of the PHS Act requires 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, including for diagnosis-related groups established under section 1886(d)(4) of the Act.

CMS previously required, in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41686 through 41688), effective January 1, 2019, hospitals to update standard charge information at least annually, or more often as appropriate to reflect current charges.

As described in the final rule, CMS recognizes that hospital charges may change more frequently than annually, and therefore encourages (but does not require) hospitals to update the standard charge data they make public more often, as appropriate, so that the public may have access to the most up-to-date charge information.

7. Special Circumstances

This collection of information does not require any special circumstances.

8. Federal Register/Outside Consultation

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, final rule (84 FR 65524).

9. Payments/Gifts to Respondents

No payments or gifts will be given to respondents for participation.

10. Confidentiality

All information collected under this information collection will be maintained in strict accordance with statutes and regulations governing confidentiality requirements. In addition, the tools used for transmission of data are considered confidential forms of communication and are Health Insurance Portability and Accountability Act (HIPAA) and Privacy Act of 1974 (5 U.S.C. 552a) compliant.

11. Sensitive Questions

There are no sensitive questions associated with this collection.

12. Burden Estimates (Hours & Wages)

We estimate that this final rule applies to 6,002 hospitals operating within the United States under the definition of “hospital”. To estimate this number, we subtract 208 federally-owned hospitals from the total number of U.S. hospitals, 6,210 hospitals² (45 CFR 180.30) (6,210 total hospitals – 208 federally-owned hospitals).

We believe the greatest impact of the regulatory requirements will be in the first year related to organizing the display of information in the form and manner required under this final rule after which the hospital would simply have to update the numbers annually. We estimated the total burden to implement the requirements of the final rule to be 150 hours at a cost of \$11,898.60 per hospital.

In order to comply with regulatory requirements in this final rule in the first year, affected hospitals will first need to review the rule. We estimate that this task will take a lawyer on average 5 hours and a general operations manager on average 5 hours.

We estimate it will take a business operations specialist, on average, 80 hours to complete necessary processes and procedures to gather and compile required information and post it to the internet in the form and manner specified by this final rule. We also finalized several requirements for posting required information as specified at 45 CFR part 180. These requirements impose form and manner standards for the applicable hospitals. We estimate that a network and computer system administrator will spend on average 30 hours to meet requirements specified by this final rule. In addition, we estimate it will take a registered nurse, on average, 30 hours to capture necessary clinical input to determine a representative services package for a given service.

We estimate hourly cost for each labor category used in this analysis by referencing the Bureau of Labor Statistics report on Occupational Employment and Wages, May 2018.³ We also have calculated the cost of overhead at 100 percent of the mean hourly wage, in line with the Hospital Inpatient and Hospital Outpatient Quality Reporting programs (81 FR 57260 and 82 FR 59477, respectively).

We conclude that the annual burden for the first year, per hospital should be calculated with all activities performed by five professions combined. We estimate the total burden for the first year to be 150 hours (5 hours + 5 hours + 80 hours + 30 hours + 30 hours) per hospital with a cost of \$11,898.60 (\$693.40 + \$595.60 + \$5,920 + \$2,511.60 + \$2,178) per hospital. We also estimate a total national burden of 900,300 hours (150 hours X 6,002 hospitals) and total cost of \$71,415,397 (\$11,898.60 X 6,002 hospitals).

SUMMARY OF INFORMATION OF COLLECTION BURDENS FOR THE FIRST YEAR

² American Hospital Association. Fast Facts on U.S. Hospitals, 2019. Available at: <https://www.aha.org/statistics/fast-facts-us-hospitals>

³ Bureau of Labor Statistics report on Occupational Employment and Wages, May 2018 Available at: https://www.bls.gov/oes/2018/may/oes_nat.htm

Occupation Title	Cost per hour	# of Hours per Hospital	# of Hospitals	Total Burden Hours	Total Cost
Lawyers	\$138.68	5	6002	30,010	\$4,161,787
General and Operations Managers	\$119.12	5	6002	30,010	\$3,574,791
Business Operations Specialists	\$74.00	80	6002	480,160	\$35,531,840
Network and Computer Systems Administrators	\$83.72	30	6002	180,060	\$15,074,623
Registered Nurses	\$72.60	30	6002	180,060	\$13,072,356
Total	-	150	6002	900,300	\$71,415,397

We also note that hospitals nationwide are at different stages of readiness to offer consumers transparent price information or are at various levels of participation in posting of charge and price information. We also believe that different hospitals may face different constraints when estimating their burden and resources required. We believe that some hospitals will already have a framework or business processes in place that they can leverage that would minimize additional burden. However, there will be other hospitals that will have additional burden, above our projected 150 hours we estimated, to meet the requirements of this rule. Therefore, we provided alternative estimates on a range of 60 hours to 250 hours.

For a low estimate, we estimate it would take a lawyer 2 hours (at \$138.68 per hour); a general operations manager 2 hours (at \$119.12 per hour); business operations specialist 32 hours (at \$74 per hour), a network and computer system administrator 12 hours (at \$83.72 per hour); and a registered nurse 12 hours (at \$72.60 per hour). Therefore, we are providing a low estimate of the total burden for the first year to be 60 hours (2 hours + 2 hours + 32 hours + 12 hours + 12 hours) per hospital with a cost of \$4,759.44 per hospital.

For a high estimate, we estimate it would take a lawyer 8 hours (at \$138.68 per hour); a general operations manager 8 hours (at \$119.12 per hour); business operations specialist 134 hours (at \$74 per hour), a network and computer system administrator 50 hours (at \$83.72 per hour); and a registered nurse 50 hours (at \$72.60 per hour). Therefore, we are providing a high estimate of the total burden for the first year to be 250 hours (8 hours + 8 hours + 134 hours + 50 hours + 50 hours) per hospital with a cost of \$19,794.40 per hospital.

COST RANGE ESTIMATES

Hours per Hospitals	Cost per Hospital	Total Cost
60	4,759.44	28,566,159
250	19,794.40	118,805,989

We anticipate that costs will decline in subsequent years after the first year of finalization of the rule as hospitals gain additional efficiencies or may utilize the business processes and system infrastructures or software that would be built or purchased during the first year. We expect that the cost associated with maintenance would be significantly less than the cost hospitals would incur in the first year and would remain relatively level for a few years. We further believe that the activities associated with maintenance would only require General and Operations Managers, Business Operations Specialists, and Network and Computer Systems Administrators professions. Utilizing their corresponding cost per hour rates from the table above, we estimate that it would take a general operations manager, on average, 2 hours to review and determine updates in compliance with requirements. Therefore, we estimate 2 burden hours per hospital, with a total of 12,004 burden hours (2 hours X 6,002 hospitals). The cost is \$238.24 per hospital (2 hours X \$119.12), with a total cost of \$1,429,916 (\$238.24 X 6,002 hospitals).

We also estimate it would take a business operations specialist, on average, 32 hours to gather and compile required information and post it to the Internet in the form and manner specified by the final rule. For this task, we estimate 32 burden hours per hospital. The total burden hours are 192,064 hours (32 hours X 6,002 hospitals). Using the cost per hour in the table above, the cost is \$2,368 per hospital (32 hours X \$74), with a total cost of \$14,212,736 (\$2,368 X 6,002 hospitals).

Lastly, we estimate that a network and computer system administrator would spend, on average, 12 hours to maintain requirements specified by this final rule. The total burden hours are 72,024 hours (12 hours X 6,002 hospitals). The cost is \$1,004.64 per hospital (12 hours X \$83.72), with a total cost of \$6,029,849 (72,024 hours X \$83.72).

Therefore, we finalized the total annual burden estimate for subsequent years to be 46 hours (2 hours + 32 hours + 12 hours) per hospital with a cost of \$3,610.88 (\$238.24 + \$2,368 + \$1,004.64) per hospital. We also estimate a total annual national burden for subsequent years of 276,092 hours (46 hours X 6,002 hospitals) and total cost of \$21,672,502 (\$3,610.88 X 6,002 hospitals).

SUMMARY OF INFORMATION OF COLLECTION BURDENS FOR SUBSEQUENT YEARS

Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Total Labor Cost of Reporting (\$)
6,002	6,002	46	276,092	\$21,672,502

Refer to section IV.B. of the final rule, entitled “ICR for Hospital Price Transparency”.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

The federal cost is based on the efforts expended by CMS staff with the following assumptions in place: (1) hospitals are required to post at a minimum once annually on a public website of the hospital's choosing, and a review or audit of the website will occur in response to complaints; (2) that a standard compliance action template is developed and uniformly enforced; and (3) 1% of the hospitals are reported for non-compliance each year.

Estimates are based in part on the State of California's Office of Statewide Health Planning and Development's chargemaster experience and a look at similar Center for Consumer Information Insurance Oversight's monitoring efforts, where insurers were required to post information on rate increases.

Estimates

To generate salary estimates, for the table below, we used: the 2020 General Schedule (GS) Locality Pay Tables⁴ published by the Office of Personnel Management (OPM) for the Washington-Baltimore-Arlington region; and an estimate of the salary for a CMS Medical Officer.⁵ The table also estimates the average benefits, as a percentage of wages for federal employees, to be 63.9% according to a recent CBO study⁶. The estimate is based on 1% of hospitals reported as non-compliant by individuals or entities, and requiring additional action (compliance action, monitoring and penalties). Staffing estimates are based on CMS duties as follows:

- During the first year (2020), CMS will develop policies and procedures for implementing the regulatory requirements effective 1/1/2021.
- Investigative action if CMS receives a complaint.
- Clarify complaint if necessary; accessing, reviewing and validating data posted on hospital website. Time estimate may vary depending on the validation procedures required.
- Notify hospital of noncompliance and need for corrective action: develop and send written warning notice and/or notice of violation requiring a corrective action plan (CAP); review and approve hospital's CAP; assist hospitals as needed to develop CAPs; monitor and evaluate hospital's compliance with the corrective action.
- Assessment of civil monetary penalties (CMPs), and posting of notice of assessment of CMPs on a CMS website and maintaining the website of these postings; responding to hospital appeals of CMPs and other legal issues.
- Provide policy guidance and technical assistance to stakeholders including hospitals as needed.
- Provide publicly available information on best practices for hospitals to demonstrate procedures for maintaining compliance and highlight exemplars.

Estimate				
Staff	Salary	Benefits	FTE Equivalent	Total
GS-13, step 4	\$112,930	\$72,162	1.0	\$185,092

⁴ <https://www.federalpay.org/gs/locality/washington-dc>

⁵ <https://www.federalpay.org/employees/occupations/medical-officer>

⁶ <https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/workingpaper/2012-04fedbenefitswp0.pdf>

Estimate				
Staff	Salary	Benefits	FTE Equivalent	Total
GS-14, step 4	\$133,447	\$85,273	1.0	\$218,720
GS-15, step 4	\$156,973	\$100,306	0.25	\$64,320
Medical Officer	\$161,825	\$103,406	0.25	\$66,308
				\$534,440

15. Changes to Burden

We solicited comments in the CY 2020 OPPTS/ASC notice of proposed rulemaking that published in the August 9, 2019 Federal Register (84 FR 39398). Based on approximately 127 comments received on the Collection of Information Requirements, we increased the total national burden estimate from 72,024 to 900,300 hours and \$6,105,474 to \$71,415,397 for the first year. As indicated above, we also added an annual burden estimate for subsequent years to be 276,092 hours with a cost of \$21,672,502. Details of the estimated changes for year one are provided in the table below.

Burden Changes Estimated for First Year

Occupation Title	Proposed hours per hospital	Final hours per hospital	Proposed Cost per hospital	Final Cost per hospital	Number of Hospitals unchanged	Final Total Hours	Final Total Cost
Lawyers	1	5	\$138.68	\$693.40	6002	30,010	\$4,161,787
General and Operations Managers	1	5	\$119.12	\$595.60	6002	30,010	\$3,574,791
Business Operations Specialists	8	80	\$296	\$5,920	6002	480,160	\$35,531,840
Network and Computer Systems Administrators	2	30	83.72	\$2,511.60	6002	180,060	\$15,074,623
Registered Nurses	0	30	0	\$2,178	6002	180,060	\$13,072,356
Total	12	150	\$637.52	\$11,898.60	6002	900,300	\$71,415,397

16. Publication/Tabulation Dates

The results of this information collection will not be published.

17. Expiration Date

The expiration date will be displayed on the website.

18. Certification Statement

There are no exceptions to the certification statement.