Hospital Price Transparency and Billing Policy

Document Number: POL-2024-002 **Effective Date:** January 1, 2024 **Last Revised:** January 1, 2024 **Department:** Revenue Cycle Management / Patient Financial Services **Approved By:** Chief Financial Officer, Chief Executive Officer, Board of Directors **Review Cycle:** Annual **Regulatory Authority:** CMS Hospital Price Transparency Final Rule (45 CFR § 180.50)

I. PURPOSE AND SCOPE

A. Purpose

This policy establishes comprehensive procedures to ensure compliance with federal price transparency regulations and to provide clear, standardized pricing and billing information to patients. The policy serves multiple objectives:

1. Comply with the Centers for Medicare & Medicaid Services (CMS) Hospital Price Transparency Final Rule, effective January 1, 2021
2. Empower patients to make informed healthcare decisions by providing accessible price information
3. Enhance trust and transparency in our pricing practices
4. Reduce surprise billing and patient financial distress
5. Streamline the revenue cycle through clear communication of costs
6. Establish accountability for maintaining accurate, up-to-date pricing information

B. Regulatory Background

The Hospital Price Transparency Final Rule requires hospitals to:

- Publish standard charges for all items and services in a machine-readable format
- Display consumer-friendly information for a minimum of 300 shoppable services
- Update information at least annually or when changes occur
- Face potential civil monetary penalties for non-compliance (up to $300 per day, up to $109,500 per year for small hospitals, and up to $2 million per year for larger hospitals)

C. Scope

This policy applies to:

- All hospital-based services, procedures, and items
- All inpatient and outpatient departments
- All revenue cycle and billing staff

- Financial counseling and patient access staff
- Clinical departments responsible for providing cost estimates
- IT staff maintaining pricing transparency tools
- Executive leadership responsible for pricing decisions

II. DEFINITIONS

Standard Charge: The regular rate established by the hospital for an item or service provided to a specific group of paying patients.

Gross Charge: The charge for an individual item or service reflected on the hospital's chargemaster absent any discounts.

Payer-Specific Negotiated Charge: The charge that a hospital has negotiated with a third-party payer for an item or service.

Discounted Cash Price: The charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.

De-identified Minimum Negotiated Charge: The lowest charge that a hospital has negotiated with all third-party payers for an item or service.

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

Chargemaster (CDM): The comprehensive list of charges for all services, procedures, supplies, medications, and equipment provided by the hospital.

Shoppable Service: A service that can be scheduled in advance by a healthcare consumer.

Machine-Readable File: A digital file in a format that can be easily processed by automated systems (e.g., JSON, CSV, XML).

Good Faith Estimate: An estimate of expected charges for a scheduled item or service provided to uninsured or self-pay patients, as required by the No Surprises Act.

III. STANDARD CHARGE PUBLICATION REQUIREMENTS

A. Machine-Readable File of All Standard Charges

Content Requirements: The hospital must publish a single digital file containing the following for all items and services:

1. **Description of each item/service:** Clear, plain-language description (e.g., "MRI of brain without contrast" not just billing code)
2. **NDC codes or HCPCS codes:** Where applicable, including CPT codes for procedures
3. **Revenue codes:** UB-04 revenue codes associated with the service
4. **Chargemaster identifier:** Internal hospital tracking number/code
5. **Five types of standard charges for each item/service:**

    - Gross charge
    - Discounted cash price
    - Payer-specific negotiated charge (for each payer and plan)
    - De-identified minimum negotiated charge
    - De-identified maximum negotiated charge

File Format:

- Must be in a non-proprietary, machine-readable format (JSON, XML, or CSV preferred)
- Must be easily accessible on hospital's website without barriers (no required login, registration, or download of special software)
- Filename convention: [HospitalName]_standardcharges_[Date].json

Location:

- Posted prominently on the hospital's public website with a clearly identifiable link (e.g., "Price Transparency" or "Standard Charges")
- Accessible from the homepage or billing/patients section
- URL must be stable and not change

Update Frequency:

- At minimum, updated annually (every January)
- Updated within 90 days when significant pricing changes occur (e.g., new payer contract, major CDM revision)
- Version control and effective dates clearly indicated

Responsibility: The Revenue Cycle Director designates the Chargemaster Coordinator to:

- Generate the machine-readable file from the CDM system
- Validate accuracy before publication
- Coordinate with IT to post the file on the website
- Maintain version history

B. Consumer-Friendly Display of Shoppable Services

Shoppable Service Requirements: In addition to the comprehensive machine-readable file, the hospital must display pricing for at least 300 shoppable services in a consumer-friendly manner.

Selection of 300 Services: The list must include:

- All 70 CMS-specified shoppable services (provided the hospital offers them) – examples include:
  - Routine blood tests (CBC, metabolic panel)
  - Common imaging (X-rays, CT scans, MRIs, ultrasounds)
  - Common procedures (colonoscopy, upper GI endoscopy, joint injections, cardiac catheterization)
  - Maternity/delivery services
  - Emergency department visit levels
  - Outpatient surgery (hernia repair, knee arthroscopy, etc.)

- At least 230 additional hospital-selected shoppable services that are commonly provided and frequently shopped by consumers

Consumer-Friendly Format: For each shoppable service, display must include:

1. **Plain-language description** of the service
2. **CPT/HCPCS code(s)** and brief definition
3. **Expected ancillary services:** List of items/services typically provided together with the primary service (e.g., anesthesia, medications, lab tests, supplies)
4. **Estimated total cost:** A bundled price or range for the primary service plus ancillaries
5. **Payer-specific estimates:** If possible, indicate cost for major insurance plans
6. **Discounted cash price:** For uninsured/self-pay patients

Display Method:

- Interactive online price estimator tool on the hospital website (preferred)
- Alternatively, a clearly organized webpage or downloadable document (PDF, Excel) that allows easy searching
- Tool should allow users to filter/search by service name, keyword, or body part
- Must be accessible without requiring login or patient portal registration

Estimator Tool Features: Our hospital's price transparency tool includes:

- Search bar for service name or procedure
- Filter by department (radiology, lab, surgery, etc.)
- Input for insurance carrier to see payer-specific estimates
- Breakdown of total cost into components (facility fee, physician fee if applicable, ancillary charges)
- Disclaimer that estimates are not guarantees and actual costs may vary based on patient-specific factors
- Contact information for financial counselors for personalized estimates

Responsibility: The Patient Financial Services Manager ensures:

- The shoppable service list is reviewed and updated annually
- The online tool is functional and accurate
- Staff are trained to assist patients in using the tool
- Feedback from patients is collected and used to improve the tool

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IV. PROCEDURE PRICING POLICY AND METHODOLOGY

A. Chargemaster (CDM) Management

CDM Structure: The hospital maintains a comprehensive chargemaster containing:

- Over 15,000 line items (procedures, services, supplies, medications, room charges)
- Organized by department and service category
- Each item with a unique hospital code, description, revenue code, CPT/HCPCS code (if applicable), and charge amount

Pricing Methodology: Standard charges in the CDM are established using:

1. **Cost Analysis:** Review of hospital's cost accounting data for each service (direct and indirect costs)
2. **Market Analysis:** Benchmarking against comparable hospitals in the region
3. **Payer Considerations:** Analysis of reimbursement rates from major payers to ensure financial sustainability
4. **Regulatory Requirements:** Compliance with price transparency and fair billing practices
5. **Value-Based Pricing:** For certain services, charges reflect outcomes and quality metrics

Gross Charges: Our CDM gross charges are the starting point for billing. We recognize that gross charges often exceed negotiated payer rates and that few patients pay gross charges (most are covered by insurance or qualify for discounts). However, gross charges must be:

- Consistently applied to all patients regardless of payer

- Reasonable and not excessive compared to market
- Justified by costs and value provided

Discounted Cash Price: For self-pay patients, the hospital offers a discount from gross charges:

- Standard self-pay discount: 60% off gross charges (resulting in discounted cash price = 40% of gross)
- Prompt payment discount: Additional 10% if paid within 30 days of service
- These discounts are posted in the price transparency file and communicated to self-pay patients

Bundled Pricing: For certain common procedures, the hospital has developed bundled prices that include all typical components (e.g., "Total Hip Replacement Package" includes surgery, implant, anesthesia, 3-day inpatient stay, PT consults, and standard medications). Bundled prices offer predictability for patients and are listed as such in the shoppable services tool.

B. Payer-Specific Negotiated Rates

Contract Management: The hospital has contracts with numerous payers (Medicare, Medicaid, commercial insurers, managed care plans). Each contract specifies:

- Payment rates for each service (often as a percentage of Medicare rates, or a fee schedule)
- Claim submission requirements
- Authorization processes
- Timely filing limits

Publishing Negotiated Rates: Per CMS requirements, the machine-readable file includes payer-specific negotiated charges for each third-party payer and plan. This includes:

- Payer name and plan name (e.g., "Blue Cross Blue Shield PPO Plan 123")
- Negotiated rate for each service code
- Effective dates of the rate

Confidentiality Considerations: While CMS requires publication of negotiated rates, some contracts contain confidentiality clauses. CMS has stated that federal law supersedes such contractual provisions, and hospitals must disclose negotiated rates for transparency. Our Legal department has reviewed contracts and supports compliance with CMS mandate.

Minimum and Maximum Negotiated Charges: For each service, we also publish:

- De-identified minimum: The lowest rate negotiated with any payer (de-identified to not disclose which payer)
- De-identified maximum: The highest rate negotiated with any payer

This gives consumers a range to understand potential variation in costs.

C. Annual Review and Updates

Chargemaster Review Process: The CDM Review Committee (comprising representatives from Finance, Revenue Cycle, Clinical Departments, and Compliance) meets quarterly to:

- Review new services or supplies to be added to CDM
- Analyze charge increases or decreases recommended by departments
- Compare our charges to regional benchmarks
- Ensure charges align with costs and payer reimbursement trends

Annual Update: Every December, the committee conducts a comprehensive review resulting in an updated CDM effective January 1. The update includes:

- Inflation adjustments (typically 2-4% on average)
- New procedure codes (new CPTs released each year)
- Discontinued codes or services
- Corrections to descriptions or coding

After approval, the new CDM is loaded into the billing system, and new standard charge files are generated and published by mid-January.

V. PATIENT COST ESTIMATES AND FINANCIAL COUNSELING

A. Good Faith Estimates for Self-Pay Patients

No Surprises Act Requirement: Under the No Surprises Act (effective 2022), uninsured (or self-pay) patients who schedule services must receive a Good Faith Estimate (GFE) of expected charges at least 3 business days before the service (or at time of scheduling if scheduled within 3 days).

GFE Content: The estimate must include:

1. Patient and provider information
2. Itemized list of services expected to be provided (with CPT/HCPCS codes)
3. Estimated charge for each item/service
4. Total estimated charges
5. Disclaimer that actual charges may differ if additional services are needed

6. Information on patient's right to a bill dispute resolution process if actual bill exceeds estimate by $400 or more

Process:

- Patient Access staff identify self-pay patients at time of scheduling
- Scheduling system flags the patient for GFE generation
- Financial Counselor or Patient Access Rep uses the price estimator tool to compile expected charges
- GFE is provided to patient via mail, email, or patient portal (with confirmation of receipt)
- Copy of GFE is placed in patient's financial record

B. Pre-Service Cost Estimates for Insured Patients

Proactive Estimates: While not federally mandated for insured patients in the same way as self-pay, our hospital's patient-centered approach includes providing cost estimates for insured patients when:

- The patient requests an estimate
- The scheduled service is high-cost (facility charge >$5,000)
- The patient has a high-deductible health plan (HDHP) and may have significant out-of-pocket responsibility

Insurance Verification and Estimation Process:

1. **Eligibility Verification:** Staff verify patient's insurance coverage, benefits, deductible, out-of-pocket max, and coinsurance percentage (see Patient Eligibility and Preauthorization Policy)
2. **Calculate Expected Charge:** Determine the contracted rate with the patient's payer for the service (from our rate tables)
3. **Calculate Patient Responsibility:**
    - If deductible not met: patient pays contracted rate up to remaining deductible, then coinsurance applies
    - If deductible met: patient pays coinsurance percentage of contracted rate
    - Apply any co-pays or stop-loss maximums
4. **Provide Written Estimate:**
   Give patient a written estimate form showing:
    - Total estimated facility charge
    - Estimated insurance payment (based on benefits)
    - Estimated patient out-of-pocket cost
    - Disclaimer: "This is an estimate based on the information available. Actual charges may vary based on services provided and your insurance plan's processing. Please contact your insurer to verify your benefits."

Financial Counseling: Financial counselors are available to meet with patients (in person, by phone, or video) to:

- Explain the estimate and what the patient will owe
- Discuss payment options (payment plans, credit options)
- Screen for financial assistance eligibility (see below)
- Answer questions about billing and insurance

C. Billing Statements and Clarity

Patient-Friendly Bills: Our billing statements are designed for clarity:

- **Header:** Account number, patient name, date of service, department
- **Itemized Charges Section:** Line-by-line list of services with date, description, charge amount, insurance adjustment, insurance payment, patient responsibility
- **Summary Section:** Total charges, total insurance payments, total adjustments, total patient balance due
- **Payment Information:** Due date, payment options (online portal, phone, mail, in-person), contact phone and email for questions
- **Message Section:** Any special notes (e.g., "Payment plan available – call us")

Statement Frequency: Statements are mailed monthly until balance is paid. Electronic statements are available via patient portal.

Dispute Resolution: If a patient believes the bill is incorrect, they may contact Patient Financial Services. We will:

- Review the account and verify charges
- Explain the bill and provide itemization/coding details
- Correct any errors and issue an adjusted bill if needed
- Escalate unresolved disputes to a billing supervisor for resolution

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VI. FINANCIAL ASSISTANCE PROGRAM

A. Purpose and Eligibility

Commitment to Access: Our hospital is committed to providing care regardless of a patient's ability to pay. The Financial Assistance Program (Charity Care Policy) provides free or discounted care to patients who meet eligibility criteria.

Eligibility Criteria: Financial assistance is available to patients whose family income is at or below specified thresholds:

- **100% charity care (free):** Family income ≤200% of Federal Poverty Level (FPL)
- **75% discount:** Family income 201-250% FPL
- **50% discount:** Family income 251-300% FPL
- **25% discount:** Family income 301-350% FPL

Family Income Definition: Income includes all household members' gross income from all sources (wages, self-employment, social security, unemployment, etc.) for the most recent 12 months or projected annual income.

FPL Reference: Federal Poverty Levels are updated annually. For 2024, 200% FPL is approximately:

- $31,200 for a family of 1
- $42,400 for a family of 2
- $53,600 for a family of 3
- $64,800 for a family of 4 (Amounts vary by year; consult current HHS poverty guidelines)

Uninsured and Underinsured: Financial assistance is available for uninsured patients and for insured patients whose out-of-pocket costs create financial hardship even after insurance payment.

B. Application Process

Notification: Information about financial assistance is:

- Posted on the hospital website (clearly labeled link from homepage and billing page)
- Included in patient admission packets
- Posted in patient access areas (registration, emergency department, billing office)
- Mentioned in billing statements ("Financial assistance may be available – call us or visit our website")

Application: Patients may apply for financial assistance:

- Before service (during pre-registration or financial counseling session)
- After service (upon receipt of bill or at any time during collections)

Application Form: The application requires:

- Patient demographic and contact information
- Household size and members
- Income documentation (recent pay stubs, tax return, unemployment statement, social security benefits, etc.)
- List of assets (optional, but may be used in hardship determination)
- Attestation of accuracy

Presumptive Eligibility: In cases where a patient cannot provide documentation (e.g., homeless, deceased with no estate, no income), financial counselors may grant presumptive charity care eligibility based on observable evidence (e.g., enrollment in other means-tested programs like Medicaid, food stamps).

Review and Decision:

- Applications are reviewed by the Financial Assistance Coordinator
- Decision rendered within 10 business days
- Patient notified of approval or denial in writing
- If approved, the discount is applied to the account and a revised bill issued
- If denied, patient is informed of the reason and may appeal or reapply if circumstances change

C. Emergency and Medically Necessary Care

Non-Discrimination: The hospital will not deny emergency or other medically necessary care due to inability to pay. All patients will be stabilized and treated regardless of financial status, per EMTALA and our mission.

Collections Limitations: For patients eligible for financial assistance:

- We will not initiate extraordinary collection actions (legal action, liens, wage garnishment) before making reasonable efforts to inform them of financial assistance and giving them 120 days to apply
- We do not report unpaid balances of charity care-eligible patients to credit bureaus if they are actively working with us on financial assistance application or payment plan

D. Publication and Transparency

Plain Language Summary: A one-page Plain Language Summary of the Financial Assistance Program is available in English and Spanish (and other languages upon request) and includes:

- Who is eligible
- What services are covered
- How to apply
- Contact information for assistance

Pricing Disclosure in Context of Financial Assistance: The price transparency publication includes a note that financial assistance is available for eligible patients, with a link to the FAP information.

VII. COMPLIANCE AND MONITORING

A. Internal Audits

Quarterly Review: The Compliance Department conducts a quarterly review of:

- Accuracy and accessibility of the machine-readable file (test the link, validate data sample)
- Functionality of the consumer-friendly price estimator tool (test searches, check for broken links)
- Patient estimate documentation (audit 20 random patient files to ensure estimates provided when required)
- Financial assistance screening and application processing (timeliness and accuracy)

Annual Comprehensive Audit: Annually, an external consultant or internal audit team performs a comprehensive price transparency audit, assessing:

- Full compliance with CMS requirements
- Comparison of published prices to actual billed charges (to ensure consistency)
- Patient satisfaction with transparency and billing communication
- Recommendations for improvement

Corrective Action: Any deficiencies identified in audits are addressed immediately:

- Incorrect data in files: corrected and re-published within 5 business days
- Website link issues: fixed same day
- Policy non-compliance: staff re-trained, processes revised

B. Patient Feedback and Continuous Improvement

Patient Surveys: After service, a subset of patients receive a survey asking about:

- Whether they received a cost estimate and if it was helpful
- Clarity of billing statements
- Awareness of financial assistance
- Suggestions for improving price transparency

Results Analysis: Patient Financial Services reviews survey results quarterly and implements improvements (e.g., revised estimate templates, more proactive financial counseling calls).

C. Regulatory Compliance and Penalties

CMS Monitoring: CMS has established a Price Transparency Compliance and Enforcement Process. CMS may:

- Monitor hospital websites for compliance
- Issue warning notices for non-compliance
- Impose civil monetary penalties (CMPs) for continued violations

Penalty Structure:

- Hospitals with <550 beds: up to $109,500/year
- Hospitals with ≥550 beds: up to $2,000,000/year
- Calculated as $300/day of non-compliance

Our Commitment: This hospital is committed to full compliance. The CFO has ultimate oversight and reports quarterly to the Board of Directors on price transparency compliance status. Any CMS inquiry or notice will be addressed within 24 hours with engagement of legal counsel if needed.

VIII. SPECIFIC PRICING SCENARIOS AND EXAMPLES

Example 1: Uninsured Patient Scheduling Colonoscopy

Service: Outpatient colonoscopy with biopsy

Pricing Information Provided:

1. **Gross Charge:** $4,500 (facility fee for procedure + $800 pathology = $5,300 total)
2. **Discounted Cash Price:** $2,120 (40% of gross, per self-pay discount policy)
3. **Good Faith Estimate issued 5 days prior to procedure:**
    - Colonoscopy with anesthesia: $1,800
    - Pathology: $320
    - Total: $2,120
4. **Payment Plan Option:** Patient may pay 50% upfront ($1,060) and remainder in 6 monthly payments of $177

Financial Assistance Screening: Patient's income is 190% FPL qualifies for 100% charity care. After application approved, bill reduced to $0.

Example 2: Insured Patient (PPO Plan) Scheduling MRI

Service: MRI of lumbar spine without contrast

Insurance: Blue Cross Blue Shield PPO, patient has $2,000 deductible (met $800 so far, $1,200 remaining), then 20% coinsurance

Pricing Information Provided:

1. **Hospital Gross Charge:** $2,800
2. **BCBS Negotiated Rate:** $1,600 (this is what hospital will accept from BCBS)
3. **Patient Estimate Calculation:**

- BCBS will pay: $0 initially (deductible not met), then 80% of remaining
- Patient owes: First $1,200 to remaining deductible, then 20% of $400 = $80
- **Total patient responsibility: $1,280**

Written Estimate Provided: "Based on your BCBS benefits, your estimated out-of-pocket cost for the MRI is $1,280. This includes $1,200 toward your deductible and $80 coinsurance. Please note this is an estimate; contact BCBS to verify."

Example 3: Emergency Department Visit (Unknown Insurance at Time of Service)

Service: ED visit, Level 4 (CPT 99284)

Pricing Information:

1. **Gross Charge:** $1,800 (ED facility fee) + any ancillary services (X-ray, labs, medications)
2. **Discounted Cash Price:** $720 + ancillaries
3. **Shoppable Service Tool lists:** "Emergency Department Visit (moderate complexity): $720-$900 estimated self-pay price"

Patient Communication: At discharge, if insurance unknown, patient is told: "Your estimated charges for today's visit are $XXX. If you have insurance, please provide information so we can bill them. If you are self-pay, you qualify for a discount. Our financial counselor will call you tomorrow to discuss."

IX. ROLES AND RESPONSIBILITIES

Chief Financial Officer (CFO):

- Overall accountability for price transparency compliance
- Approve pricing policies and methodologies
- Report to Board on compliance and financial impact

Revenue Cycle Director:

- Oversee day-to-day operations of price transparency activities
- Ensure timely publication and updates of price files
- Coordinate with IT and web team
- Manage billing and patient financial services teams

Chargemaster Coordinator:

- Maintain CDM accuracy
- Generate machine-readable files
- Coordinate CDM updates and pricing reviews

Patient Financial Services Manager:

- Oversee patient cost estimate process
- Manage financial counseling staff
- Administer financial assistance program
- Monitor patient satisfaction with billing and pricing

Compliance Officer:

- Conduct audits and monitoring
- Ensure policy adherence
- Address regulatory inquiries or investigations
- Update policy as regulations change

IT/Web Team:

- Maintain price transparency web pages and tools
- Ensure website accessibility and functionality
- Assist with machine-readable file posting and updates

X. REFERENCES AND RESOURCES

1. CMS Hospital Price Transparency Final Rule: 45 CFR § 180 (Federal Register Vol. 84, No. 229, November 27, 2019)
2. CMS Fact Sheet: Hospital Price Transparency cms.gov
3. CMS Frequently Asked Questions on Hospital Price Transparency
4. No Surprises Act (Consolidated Appropriations Act, 2021) – Good Faith Estimate Requirements
5. American Hospital Association (AHA): Price Transparency Resources
6. Healthcare Financial Management Association (HFMA): Best Practices for Patient Cost Estimation

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XI. APPENDICES

Appendix A: Link to Hospital's Machine-Readable File (updated quarterly)

Appendix B: Link to Shoppable Services Price Estimator Tool

Appendix C: Good Faith Estimate Template

Appendix D: Financial Assistance Application Form

Appendix E: Plain Language Summary of Financial Assistance Policy (English and Spanish)

Appendix F: CDM Review Committee Charter

END OF POLICY

For questions, contact:

- Pricing/Chargemaster: Chargemaster Coordinator at (555) 100-2000
- Patient Estimates: Patient Financial Services at (555) 100-3000
- Financial Assistance: Financial Counselor at (555) 100-3100
- Compliance: Compliance Officer at (555) 100-4000

Document Control:

- Version: 1.0

- Effective: January 1, 2024
- Next Review: January 1, 2025