

Background

In the FY 2019 Inpatient Prospective Payment System Final Rule CMS announced an update to 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. This could be in the form of the chargemaster itself or another form of the hospital's choice, as long as the information is in machine readable format. This provision is effective on January 1, 2019.

Following release of the rule, CMS has subsequently released some additional information on how hospitals may comply with this policy.

CMS has clarified the following:

1. Participation in an Online Pricing Tool

Contrary to previous guidance from CMS, participation in Iowa Hospital Charges Compare no longer satisfies the requirements of this policy. IHA encourages hospitals to continue to link to Iowa Hospital Charges Compare to provide additional information on this topic.

2. Machine Readable

A "machine readable format" is a format that can be easily integrated into a computer system or statistical program (e.g., XML, CSV). Traditional word processing formats (e.g., PDF) are difficult for machines to read, and require information to be re-entered manually; therefore, they are not considered machine readable.

3. "Standard Charge"

Beginning January 1, 2019, hospitals will need to make available the list of their current standard charges. CMS has left the actual format up to hospitals, but they have established some guardrails:

- The list must include every item and service provided by the hospital;
- The list must include the charge for each item and service, as it is represented in the hospital's chargemaster. This also require, at a minimum, an identifier for the item or service associated with each charge, such as a corresponding description.
- Hospitals are not required to publish their entire chargemaster; however, the chargemaster must be the source of the charge information the hospital posts.
- CMS has clarified that diagnosis-related groups or any other way of grouping charges would not satisfy this requirement.

4. Applicable Hospitals

All hospitals, including Critical Access Hospitals, must post this information.

5. Enforcement.

CMS has not indicated how it will enforce these requirements. However, through the RFI process, CMS sought comments on the appropriate mechanisms for CMS to enforce price transparency requirements. Enforcement mechanisms may be included in future policymaking.

IHA Position

IHA strongly opposes this policy as it is clear that the posting of hospital chargemaster data will not be useful in promoting better consumer health care decision making. IHA will continue to advocate that CMS revise or repeal this policy and work with hospitals to develop appropriate cost estimate/calculation tools for consumers.

Patients deserve access to information about the price of the care they may receive in a hospital. Iowa hospitals stand ready to work with policymakers on innovative ways to build on efforts already occurring at the state level, and share information that helps consumers make better choices about their health care.

Facts Regarding Hospital Pricing

Consumers are likely to require additional information to fully understand how and why hospitals price certain services. The following information can be used as a means to assist in explaining the information.

General Facts:

- Hospital charge data is being provided as part of a federal regulatory policy mandated by the U.S. Department of Health & Human Services and Centers for Medicare & Medicaid Services.
- Hospital charge data is not representative of a patient's expected out-of-pocket costs. Because each patient's case is different based on specific medical conditions, the actual amount owed by a patient will depend on that patient's insurance coverage.
- Hospital charge data is the amount a hospital bills an insurer for a service. In the vast majority of cases, however, hospitals are reimbursed by insurance companies and Medicare/Medicaid at a rate that is considerably less than the amount charged.
- Patients should talk with their insurance provider to understand which costs will be covered, and which will be the patient's responsibility.
- Hospital charges can include unlisted procedures, services, supplies, and tests as well as any fees associated with services, such as equipment fees and room charges.

Facility Charges vs. Patient Out-of-Pocket Financial Obligations

The amount a facility bills for a patient's care is known as the "charge." This is not the same as the actual cost or amount paid for the care. The amount collected by a hospital for each service is almost always less than the amount billed. The following are common examples of why hospitals do not receive billed charges:

- Government programs such as Medicare, Medicaid and Hawk-I typically pay health care providers much less than the billed charge. These payments are determined solely by the government, and hospitals have no ability to negotiate the reimbursement rates for government-paid services.
- Commercial insurers or other purchasers of health care services usually negotiate discounts with health care facilities on behalf of the patients they represent.
- Hospitals have policies that allow low-income persons to receive reduced-charge or free care.
- Negotiations between facilities and health care purchasers generally begin with the charge amount. While each facility's charge structure may vary in important ways, charges represent a consistent, though imperfect, way to compare health care costs.

Explaining Differences in Charges Across Hospitals

There are many reasons that charges may differ among hospitals. Among them are the following:

- **Payer mix** – As with other businesses, hospitals cannot survive if costs exceed revenues over a long period of time. Government programs (like Medicare, Medicaid, and Hawk-I) generally reimburse facilities at rates that do not cover the costs they incur to provide care. Therefore, hospitals that have a relatively high percentage of government-program patients are forced to recover a greater percentage of their operational costs from privately insured and self-pay patients through higher charges.
- **Facility cost structures** – Facilities differ in their approach to pricing based on operational costs. Some facilities try to spread the cost of all services and equipment among all patients. Others establish charges for specific services based on the cost to provide each specific service. Furthermore, some facilities may decide, or be forced, to provide certain services at a loss while other facility operations subsidize the losses. Any of these situations can result in significantly different charges among hospitals for a given type of service.
- **New technology** - The equipment facilities use to provide services differs in age, sophistication, and frequency of use and may impact the charges of the hospital.
- **Staffing costs** - Salary scales may differ by region and are typically higher in urban areas. Shortages of nurses and other medical personnel may affect regions differently. Where shortages are more severe, staffing costs, and, therefore charges, may be higher.
- **Intensity of care** - Some facilities are equipped to care for more severely ill patients than others. Patients within the same diagnosis or procedure category may need very different levels of service and staff attention, causing a variation in charges.

- **Range of services provided** - Facilities differ in the range of services they provide to patients. Some may provide the full range of services required for diagnosis and treatment during the stay. Others may stabilize patients and then transfer them to another facility for more specialized or rehabilitative care.
- **Service frequency** – The per-patient cost of services is generally higher if the type of hospitalization occurs infrequently at the facility. Furthermore, a single case with unusually high or low charges can greatly affect a facility’s average charge if the facility reported only a few cases in a given time period.
- **Documentation** - Hospitals are required to follow correct coding guidelines and to code all the conditions documented in the patient’s medical record. The hospital bill will reflect charges to the greatest level of specificity as documented in the medical record by clinicians.
- **Capital expenses** - Facilities differ in the amount of debt and depreciation they must cover in their charge structure. A facility with a lot of debt may have higher charges than a facility not facing such expenses. Furthermore, facilities may choose to lease or purchase equipment or facilities. The choices made about financing of capital projects may affect charges in different ways.

References:

[Affordable Care Act, Section 2718](#)
[FY 2015 IPPS Final Rule Homepage](#)
[FY 2019 IPPS Final Rule Homepage](#)

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