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Assessing Implementation of Hospital Price Transparency

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Executive Summary

While most stakeholders agree on the need for more transparency in our health care system, there is substantial debate about how to make meaningful progress toward this goal in specific cases.[1] This Manatt study focuses on one such case—the federal price transparency rules for hospitals that took effect in January 2021. The study, which is based on a review of New York hospital websites in July 2021, looks at how hospitals responded to key elements of the federal rules in the first six months of implementation. The results are preliminary in nature given an ongoing implementation process since July, but the findings do illuminate the early state of play in one state that may or may not be representative of other states.

The study looked at how 32 New York hospitals responded to key elements of the federal price transparency requirements in the first six months of implementation.

Federal rule requirements. The federal price transparency rules require hospitals to publish five categories of standard charges for all hospital services: gross charges, discounted cash prices, payer-specific negotiated charges, de-identified minimum negotiated rates and de-identified maximum negotiated rates. These standard charges must be provided on a publicly available website that is routinely updated. The information must be provided in two ways:

Machine readable files must cover five categories of standard charges for all hospital services.

- **Machine-readable files.** These files must contain comprehensive information on all items and services offered by the hospital, with the information covering all five of the required categories of standard charges for each item or service.
- **Consumer-friendly display of 300 of the most common "shoppable" services.** Hospitals can fulfill the shoppable services requirement by either providing a web display or file of the five standard charges, or by developing a consumer-friendly, Internet-based price estimator tool that provides consumers with an estimate of "the amount they will be obligated to pay the hospital for the service."

Hospitals can provide prices for at least 300 shoppable services through a consumer-friendly shopping tool.

Methodology. Manatt Health examined a sample of 32 New York hospitals to assess each hospital's level of implementation by focusing on a select set of issues. Recognizing that implementation is an incremental process, the study looked broadly at how well hospitals were meeting the "spirit of the law" rather than focusing on the compliance questions that many other studies have opined on and that the federal government is still in the early stages of addressing. For shoppable services, the question was whether the hospital had developed consumer-friendly search tools and/or files, with assessment focused on how readily an uninsured consumer could

The study looked at implementation as an incremental process and focused on how well hospitals were meeting the "spirit of the law" with respect to key requirements.

obtain the cash price for a CT scan of the abdomen. For machine-readable files, the question was whether the hospital had developed the capacity—the files and tools—to build out machine-readable files, with the assessment focused on whether the files included price data for all five categories of charges without assessing the completeness or accuracy of the underlying data.

Levels of implementation. The study classified each hospital's level of implementation as not implemented, partially implemented or implemented. The evaluation criteria for each level of implementation were customized to reflect the different audiences for machine-readable files versus shoppable services tools.

12% of hospitals implemented and 69% partially implemented the machine-readable file requirements.

Findings. Overall, this study found the pace of implementation to be slower for the machine-readable file requirements than for the shoppable service requirements, with 69% of hospitals implementing the shoppable services requirement as compared to 69% only partially implementing the machine-readable requirement.

69% of hospitals implemented and 9% partially implemented the shoppable services requirements.

For the **machine-readable file** requirement, 19% of hospitals had not implemented, 69% had partially implemented, and 12% had implemented the requirements by providing price information in all five categories of charges. Most of the 28 hospitals that did not implement or partially implemented the machine-readable file requirements were missing information about discounted cash prices or payer-specific negotiated prices, or both.

- For the **shoppable services** requirement, 22% of hospitals had not implemented, 9% had partially implemented, and 69% had implemented the requirements by providing a cash price for a CT scan of the abdomen. Most of the 22 hospitals that demonstrated implementation did so by providing a consumer-friendly online price estimator tool rather than a file with prices for 300+ services.

Examples of effective implementation sought to maximize the utility of the file or tool for the intended audience.

Examples of effective implementation. Among the hospitals that demonstrated implementation of the machine-readable file federal requirements, the most effective examples were those that maximized the utility of the file for a broad range of audiences—including consumers, researchers, data aggregators, app developers and competitors—generally looking for hospital pricing data that is comprehensive, accurate and comparable across the industry. In the case of shoppable services, the most effective examples maximized the utility of a consumer-friendly online price estimator tool in helping individual consumers shop for services based on price. While none of the featured examples are developed enough to be considered best practices, all of them could mature into replicable best practices as they are refined over time.

The study found examples of effective implementation that could mature into best practices.

Conclusion. Key takeaways from this study include:

- Shoppable service requirements are most likely to be helpful to individual consumers interested in simple and straightforward price comparisons, but comprehensive machine-readable files are more likely to be helpful to broader audiences such as researchers, app developers and competitors, for whom machine-readable files offer more valuable information than consumer search tools.
- Even for individual consumers, the more useful shopping tools will seek to streamline comparison shopping across multiple hospitals. These tools are likely to come from data aggregators and app developers using data from machine-readable files to simplify the shopping experience for consumers.

The more useful tools will simplify the shopping experience for consumers by making it easy to compare prices across multiple hospitals.

- The recent decision to increase penalties for noncompliance may focus more attention on compliance issues that are beyond the purview of this study. As federal transparency rules for insurers take effect in 2022, those rules should seek to include more clarity as to how disclosure should work in cases where the consumer share of the hospital's payer-specific negotiated charge is complicated. The underlying principle of the federal rules is dual responsibility for payers and providers, but there should be more clarity for both insurers and hospitals about exactly what must be disclosed by each of them, respectively.

The rules should clarify insurer and hospital disclosure requirements where determining the consumer's share of the hospital bill is more nuanced due to complex cost-sharing rules.

- As compliance with machine-readable file requirements improves, it may make sense to form a user group to discuss standardizing certain conventions to make these files easier to use. In the long term, industry-leading hospitals can work with researchers to translate examples of effective implementation into best practices that can be replicated across the hospital sector.

Introduction and Overview

While most stakeholders agree on the need for more transparency in our health care system, there is substantial debate about how to make meaningful progress toward this goal in specific cases.[2] This Manatt study focuses on one such case—the federal price transparency rules for hospitals that took effect in January 2021. The study, which is based on a review of New York hospital websites in July 2021, looks at how hospitals responded to key elements of the federal rules in the first six months of implementation. The results are preliminary in nature given an ongoing implementation process since July, but the findings do illuminate the early state of play in one state that may or may not be representative of other states.

Since 2010, under the Affordable Care Act, the federal government has required hospitals to "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."[3] The Centers for Medicare & Medicaid Services (CMS) guidance defined standard charges as a hospital's chargemaster, which hospitals were required to update and publish annually. Chargemasters display the non-discounted prices for a hospital's services,[4] which very few consumers, insurers or any other payers actually pay.

In November 2019, CMS adopted a more comprehensive Hospital Price Transparency Final Rule, which recognized that there are multiple forms of hospital pricing and multiple audiences for pricing information.[5]

Multiple forms of pricing. The rule recognizes that hospitals use multiple forms of pricing and within each form of pricing there is substantial variability. The transparency rule expands the amount of information that hospitals are required to publish as "standard charges" under section 2718(e),[6] redefining "standard charges" to include five categories of charges:[7]

The rule recognizes that hospitals use multiple forms of pricing and within each form of pricing there is substantial variability.

- **Gross charges**: the non-discounted rate, as reflected in a hospital's chargemaster;
- **Discounted cash prices**: the rate the hospital would charge individuals who pay cash or cash equivalent;
- **Payer-specific negotiated charges**: the rate that a hospital has negotiated with a third-party payer (for example, an insurer) for an item or service provided in the hospital;
- **De-identified minimum negotiated rates**: the lowest rates that a hospital has negotiated with all third-party payers, without identifying the payer; and
- **De-identified maximum negotiated rates**: the highest rates that a hospital has negotiated with all third-party payers, without identifying the payer.

Under the transparency rules, which took effect on January 1, 2021, hospitals[8] operating in the United States must publish their prices in all five categories on a public website that is routinely updated.

Multiple audiences. The rule also recognizes that there are multiple audiences for hospital pricing information. For some audiences, especially individual consumers, the most important aspect of hospital pricing is having easily accessible information about non-urgent but medically important "shoppable" services. For that audience, the rule requires a consumer-friendly display of 300 of the most common shoppable services and their associated standard charges, or, a consumer-friendly, Internet-based price estimator tool that provides consumers with an estimate of "the amount they will be obligated to pay the hospital for the service."

For other audiences, including researchers, consumer app developers and competitors, the most important aspect of hospital pricing is having complete and comprehensive information in a machine-readable file for all items and services offered by the hospital.

This new federal rule establishes baseline requirements for the industry to advance price transparency, and the focus is now shifting to how these new requirements are being implemented. A comprehensive list of the federal price transparency requirements is available in Appendix I.

Assessing Hospital Implementation

Although the federal rule is premised on seemingly straightforward requirements, virtually every study that has examined how hospitals have responded to the new federal requirements has found hospital implementation to be uneven and incremental in these early months, with many studies citing the various challenges hospitals may face in operationalizing these new rules. If the question is whether hospitals have all achieved implementation of these federal rules, most studies to date would suggest that implementation is still incremental.[9,10,11] In fact, because the federal regulatory language is not specific as to how hospitals are expected to report consumer cost-sharing obligations, and is ambiguous in defining certain requirements (such as requirements that seek to improve consumer-friendliness),[12] studies that seek to assess hospital "compliance" generally define the parameters of compliance differently from study to study, limiting the comparability of findings to meaningfully assess overall progress.

Therefore, this study takes a different approach by specifically examining a sample of 32 New York hospitals and assessing implementation on a continuum. Rather than focusing on issues of compliance, this study recognizes that implementing a complex rule is often a multi-step process, with partial implementation possible, and worthy of observation, especially since this study's review of websites was conducted six months after the regulation went into effect. This study also considers the two parts of the regulation differently, reflecting the fact that the primary audiences for each part are different, and only focuses on a specific study question for each set of requirements.

This study looks at implementation as an incremental process.

The two parts of the rule—shoppable services and machine-readable files—serve different audiences.

Multi-step process. This study's assessment focused on whether sampled New York hospitals have established the capacity—the files and tools—required by law to support price transparency; it did not assess the completeness or accuracy of the underlying data. In the case of machine-

readable files, this study considered the level of data provided across all five types of standard charges. In the case of shoppable services, this study focused on how readily an uninsured consumer could obtain the cash price for a specific service.

Machine-readable files. While the audiences for machine-readable files include individual consumers to some extent, the audiences most likely to use these files include a broad spectrum of researchers, third-party vendors and innovators, such as app developers, and others.

These audiences do not necessarily need consumer-friendly presentation of pricing data; their interest is data that is comprehensive, accurate and comparable across hospitals. Each of these audiences benefits from the broader availability of hospital pricing data for its own purposes, ranging from studying it to identify potential market failures or distortions to looking for insights to inform potential policy interventions to developing consumer shopping tools that allow consumers to easily compare prices across hospitals.

Consumer friendly shopping tools are most relevant for individual consumers.

Shoppable services. The shoppable services requirements are more likely to be relevant for individual consumers shopping for specific services. To facilitate price shopping, consumers would benefit most from hospitals making the shoppable services portion of their websites as consumer friendly as possible, ideally with pricing tools that make the shopping process as easy as it is on the best-in-class commercial websites for other goods and services, such as airfare or hotel booking. The regulations allow hospitals the option to either offer consumers an online price estimator tool to fulfill the shoppable services requirements or to provide a list of 300 shoppable services offered by the hospital. This study found that within the sampled New York hospitals, most hospitals opted to develop an online price estimator tool.

This study selected only one specific service for review and focused on how readily an uninsured consumer could obtain the cash price for that specific service, since cash-paying consumers may be one of the groups most likely to benefit from shopping tools. While most consumers are insured and have the advantage of insurer-negotiated discounts, the actual price these insured consumers pay is not the insurer-negotiated price. In the vast majority of cases, insured consumers only pay their cost-sharing portion of the insurer's negotiated price, and the federal regulations do not address in detail how hospitals should provide their insured customers with a precise price that accounts for deductibles and other cost-sharing nuances. In today's market, insurer products may include "value-based insurance designs" (VBID) that vary cost-sharing depending on the patient's condition or whether they are using a bundled service.

A forthcoming companion price transparency rule will soon require insurers to account for these variations in providing their customers with their portion of hospital bills.[13] While the insurer regulations will give consumers a second source of information, the new rule will not change the hospital obligation; the two regulations are intended to work in tandem to ensure that consumers have access to accurate pricing information from both their insurer and their hospital.

Federal regulations do not address in detail how hospitals should provide their insured customers with a precise price that accounts for deductibles and other cost-sharing nuances.

Effective implementation. Because this study's approach is oriented to the "spirit of the law" and not to a compliance review, this study also sought to identify the most effective examples of implementation, where sampled New York hospitals went beyond minimal implementation to advance the law's transparency goals. These examples are not yet developed enough to be considered best practices in the field, but could mature into replicable best practices as they are refined over time and implementation continues to progress. In the case of machine-readable files, examples of effective implementation were those that maximized the utility of the file for its most likely audiences—including researchers, data aggregators, app developers and competitors—that are generally looking for hospital pricing data that is comprehensive, accurate and comparable across the industry. In the case of shoppable services, examples of effective implementation were those that demonstrated consumer-orientation in design or function (e.g., were created in a way that enhanced the overall utility of the provided tool or information for the intended audience).

Overall Findings

Overall, this study found the pace of implementation to be slower for the machine-readable file requirements than for the shoppable service requirements, with 69% of hospitals implementing the shoppable services requirement as compared to 69% partially implementing the machine-readable requirement.

- For the **machine-readable file** requirement, 19% of hospitals had not implemented, 69% had partially implemented, and 12% had implemented the requirements by providing price information in all five categories of charges. Most of the 28 hospitals that had not implemented or partially implemented the machine-readable file requirements were missing information about discounted cash prices or payer-specific negotiated prices, or both.
- For the **shoppable services** requirement, 22% of hospitals had not implemented, 9% had partially implemented, and 69% had implemented the requirements by providing a cash price for a CT scan of the abdomen. Most of the 22 hospitals that demonstrated implementation did so by providing a consumer-friendly online price estimator tool rather than a file with prices for 300+ services.

12% of hospitals implemented and 69% partially implemented the **machine-readable file** requirements.

69% of hospitals implemented and 9% partially implemented the **shoppable services** requirements.

Methodology

Manatt Health reviewed a semi-random sample of 32 New York hospital websites, out of the 214 total New York hospital websites that are subject to the federal rules.

Hospital sampling. To select a hospital sample for assessment, Manatt used data from the American Hospital Directory® and the New York State Department of Health (NYSDOH) Statewide Planning and Research Cooperative System (SPARCS) database to develop an inventory of all 214 hospitals in New York State and their detailed attributes (including name, address, ZIP code, ACA rating region, patient volume, etc.) and removed hospitals with missing or incomplete data entries from the sample. This resulted in a sample of 190 hospitals.

The study reviewed a semi-random sample of 32 New York hospital websites, out of the 214 total New York hospital websites that are subject to the federal rules.

Manatt then selected hospital attributes of interest to develop "segments" for analysis, including ACA rating region, hospital size by bed count, hospital size by 2019 gross revenues, hospital profit margin, hospital system affiliation status and proportion of Medicaid, uninsured and/or dual-eligible populations. See Appendix II for full details on these selected hospital characteristics.

Hospital sample selection criteria. Using established parameters for segmentation, Manatt generated a semi-random sample of hospitals that were broadly representative of the characteristics selected for analysis (e.g., hospital size by number of beds, hospital size by 2019 total revenue, ACA rating region, high Medicaid population).[14]

The sample was then manually adjusted by selected hospital characteristics to provide a generally representative sample of 32 varying hospitals across the state. Detailed tables of the study sampling methodology are available in Appendices III–V.

Evaluation Methodology

This study reviewed the 32 selected hospitals and their publicly available websites from July 19, 2021, through July 30, 2021, to examine implementation of federal price transparency rules. Manatt Health retrieved each hospital's respective price transparency page by either conducting an Internet search of the hospital name and "price transparency," or navigating to the appropriate page from each respective hospital's home web page if the appropriate page was challenging to find from the initial Internet search.

The evaluation criteria for each level of implementation were customized to reflect the different audiences for machine-readable files versus shoppable services tools.

Levels of implementation. The study classified each hospital's level of implementation as not implemented, partially implemented or implemented. The evaluation criteria for each level of implementation were customized to reflect the different audiences for machine-readable files versus shoppable services tools. See Appendix VI for more information about the evaluation criteria.

Machine-Readable File of Standard Charges

To evaluate implementation of a machine-readable file of standard charges, Manatt examined whether a file was present, and within provided files, whether required pricing elements were represented in the file. This study did not examine the accuracy and completeness of the data provided, but the study did examine whether the information provided was the kind of information that would likely benefit key audiences for machine-readable files, including researchers, data aggregators, app developers, and others. Three levels of implementation were observed among hospitals implementing the machine-readable file of standard charges:

To evaluate implementation of a machine-readable file of standard charges, the study examined whether a file was present, and within provided files, whether required pricing elements were represented in the file.

- **Hospitals that implemented the regulation** provided a prominently displayed, well-formatted, accessible machine-readable data file containing generally complete and comprehensive information for all required hospital standard charges, including gross charges, discounted cash prices, payer-negotiated rates, maximum and minimum charges, names of the payers and plans associated with provided negotiated rates, and any relevant billing codes.
- **Hospitals that partially implemented the regulation** provided machine-readable files with certain components of the federal requirements missing, including many of the required standard charges. Other components of the rule that seek to improve file accessibility were also lacking, such as not being prominently displayed on the appropriate websites, failing to disclose the specific payers/plans with which negotiated rates are associated, not providing any clear billing or service codes, and/or otherwise not exemplifying the purpose or intention of the federal price transparency guidelines.
- **Hospitals that did not implement the regulation** provided files that were either not machine-readable or inaccessible to the user (e.g., a file was broken, corrupted or otherwise inaccessible), providing no standard charge information online.

Shoppable Services Online Price Estimator or Shoppable Services Display

To test the functionality of hospitals' shoppable services tools against the regulatory requirements, Manatt selected a single, common, uniform service (CT scan of the abdomen with contrast, or Current Procedural Terminology (CPT) code 74177) and sought to navigate to a discounted cash price for that selected service for each surveyed hospitals. Manatt did not look at payer-negotiated prices, as obtaining an estimate for the out-of-pocket costs for an insured consumer requires knowledge of a particular product type and product cost-sharing rules.[15] Three levels of implementation were observed among hospitals implementing the shoppable services requirement:

To test the functionality of hospitals' shoppable services tools against regulatory requirements, the study examined the availability of the cash price for a CT scan of the abdomen.

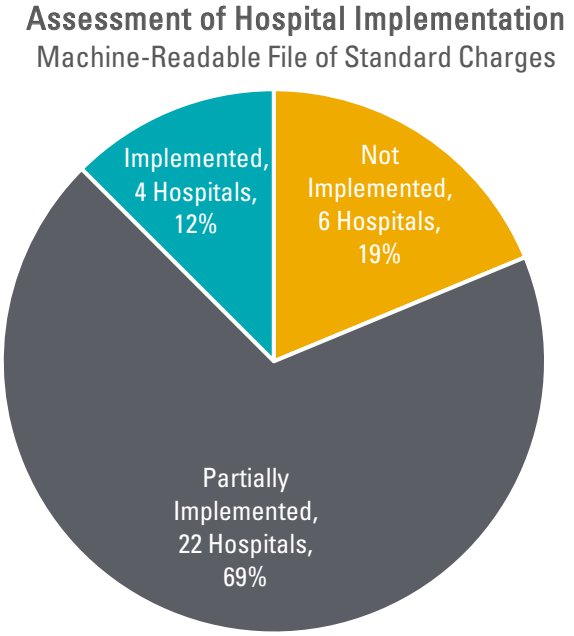
- **Hospitals that implemented the regulation** provided either:
  - A well-displayed, consumer-friendly, accessible and functional online price estimator tool that provided an estimate of an uninsured consumer's estimated out-of-pocket cost for a specified shoppable service (CT scan of the abdomen with contrast, or CPT code 74177); or
  - A well-displayed, consumer-friendly, accessible, searchable display of 300 shoppable services that included the discounted cash price for a specified shoppable service (CT scan of the abdomen with contrast, or CPT code 74177).
- **Hospitals that partially implemented the regulation** provided either:
  - A somewhat well-displayed, somewhat consumer-friendly, functional price estimator tool that provides the consumer with an estimate of "the amount a consumer would be obliged to pay" for a specified shoppable service, demonstrating partial implementation of federal price transparency rules; or
  - A somewhat well-displayed file or display of shoppable services with limited accessibility (e.g., requiring personally identifiable information or registration/password), demonstrated limited consumer friendliness (e.g., does not use plain language descriptors), with certain components of the required standard charges missing—such as the discounted cash price or payer-negotiated rates—demonstrating partial implementation of federal price transparency rules.
- **Hospitals that did not implement the regulation** did not provide any form of tool, display or file that offers information on the hospital's shoppable services.

Findings

Machine-Readable File of Standard Charges

Across the 32 New York State hospitals that were assessed for their implementation of a machine-readable file of standard charges, 19% of hospitals had not implemented, 69% had partially implemented, and 12% had implemented the requirements by providing price information in all five categories of charges.

Four of the 32 hospitals (12%) provided generally complete machine-readable files for all five categories of standard charges. Notably, two of the four implementing hospitals provided .JSON file formats, and the other two provided .XLSX files. While providing a .JSON file format meets federal requirements, this study's ability to assess the file in its full form was limited due to the .JSON file structure.



The other 28 hospitals (88%) provided .XLSX files but demonstrated partial or no implementation because they were deficient in one or more categories:

- More than half of the 32 hospitals (22, or 69% of the sample) demonstrated partial implementation because they did not provide either discounted cash prices, payer negotiated charges or both.
- Six hospitals (19%) either did not provide any machine-readable files of standard charges or provided machine-readable files that did not provide any of the required standard charges.

When examining general trends[16] in levels of implementation by hospital segment, several observations emerged:

- Sampled hospitals in the Southern Tier (Rating Area 6) were observed as generally having the highest levels of implementation.
- Little difference in hospital implementation was observed when comparing sampled hospitals by size and gross revenue.[17]
- Sampled hospitals operating at a profit were generally observed as having higher levels of implementation compared to the hospitals operating with a break-even or loss margin.
- Sampled hospitals affiliated with a health system were generally observed as having higher levels of implementation compared to non-affiliated sampled hospitals.

Shoppable Services Implementation

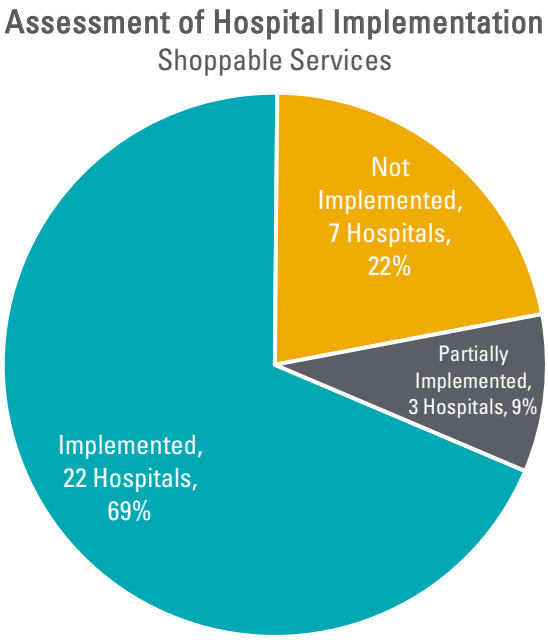
Across the 32 New York State hospitals that were assessed for their shoppable services implementation, 22% of hospitals had not implemented, 9% had partially implemented, and 69% had implemented the requirements by providing a cash price for a CT scan of the abdomen.

Most hospitals (22, or 69%) implemented the shoppable services requirement by providing either a:

- Price estimator tool (19 of 22 hospitals, 86%); or
- Consumer-friendly display[18] of shoppable services (three of 22, 14%).

Of the remaining ten sampled hospitals:

- Three hospitals (30%) demonstrated only partial implementation by providing a display of shoppable services that had several missing categories of required standard charges.
- Seven hospitals (70%) did not demonstrate implementation by not providing a price estimator tool or by not providing a consumer-friendly display for shoppable services at all, or by providing a tool that was not functional or did not provide a cash discounted price or other key information required by the federal regulation.



When examining general trends[19] in levels of implementation by hospital segment, several observations emerged:

- Sampled hospitals in Western New York (Rating Area 2) and New York City (Rating Area 4) were observed as having the highest levels of implementation compared to hospitals sampled from other ACA rating areas.
- Sampled hospitals affiliated with a health system were observed as having slightly higher levels of implementation compared to non-affiliated hospitals. Several system-affiliated hospitals used a system-provided tool/display to fulfill federal requirements.
- Large hospitals by gross revenue were observed as having higher levels of implementation compared to medium and small hospitals within the sample.

Please see Appendix VI for a detailed guide to the implementation scoring system and Appendix VII for a full breakdown of average implementation scores by segment.

Examples of Effective Implementation

The study found examples of effective implementation that could mature into best practices.

Collectively, passage of these federal price transparency requirements in January 2021 mark only the beginning of improving price transparency within the health care industry. The findings in this study indicate that many hospitals are in the process of implementation, though the study did find some examples of effective implementation of baseline federal requirements, which are featured below. These examples are not developed enough to be considered best practices but could mature into replicable best practices as they are refined over time. As hospitals continue to implement the rules and develop innovative approaches to price transparency tools, best practices that emerge should be replicated across hospitals and health systems to further advance price transparency.

Examples of Effective Machine-Readable File Implementation

Within this survey, hospitals that effectively implemented the machine-readable file were those that sought to maximize the utility of the file for its most likely audiences. Because of the nature of the file format required for implementation (e.g., .XML, .JSON or .CSV), the target audience for these files may include researchers, academic institutions seeking to analyze hospital pricing data, and data aggregators and/or innovators seeking to develop third-party, consumer-friendly tools and platforms that support price comparisons. Ultimately, one purpose of requiring a machine-readable file of standard charges is to provide an accessible and complete source of hospital pricing data that can further advance price transparency for the broader public. With this in mind, there are several key features that distinguish effectively implemented files from those that simply meet federal requirements.

Files that demonstrated effective implementation were those that:

- Provided clearly labeled, well-formatted, intuitively organized columns and rows;
- Allowed the user to conduct a digital search on the document; and
- Included data that appeared generally comprehensive and complete.

Common characteristics among these examples from within the sample included:

- Easily importable file and field formats;
- Available data dictionaries or upfront explanations of the data contents and layout; and
- Comprehensive billing information for a full assessment of patient costs, including CPT codes, Healthcare Common Procedure Coding System (HCPCS) codes, revenue codes or International Classification of Disease (ICD) codes, as appropriate.

Many hospitals that demonstrated implementation of federal requirements provided a single Excel file with a single Excel sheet inclusive of the required information, separated by columns. See Figure 1 for a sample single Excel worksheet that is an example of effective implementation of the federal requirements for machine-readable files.

Another hospital that demonstrated effective implementation of federal requirements did so in a slightly different way, providing a workbook of separated pages (worksheets). The first "page" provided legal information and a data overview of the workbook contents to support user navigation and understanding of the workbook contents, followed by separate pages of offered hospital services based on their specific service code type (e.g., in chargemaster format, by CPT code or by Diagnosis Related Group (DRG)). See Figure 2 for an example of a workbook and its separate contents per page.

Figure 1. Sample of Hospital Y Machine-Readable File of Standard Charges—Single Excel Worksheet

CDM Item Number	Revenue Code	Service ID	Service Description	Charge Type	Gross Charge	Discounted Cash Price	Uninsured Discount Price	Minimum Negotiated Charge	Maximum Negotiated Charge	Payer/Plan A	Payer/Plan B	Payer/Plan C
6810022	360	10005	FINE NEEDLE ASPIRATION US	CPT/HCPCS Code	417.00	417.00	291.90	65.78	384.06	312.75	258.54	308.91
10021P	982	10021	Fine needle aspiration; without imaging guidance	CPT/HCPCS Code	191.00	191.00	133.70	68.24	162.35	88.62	118.42	69.03
10021	510	10021	Fine needle aspiration; without imaging guidance	CPT/HCPCS Code	391.00	391.00	273.70	50.18	360.11	293.25	242.42	289.65
10021T	510	10021	Fine needle aspiration; without imaging guidance	CPT/HCPCS Code	200.00	200.00	140.00	50.18	184.20	150.00	124.00	148.16
10022		10022	Fine needle aspiration; with imaging guidance	CPT/HCPCS Code	417.00	417.00	291.90	175.14	384.06	312.75	258.54	308.91
2410040	450	10040	REMOVAL INGROWN HAIR	CPT/HCPCS Code	125.00	125.00	87.50	46.89	115.13	93.75	77.50	92.60
10040		10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	CPT/HCPCS Code	125.00	125.00	87.50	46.89	115.13	93.75	77.50	92.60
10060P	982	10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	CPT/HCPCS Code	126.00	126.00	88.20	94.41	198.21	124.74	198.21	108.90
10060	510	10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	CPT/HCPCS Code	340.00	340.00	238.00	94.41	313.14	255.00	210.80	251.87
10060T	510	10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	CPT/HCPCS Code	214.00	214.00	149.80	89.88	197.09	160.50	132.68	158.53
2010059	450	10060	DRAIN ABCESS-FAC CHG	CPT/HCPCS Code	97.00	97.00	67.90	40.74	94.41	72.75	60.14	71.86
2010060	450	10060	DRAINAGE SKIN ABCESS	CPT/HCPCS Code	340.00	340.00	238.00	94.41	313.14	255.00	210.80	251.87
2400014	361	10060	INCISION & DRAINAGE	CPT/HCPCS Code	181.00	181.00	126.70	76.02	166.70	135.75	112.22	134.08
2010061	450	10061	DRAINAGE SKIN ABCESS	CPT/HCPCS Code	553.00	553.00	387.10	166.96	670.00	414.75	342.86	409.66
10061		10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or [illegible]bia); complicated or	CPT/HCPCS Code	553.00	553.00	387.10	166.96	670.00	414.75	342.86	409.66

Figure 2. Sample of Hospital Z Machine-Readable File of Standard Charges—Excel Workbook With Multiple Sheets

Sheet 1: Legal Notice. Includes file description, financial assistance information, notice about pricing reflecting actual costs, definitions and additional information, and reference to the federal price transparency rules.

Sheet 2, titled "CDM"

Facility ID	Charge Master Code	Charge Master Description	Revenue Code	Revenue Description	Gross Charge	Cash Charge
xxxxx	1000000	ALLERGEN, COTTON WOOD TREE	301	LABORATORY CHEMISTRY	43	21.5
xxxxx	1000001	T CELL ANTIGEN RECEPTOR	301	LABORATORY CHEMISTRY	491.84	245.92
xxxxx	1000004	FRAGILE X CHARACTER	301	LABORATORY CHEMISTRY	788.75	394.38
xxxxx	1000005	CYTOGENOMIC MICROARRAY	301	LABORATORY CHEMISTRY	1982.07	991.03
xxxxx	1000008	ADENOSINE DEAMINASE	301	LABORATORY CHEMISTRY	166	83
xxxxx	1000012	HIV GEONOTYPE	301	LABORATORY CHEMISTRY	727	363.5
xxxxx	1000015	ALLERGEN, GOLDENROD	301	LABORATORY CHEMISTRY	43	21.5
xxxxx	1000016	PARIETAL CELL AB	301	LABORATORY CHEMISTRY	63	31.5
xxxxx	1000017	DIRECT BILIRUBIN	301	LABORATORY CHEMISTRY	29	14.5
xx		CULTURE TYPNG		LABORATORY CHEMISTRY		

Sheet 3, titled "CPT"

Facility ID	CPT	Description	Min Negotiated Rate	Max Negotiated Rate	Payer/Plan A	Payer/Plan B	Payer/Plan C
xxxxx	0001U	RBC DNA HEA 35 ag 11 bld grp	720	720	720	720	720
xxxxx	0002M	LIVER DIS 10 ASSAYS SERUM ALGORITHM W/ASH	503.4	503.4	503.4	503.4	503.4
xxxxx	0002U	Onc clrct 3 ur metab alg plp	25	25	25	25	25
xxxxx	0003M	LIVER DIS 10 ASSAYS SERUM ALGORITHM W/NASH	503.4	503.4	503.4	503.4	503.4
xxxxx	0003U	Onc ovar 5 prtn ser alg scor	950	950	950	950	950
xxxxx	0004M	SCOLIOSIS 53 SNPS SALIVA PROGNOSTIC RISK SCORE	79	79	79	79	79
xxxxx	0005U	Onco prst8 3 gene ur alg	760	760	760	760	760
xxxxx	0006M	ONCOLOGY HEP MRNA 161 GENES RISK CLASSIFIER	150	150	150	150	150
xxxxx	0006U	Detc ia meds 120+ analytes	246.92	246.92	246.92	246.92	246.92
xx		ASTRO 51 GENES NOMOGRAM		375	375		375

Sheet 4, titled "DRG"

Facility ID	MS-DRG	Description	Min Negotiated Rate	Max Negotiated Rate	Payer/Plan A	Payer/Plan B	Payer/Plan C
xxxxx	1	Heart Transplant Or Implant Of Heart Assist System With MCC	127396.28	658507.99	658507.99	658507.99	658507.99
xxxxx	10	Pancreas Transplant	16480.11	82246.43	82246.43	82246.43	82246.43
xxxxx	100	Seizures With MCC	8535.02	42595.27	42595.27	42595.27	42595.27
xxxxx	101	Seizures Without MCC	4040.65	20165.46	20165.46	20165.46	20165.46
xxxxx	102	Headaches With MCC	5246.47	26183.27	26183.27	26183.27	26183.27
xxxxx	103	Headaches Without MCC	3772.79	18828.67	18828.67	18828.67	18828.67
xxxxx	11	Tracheostomy For Face, Mouth And Neck Diagnoses Or Laryngectomy With	22851.76	114045.11	114045.11	114045.11	114045.11

Examples of Effective Shoppable Services Implementation

Within this survey, hospital online price estimator tools and/or shoppable services displays that emerged as examples of effective implementation were those that demonstrated consumer-orientation in their design or function (e.g., were created in a way that enhanced the overall utility of the provided tool or information for the intended audience). There are several key features that distinguish these examples of effective implementation from simply meeting federal requirements.

Online Price Estimator Tool

The most effective examples of consumer-friendly **online shoppable service tools** identified in this survey:

- Were easily found via the hospital's web page;
- Asked the user simple, easy-to-understand questions regarding hospital location, insurance coverage and the service(s) of interest; and
- Provided clear estimates of a consumer's expected out-of-pocket costs for the specified service.

The most effective, consumer-oriented **price estimate displays** identified in this study's investigation were those that:

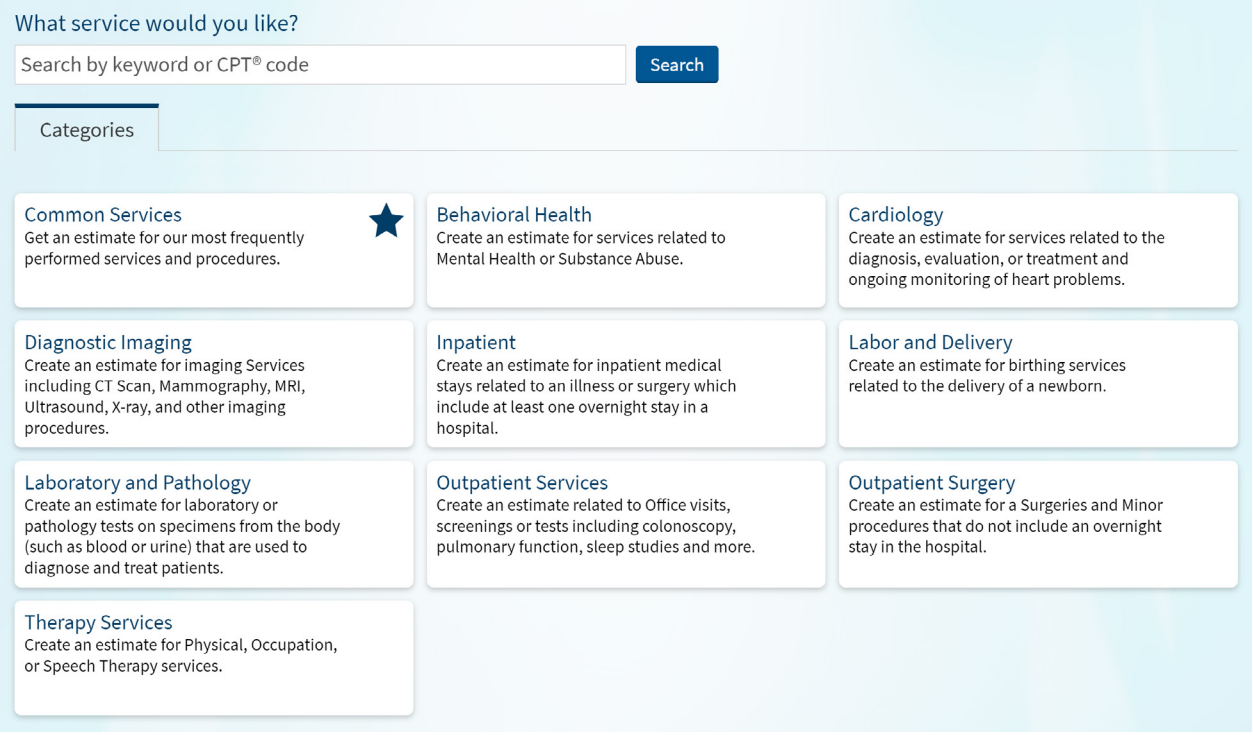
- Clearly indicated an estimated out-of-pocket cost on the web page; and
- Provided an intuitive layout for any additional information provided regarding that estimate (including the shoppable service name, the hospital location and any breakdown of that estimate).

Figure 3 below provides an example of the navigation process and ultimate price estimate provided by an effective online price estimator tool. The tool was easy to find on the hospital's designated price transparency web page, was designed in a consumer-friendly way with straightforward instructions for consumer navigation and required few selections to generate a final price estimate. The final price estimate clearly displays information on the hospital name and location, with the specific service for which the user has requested an estimated price across the top. An estimated out-of-pocket cost is highlighted in large, green text on the left-hand side, with an itemized breakdown of how this quote was generated on the right-hand side of the page. With such a display, consumers do not need to deduce any information from the surrounding text to understand what their estimated out-of-pocket cost would be.

Several hospitals that implemented an online price estimator tool provided additional information to users beyond the federal requirements—additional disclaimers or information explaining the charges, patient utilization of related services (as shown in Figure 3 below) and more. This additional information can enhance the consumer experience and may support a clearer understanding of the information being presented.

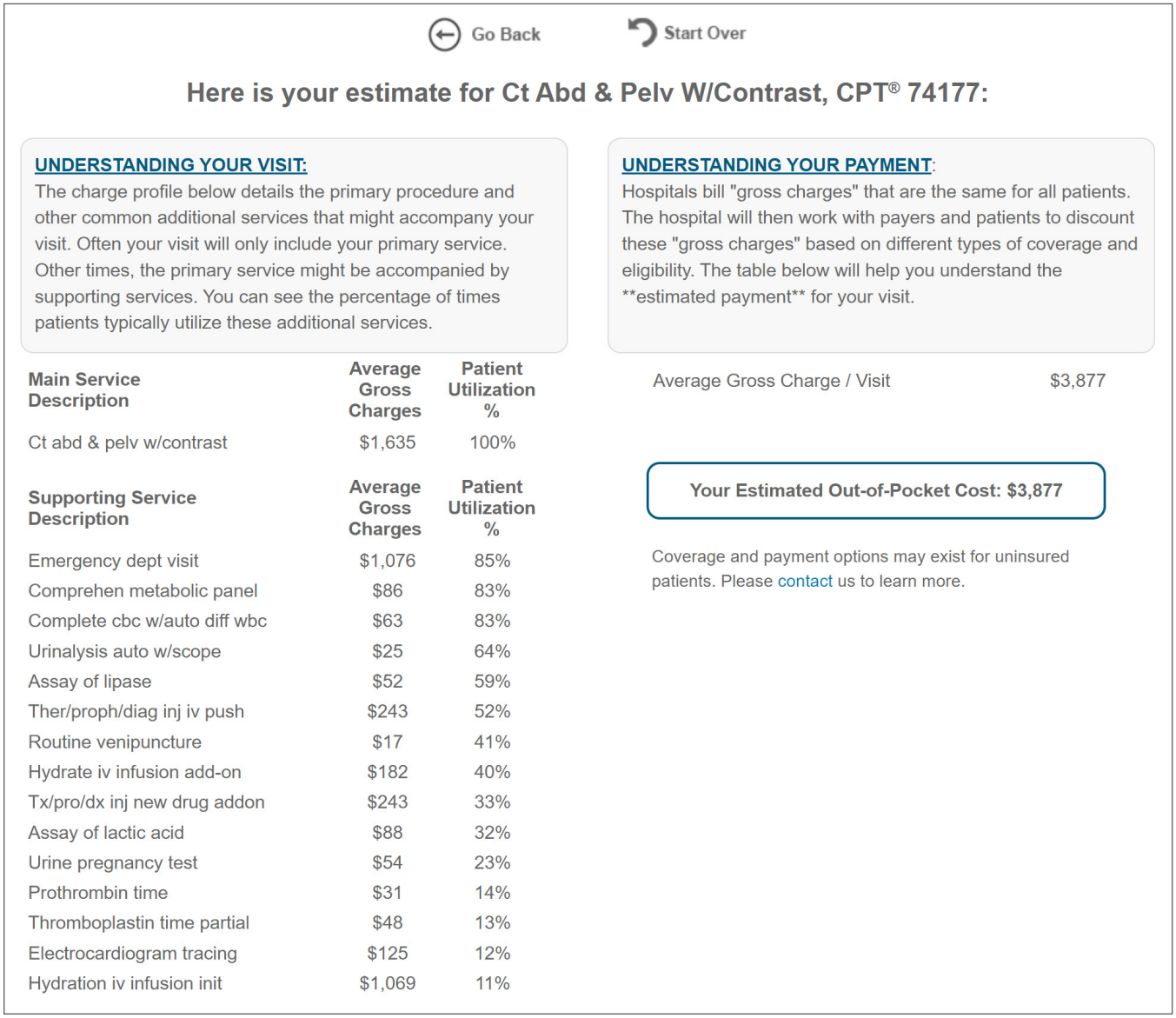
Figure 3. Sample Hospital 1: Navigating Through a Price Estimator Tool to Generate an Estimated Out-of-Pocket Cost for a Selected Service

1. On the hospital's dedicated Price Transparency web page, the user is provided with a prominently displayed, clearly labeled button for the hospital's "Price Estimator," accompanied by a brief explanation of what information the tool provides.
2. After selecting the Price Estimator button, the user is directed to a brief disclaimer page that articulates the limitations of the estimate the hospital will provide through the tool.
3. In accepting the terms and continuing forward, the user is provided the following page to begin a search for the desired procedure. The user is provided a set of service categories to choose from that are displayed in a clear manner. The user is also provided the option to perform a text search using the search bar at the top of the page. Within this study, a CT scan of the abdomen with contrast (CPT code 74177) was used for the purposes of testing price estimator tools. Recognizing many users would not be familiar with the specific CPT code associated with the procedure they are pursuing an estimate for, in this sample, the user selected "Imaging."



4. The user is then provided a page with all the available services within the category of "Imaging." Each service is displayed in a tile format similar to previous pages, with a service name, a CPT code and a brief description of the service in plain language.
5. Once the user selects the desired service, the user is provided a new page with available insurance companies and respective plan types to choose from, again displayed in the tile format similar to previous pages. "Continue without insurance" is selected to advance the page.
6. The user is provided a final page with a prominently displayed estimate of the price of the service for that user, accompanied by an itemized breakdown of how that estimate was generated.

Figure 4. Sample Hospital 2 Price Estimator Tool With Average Gross Charge, Patient Utilization Rate and an Estimated Out-of-Pocket Cost



Go Back Start Over

Here is your estimate for Ct Abd & Pelv W/Contrast, CPT® 74177:

UNDERSTANDING YOUR VISIT:
The charge profile below details the primary procedure and other common additional services that might accompany your visit. Often your visit will only include your primary service. Other times, the primary service might be accompanied by supporting services. You can see the percentage of times patients typically utilize these additional services.

UNDERSTANDING YOUR PAYMENT:
Hospitals bill "gross charges" that are the same for all patients. The hospital will then work with payers and patients to discount these "gross charges" based on different types of coverage and eligibility. The table below will help you understand the **estimated payment** for your visit.

Main Service Description	Average Gross Charges	Patient Utilization %
Ct abd & pelv w/contrast	$1,635	100%

Supporting Service Description	Average Gross Charges	Patient Utilization %
Emergency dept visit	$1,076	85%
Comprehen metabolic panel	$86	83%
Complete cbc w/auto diff wbc	$63	83%
Urinalysis auto w/scope	$25	64%
Assay of lipase	$52	59%
Ther/proph/diag inj iv push	$243	52%
Routine venipuncture	$17	41%
Hydrate iv infusion add-on	$182	40%
Tx/pro/dx inj new drug addon	$243	33%
Assay of lactic acid	$88	32%
Urine pregnancy test	$54	23%
Prothrombin time	$31	14%
Thromboplastin time partial	$48	13%
Electrocardiogram tracing	$125	12%
Hydration iv infusion init	$1,069	11%

Average Gross Charge / Visit $3,877

Your Estimated Out-of-Pocket Cost: $3,877

Coverage and payment options may exist for uninsured patients. Please contact us to learn more.

Consumer-Friendly Display of Shoppable Services

Within this survey, the most effective examples of implementation of a consumer-friendly display of shoppable services (instead of the price estimator tool) were those that provided shoppable services files that included:

- Clearly labeled, well-formatted, intuitively organized columns and rows that allow the user to conduct a digital search on the document; and
- Clear, plain language descriptors for each shoppable service.

By the nature of the predominant display format used for implementation of this federal requirement (e.g., an Excel file containing information on standard charges for available shoppable services), hospitals were less successful in making the Excel file consumer friendly beyond ensuring that the file formatting and data contents were clear and intuitively organized. Beyond meeting baseline federal requirements, the most effective examples of implementing shoppable service files observed in this survey sought to provide information on the "bundles" of services available, which allow users to understand the specific items that comprise the associated hospital charge.

Figure 5 provides an example of a sample hospital that demonstrated implementation of federal requirements while providing additional bundled service information in a consumer-friendly way. In Figure 5, the hospital provides a primary service code and its relevant standard charges and lists additional claims codes that are bundled with the primary service. The file indicates "included" for each additional add-on underneath the charge price for the primary service, formatted in an intuitive way so that users can easily understand the service bundle and the associated range of prices.

Figure 5. Sample Hospital A Consumer-Friendly Shoppable Services Display

Facility Name	Primary Code	Primary Description	Code	Code Description	Service Type	Charges	Cash Price	Min Allowable	Max Allowable	Payer/Plan A	Payer/Plan B	Payer/Plan C
Hospital A	74177	Ct abd & pelv w/contrast	CLAIM		OP	$2,889.00	$428.45	$13.17	$2,110.21	$432.73	$441.30	$445.59
			0636	Drugs Require Specific ID: Drugs requiring detail coding		Included						
			0352	CT Scan: Body		Included						
			0350	CT Scan		Included						
			0301	Laboratory - Clinical Diagnostic: Chemistry		Included						
			0300	Laboratory - Clinical Diagnostic		Included						

Conclusion

This Manatt study focuses on hospital implementation of the federal price transparency rules for hospitals that took effect in January 2021. The study looked at a sample of New York hospitals in July 2021 and assessed their implementation progress on a continuum from not implemented to partially implemented to implemented. The results are preliminary in nature given an ongoing implementation process since July, but the findings do illuminate the early state of play in one state that may or may not be representative of other states.

The more useful tools will simplify the shopping experience for consumers by making it easy to compare prices across multiple hospitals.

This study found that from a broad "spirit of the law" perspective, most sampled hospitals were making some incremental progress toward greater price transparency, but also that much remains to be done to achieve broad transparency. Most New York hospitals had partially implemented or implemented at least some of the federal requirements, with greater progress in implementing the shoppable services requirements than the machine-readable file requirements. Both sets of requirements are important. Shoppable service requirements are likely to be most helpful to individual consumers interested in simple and straightforward price comparisons. Machine-readable files are most likely to be helpful to audiences such as researchers, app developers and competitors. Even for individual consumers, the more useful shopping tools are likely to be those that allow comparison shopping across multiple hospitals—those that are likely to come from data aggregators and app developers using data from machine-readable files to simplify the shopping experience for consumers. While industry-leading best practices have yet to emerge, there are examples of effective implementation that show promise.

Looking ahead, next steps on implementation of the federal price transparency rules could include the following considerations:

- The recent decision to increase penalties for noncompliance may focus more attention on compliance issues that are beyond the purview of this study. As federal transparency rules for insurers take effect in 2022, those rules should seek to include more clarity as to how disclosure should work in cases where the consumer share of the hospital's payer-specific negotiated charge is complicated. The underlying principle of the federal rules is dual responsibility for payers and providers, but there should be more clarity for both insurers and hospitals about exactly what must be disclosed by each of them, respectively.

The rules should clarify insurer and hospital disclosure requirements where determining the consumer's share of the hospital bill is more nuanced due to complex cost-sharing rules.

- As compliance with machine-readable file requirements improves, it may make sense to form a user group to discuss standardizing certain conventions to make these files easier to use. In the long term, industry-leading hospitals can work with researchers to translate examples of effective implementation into best practices that can be replicated across the hospital sector.

Appendices

Appendix I: Detailed Federal Price Transparency Rules

Below is a summary of the requirements set forth by federal requirements that became effective January 1, 2021. The chart below was developed from CMS' Hospital Price Transparency Frequently Asked Questions (FAQs) document[20] and Hospital Price Transparency Requirements Quick Reference Checklists.[21]

Requirements from CMS' Hospital Price Transparency Final Rule, Effective January 1, 2021

	Machine-Readable File of Standard Charges	Consumer-Friendly Display of Shoppable Services	
		Display/File of Shoppable Services	**Online Price Estimator Tool**
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. 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.	Allows health care 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.
Price disclosure requirements	• Gross charge • Discounted cash price • Payer-specific negotiated charges • De-identified minimum negotiated charge • De-identified maximum negotiated charge	• Discounted cash price (or gross charge, if the hospital has not established a discounted cash price) • Payer-specific negotiated charges • De-identified minimum negotiated charge • De-identified maximum negotiated charge	Must provide estimates for as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services, including as many of the 70 CMS-specified shoppable services as are provided by the hospital.
Description of item/service, 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 plain-language 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.	Not defined in rule

	Machine-Readable File of Standard Charges	Consumer-Friendly Display of Shoppable Services	
		Display/File of Shoppable Services	Online Price Estimator Tool
Service not offered by hospital	Not defined in rule	Use an indicator when one or more of the CMS-specified shoppable services are not offered by the hospital (for example, N/A).	Not defined in rule
Format	A single digital file that is machine- readable	Not defined in rule	Not defined in rule
Naming convention	Must adhere to the CMS naming convention: <ein>_<hospital-name>_standard charges.[json|xml|csv]	Not defined in rule	Not defined in rule
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.		
Access to information	Must be free of charge and may not require a log-in or password, other barriers and/or the submission of personal identifying information (PII).		Must be accessible to the public without charge and without having to register or establish a user account or password.
Search capability	Digitally searchable.	Searchable by service description, billing code and payer.	Not defined in rule
Updates	Annually—with date of last update clearly indicated.	Annually—with date of last update clearly indicated.	Not defined in rule

Appendix II: Hospital Characteristics

1. **ACA Rating Regions in New York State.** There are eight total ACA rating regions in New York State that encompass unique geographic regions across the state.
2. **Hospital Size by Beds.** These parameters were set based on Manatt's analysis of New York State hospital data. Comparatively, the American Hospital Association generally defines a small hospital as having fewer than 100 beds, a medium hospital as having between 100 and 499 beds and large hospitals as having 500 or more. Because hospitals in New York State are generally in the larger size by bed, Manatt defined its hospital size parameters according to the following:
   a. Small hospitals were defined as having fewer than 200 beds.
   b. Medium hospitals were defined as having between 200 and 499 beds.
   c. Large hospitals were defined as having more than 500 beds.
3. **Hospital Size by Gross Revenues.** Based on Manatt's analysis of New York State hospital gross revenues:
   a. Small hospitals were defined as having less than $400 million in gross revenues.
   b. Medium hospitals were defined as having between $400 million and $1 billion in gross revenues.
   c. Large hospitals were defined as having more than $1 billion in gross revenues.
4. **Hospital Profit Margin.** These parameters were set based on Manatt's analysis of New York State hospitals. Hospitals were classified by their FY2019 net income to gross revenues ratio.
   a. Profit hospitals were defined as those with a profit margin greater than 0.75%.
   b. Break-even hospitals were defined as those within a 0.75% profit or loss margin.
   c. Loss hospitals were defined as those with a loss margin of greater than 0.75%.
5. **Health System Affiliation.** Hospitals were characterized as being affiliated with a larger health system or not affiliated with a larger health system.
6. **Hospitals Serving High-Proportion Medicaid, Uninsured and/or Dual-Eligible Populations.** These parameters were adopted from the New York State Department of Health definition of Safety Net Provider.
   a. High Medicaid, uninsured and/or dual-eligible population hospitals were defined as those with at least 35% outpatient (across all lines of business) and at least 30% inpatient discharges associated with Medicaid, uninsured or dual-eligible individuals.
   b. Hospitals that are not high Medicaid, uninsured and/or dual-eligible population hospitals were defined as those with either less than 35% outpatient (across all lines of business) or less than 30% inpatient discharges associated with Medicaid, uninsured or dual-eligible individuals.

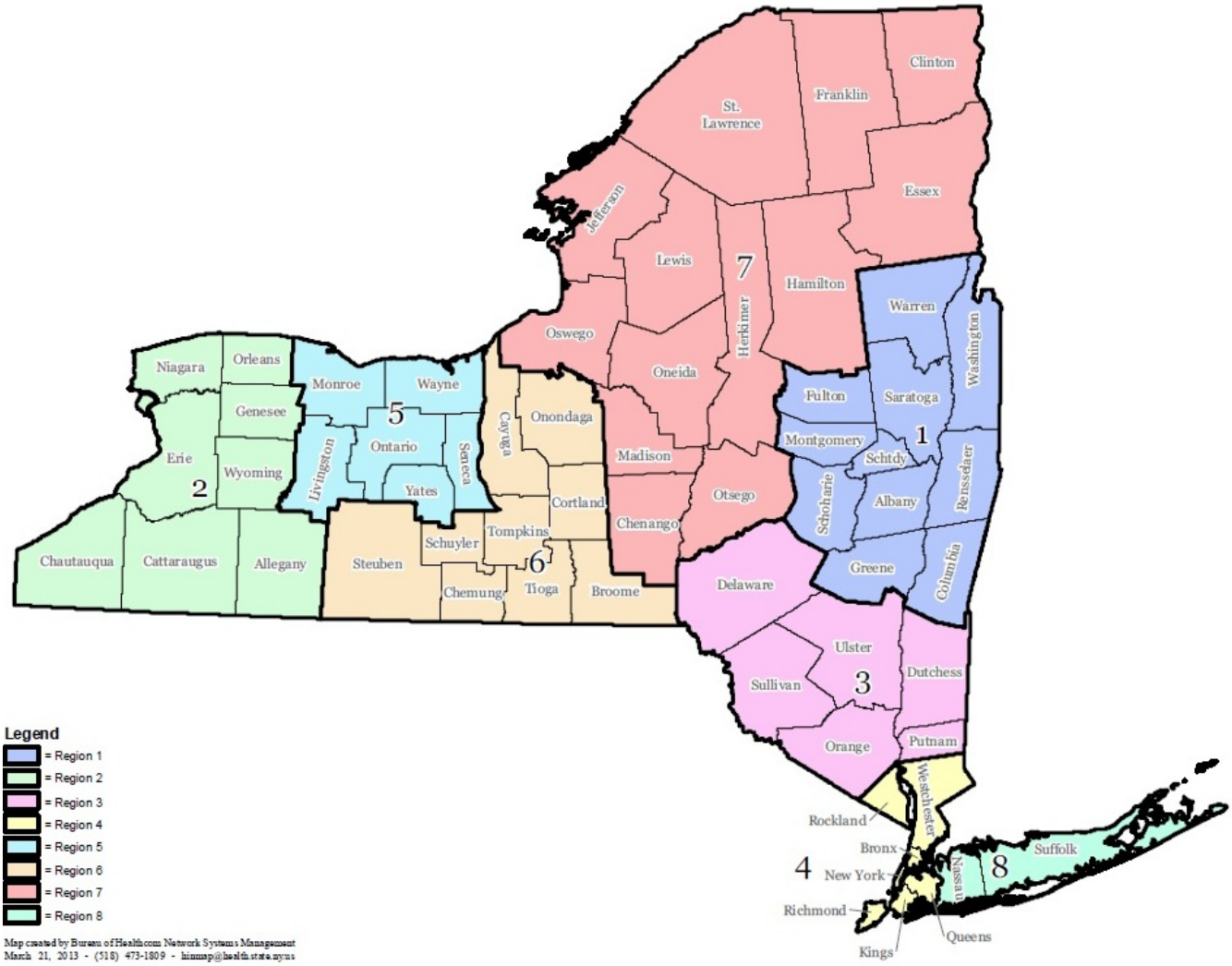
Appendix III: Selected Hospital Sample

Selected Characteristics and Distribution of Hospital Sample

Hospital Characteristic	Parameters	Hospital Count From Sample	Percentage Distribution
Hospital Region Hospital region by ACA rating area (CMS data, Manatt analysis)			
Rating Area 1	Albany, Rensselaer, Saratoga, Schenectady, Columbia, Fulton, Green, Montgomery, Warren, Washington, Schoharie	**3**	9%
Rating Area 2	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	**3**	9%
Rating Area 3	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster	**4**	13%
Rating Area 4	Queens, Richmond, Rockland, New York, Kings, Bronx, Westchester	**9**	28%
Rating Area 5	Livingston, Monroe, Ontario, Seneca, Wayne, Yates	**2**	6%
Rating Area 6	Onondaga, Broome, Chemung, Cortland, Schuyler, Tioga, Cayuga, Steuben, Tompkins	**3**	9%
Rating Area 7	Chenango, Clinton, Hamilton, Essex, Franklin, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	**2**	6%
Rating Area 8	Nassau, Suffolk	**6**	19%
Total		**32**	100%
Hospital Size by Beds Number of beds per hospital (American Hospital Directory data)			
Large	500+ beds	**16**	50%
Medium	200–499 beds	**9**	28%
Small	< 200 beds	**7**	22%
Total		**32**	100%
Hospital Size by Gross Revenue Hospital gross revenues, 2019 (American Hospital Directory data)			
Large	> $1 billion	**21**	66%
Medium	$400 million – $1 billion	**7**	22%
Small	< $400 million	**4**	13%
Total		**32**	100%

Hospital Characteristic	Parameters	Hospital Count From Sample	Percentage Distribution
Profit Margin Hospital Net Income to Gross Revenue Ratio (American Hospital Directory Data, Manatt analysis)			
Profit	Generated greater than 0.75% profit margin	**16**	50%
Break-even	Generated within 0.75% profit or loss margin	**10**	31%
Loss	Generated greater than 0.75% loss margin	**6**	19%
Total		**32**	100%
Health System Affiliation Hospital affiliation status (Manatt analysis)			
Yes	Affiliated with a health system	**28**	88%
No	Not affiliated with a health system	**4**	13%
Total		**32**	100%
Hospitals Serving High Medicaid, Uninsured and/or Dual-Eligible Populations Hospital safety net classification, 2015 (New York State Department of Health)			
Yes	Total outpatient volume associated with Medicaid, uninsured and dual- eligible individuals is at least 35%; and	**19**	59%
	Total inpatient volume associated with Medicaid, uninsured and dual- eligible individuals is at least 30%.		
No	Total outpatient volume associated with Medicaid, uninsured and dual- eligible individuals is less than 35%; or	**13**	41%
	Total inpatient volume associated with Medicaid, uninsured and dual- eligible individuals is less than 30%.		
Total Sample		**32**	**100%**

Appendix IV: New York State ACA Rating Regions



Source: New York Standardized Rating Regions Map, New York State Department of Financial Services. Available here: https://dfs.ny.gov/system/files/documents/2021/02/std_rating_regions_map.pdf.

Appendix V: Sampling by Region

Manatt used total regional revenue distribution to determine regional hospital sample size.

- For sampling purposes, a floor of two hospitals per rating area was set.
- Manatt examined sampling by region using cumulative revenues by region and using hospital density.

Sample by Region, Distributed by Revenues (selected sampling strategy)

Region	Gross Revenue by Region	Proportion of Revenue by Region	Proportion of Revenue* 30 (target sample)	Proposed Sample
Rating Area 4	$151,523,933,436	55.9%	16.78	**9**
Rating Area 8	$57,511,096,272	21.2%	6.37	**6**
Rating Area 3	$18,043,080,860	6.7%	2.00	**4**
Rating Area 1	$12,369,449,288	4.6%	1.37	**3**
Rating Area 6	$12,069,903,906	4.5%	1.34	**3**
Rating Area 2	$11,091,977,809	4.1%	1.23	**3**
Rating Area 7	$7,087,815,968	2.6%	0.78	**2***
Rating Area 5	$1,220,032,666	0.5%	0.14	**2***
Grand Total	**$270,917,290,205**	**100%**	**30**	**32**

Sample by Region, Distributed by Hospital Density

Region	Total Hospital Count by Region	Hospital Density by Region	Hospital Density* 30 (target sample)	Proposed Sample
Rating Area 4	66	35%	10.42	9
Rating Area 8	25	13%	3.95	4
Rating Area 7	24	13%	3.79	4
Rating Area 2	22	12%	3.47	4
Rating Area 3	18	9%	2.84	3
Rating Area 6	16	8%	2.53	3
Rating Area 1	14	7%	2.21	3
Rating Area 5	5	3%	0.79	2*
Grand Total	**190**	**100%**	**30**	**32**

*A floor of two hospitals per rating area was set.

Appendix VI: Detail on Implementation Scoring Levels and Assessment of Hospital Price Transparency Implementation

Standard Charges	Not Implemented	Partially Implemented	Implemented
	1 point	2 points	3 points
Machine-readable file	• No file is present • File is present but not functional (broken link, download does not work, etc.)	• Somewhat prominently displayed • Machine-readable file that is somewhat accessible (e.g., difficult to navigate, or otherwise not exemplifying the purpose of the federal rules) • Missing either a discounted cash price or payer-specific negotiated rates, lacking most of the required standard charges and providing only limited price information within the file (e.g., only a gross charge)	• Prominently displayed • Accessible, machine-readable file • Contains generally complete and comprehensive information on all required standard charges, including: – Gross charge, discounted cash price – Payer-specific negotiated charges – De-identified min. and max. charges – Payer and plan names for all payer-specific negotiated prices – Billing codes for items and services
Shoppable Services	**Not Implemented**	**Partially Implemented**	**Implemented**
	1 point	**2 points**	**3 points**
Online price estimator tool	• No price estimator tool is present • Not functional (e.g., does not provide an estimate for a CT scan or any other attempted shoppable service)	• Poorly displayed • Not consumer friendly • Functional (e.g., allows users to obtain an estimate of the amount they will be obligated to pay the hospital for a CT scan)	• Prominently displayed • Generally consumer friendly • Functional (e.g., allows users to obtain an estimate of the amount they will be obligated to pay the hospital for a CT scan)
Shoppable services display	• No shoppable services display or file is provided	• Poorly displayed • Poor accessibility (requires PII or registration/password) • Not consumer friendly (e.g., doesn't use plain language) • Does not display 300+ shoppable services • Lacks most of the required standard charges, including discounted cash price and payer-negotiated rates	• Prominently displayed • Accessible (does not require PII or registration/password) • Consumer friendly (e.g., uses plain language) • Displays 300+ shoppable services • Contains generally complete and comprehensive information on all required hospital standard charges

Appendix VII: Average Implementation Score by Segment

Hospital Characteristic	Parameters	Hospital Count From Sample	Machine-Readable File (Avg. Score)	Shoppable Services (Avg. Score)
Hospital Region Hospital region by ACA rating area (CMS data, Manatt analysis)		Hospital Count From Sample: 32	Average Score: 1.94	Average Score: 2.47
Rating Area 1	Albany, Rensselaer, Saratoga, Schenectady, Columbia, Fulton, Green, Montgomery, Warren, Washington, Schoharie	3*	1.67	2.33
Rating Area 2	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	3*	2.00	3.00
Rating Area 3	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster	4*	2.00	2.25
Rating Area 4	Queens, Richmond, Rockland, New York, Kings, Bronx, Westchester	9	1.89	2.67
Rating Area 5	Livingston, Monroe, Ontario, Seneca, Wayne, Yates	2*	1.50	2.00
Rating Area 6	Onondaga, Broome, Chemung, Cortland, Schuyler, Tioga, Cayuga, Steuben, Tompkins	3*	2.33	2.33
Rating Area 7	Chenango, Clinton, Hamilton, Essex, Franklin, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	2*	2.00	2.50
Rating Area 8	Nassau, Suffolk	6	2.00	2.33
Hospital Size by Beds Number of beds per hospital (American Hospital Directory data)		Hospital Count From Sample	Average Score	Average Score
Large	500+ beds	16	2.00	2.56
Medium	200–499 beds	9	1.78	2.67
Small	< 200 beds	7	2.00	2.00
Hospital Size by Gross Revenue Hospital gross revenues, 2019 (American Hospital Directory data)		Hospital Count From Sample	Average Score	Average Score
Large	> $1 billion	21	2.05	2.67
Medium	$400 million – $1 billion	7	1.71	2.14
Small	< $400 million	4*	1.75	2.00

Hospital Characteristic	Parameters	Hospital Count From Sample	Machine-Readable File (Avg. Score)	Shoppable Services (Avg. Score)
Profit Margin Hospital Net Income to Gross Revenue Ratio (American Hospital Directory Data, Manatt analysis)		Hospital Count From Sample	Average Score	Average Score
Profit	Generated greater than 0.75% profit margin	16	2.20	2.50
Break-even	Generated within 0.75% profit or loss margin	10	1.67	2.50
Loss	Generated greater than 0.75% loss margin	6*	1.88	2.44
Health System Affiliation Hospital affiliation status (Manatt analysis)		Hospital Count From Sample	Average Score	Average Score
Yes	Affiliated with a health system	28	2.04	2.50
No	Not affiliated with a health system	4*	1.25	2.25
Hospitals Serving High Medicaid, Uninsured and/or Dual-Eligible Populations Hospital safety net classification, 2015 (New York State Department of Health)		Hospital Count From Sample	Average Score	Average Score
Yes	Total outpatient volume associated with Medicaid, uninsured and dual-eligible individuals is at least 35%; and Total inpatient volume associated with Medicaid, uninsured and dual-eligible individuals is at least 30%.	19	2.00	2.47
No	Total outpatient volume associated with Medicaid, uninsured and dual-eligible individuals is less than 35%; or Total inpatient volume associated with Medicaid, uninsured and dual-eligible individuals is less than 30%.	13	1.85	2.46

*Due to the small sample size, average implementation scores for each requirement have limited generalizability.

[1] "Association Between Availability of a Price Transparency Tool and Outpatient Spending," Desai S., Hatfield L.A., Hicks A.L., Chernew M.E., Mehrotra A. *JAMA*. 2016;315(17):1874–1881. doi:10.1001/jama.2016.4288. Available here: https://jamanetwork.com/journals/jama/fullarticle/2518264

[2] "Association Between Availability of a Price Transparency Tool and Outpatient Spending," Desai S., Hatfield L.A., Hicks A.L., Chernew M.E., Mehrotra A. *JAMA*. 2016;315(17):1874–1881. doi:10.1001/jama.2016.4288. Available here: https://jamanetwork.com/journals/jama/fullarticle/2518264

[3] 45 C.F.R. § 158.101. Available here: https://www.law.cornell.edu/cfr/text/45/158.101#:~:text=Subpart%20C%20implements%20the%20provision,may%20destabilize%20the%20individual%20market

[4] "New Year, New CMS Price Transparency Rule for Hospitals." Wheeler, C., Taylor, R. *Health Affairs Blog*. January 2021. Available here: https://www.healthaffairs.org/do/10.1377/hblog20210112.545531/full/

[5] 45 C.F.R. Subchapter E, "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," Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Final Rule. November 27, 2019. Available here: https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf

[6] "New Year, New CMS Price Transparency Rule for Hospitals." Wheeler, C., Taylor, R. *Health Affairs Blog*. January 2021. Available here: https://www.healthaffairs.org/do/10.1377/hblog20210112.545531/full/

[7] 45 C.F.R. § 180.40(a). Available here: https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf

[8] Federally owned/operated facilities are deemed to have met these transparency requirements.

[9] Nikpay S, Golberstein E, Neprash HT, Carroll C, Abraham JM. "Taking the Pulse of Hospitals' Response to the New Price Transparency Rule," Medical Care Research and Review. June 2021. doi:10.1177/10775587211024786. Available here: https://twin-cities.umn.edu/news-events/us-hospitals-slow-respond-new-price-transparency-rule

[10] "Semi-Annual Hospital Price Transparency Compliance Report," Patient Rights Advocate. July 2021. Available here: https://context-cdn.washingtonpost.com/notes/prod/default/documents/ccb84a11-75f7-450c-a44f-b752e35940f2/note/83ba8b81-fa73-483b-8d4d-3f3563ee6388.#page=1

[11] Gondi S, Beckman AL, Ofoje AA, Hinkes P, McWilliams JM. "Early Hospital Compliance With Federal Requirements for Price Transparency," JAMA Intern Med. 2021;181(10):1396–1397. doi:10.1001/jamainternmed.2021.2531. Available here: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2781019

[12] For example, online price estimator tools are required to be "prominently displayed" on hospital websites, but what qualifies as "prominent" versus "not prominent" is not defined in regulation.

[13] CMS-9915-F, Transparency in Coverage, Final Rule (October 29, 2020). Available here: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf. On August 20, 2021, CMS postponed the effective date of the requirement by six months, from January 1, 2022, to July 1, 2022.

[14] All 190 hospitals were then assigned a random number and sorted by the assigned random number. The dataset was then filtered by ACA region, and the first grouping of hospitals was selected based on the designated sample size for that region. For example:

- For ACA region 1, the first three randomized hospitals in the sheet were selected for inclusion.
- For ACA region 2, the first three randomized hospitals in the sheet were selected for inclusion.
- For ACA region 3, the first four randomized hospitals in the sheet were selected for inclusion.

[15] Providing real-time cost-sharing obligations to consumers will also be required under a companion price transparency rule for insurers, though the effective date of the requirement was recently delayed from January 1, 2022, to July 1, 2022.

[16] Note that several of the segmentations examined have an n that is less than 5. Average implementation scores by segment are for observational purposes only and are not generalizable. Specific segments with an n less than 5 are indicated in Appendix VII.

[17] By hospital bed size, small hospitals had the highest average implementation score, at 2.57, followed by large hospitals (2.25). By gross revenue, this trend was flipped; hospitals with larger gross revenues had a higher average implementation score (2.33) compared to hospitals with medium/small gross revenues (both averaged 2.00).

[18] For purposes of this study, hospitals that provided a downloadable file were considered to have met the requirements for a "consumer-friendly display of shoppable services."

[19] Note that several of the segmentations examined have an n that is less than 5. Average implementation scores by segment are for observational purposes only and are not generalizable. Specific segments with an n less than 5 are indicated in Appendix VII.

[20] "Hospital Price Transparency Frequently Asked Questions (FAQs)," Centers for Medicare & Medicaid Services, current as of January 15, 2021. Available here: https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf

[21] "Hospital Price Transparency Requirements, Quick Reference Checklists," Centers for Medicare & Medicaid Services. Available here: https://www.cms.gov/files/document/hospital-price-transparency-final-rule-quick-reference-checklists.pdf

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