Billing Code 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 424, and 495

[CMS-1694-F]

RIN 0938-AT27

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2019. Some of these changes implement certain statutory provisions contained in the 21st Century Cures Act and the Bipartisan Budget Act of 2018, and other legislation. We also are making changes relating to Medicare graduate medical education (GME) affiliation agreements for new urban teaching hospitals. In addition, we are providing the

market basket update that will apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis, subject to these limits for FY 2019. We are updating the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2019.

In addition, we are establishing new requirements or revising existing requirements for quality reporting by specific Medicare providers (acute care hospitals, PPS-exempt cancer hospitals, and LTCHs). We also are establishing new requirements or revising existing requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (now referred to as the Promoting Interoperability Programs). In addition, we are finalizing modifications to the requirements that apply to States operating Medicaid Promoting Interoperability Programs. We are updating policies for the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program.

We also are making changes relating to the required supporting documentation for an acceptable Medicare cost report submission and the supporting information for physician certification and recertification of claims.

DATES: This final rule is effective on October 1, 2018.

FOR FURTHER INFORMATION CONTACT:

Home Office Cost Statement) must correspond to the costs reported in the provider's cost report.

X. Requirements for Hospitals to Make Public a List of Their Standard Charges via the Internet

In the FY 2015 IPPS/LTCH proposed rule and final rule (79 FR 28169 and 79 FR 50146, respectively), we discussed the implementation of section 2718(e) of the Public Health Service Act, which aims to improve the transparency of hospital charges. We noted that section 2718(e) of the Public Health Service Act, which was enacted as part of the Affordable Care Act, requires that each hospital operating within the United States, for each year, establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act. We reminded hospitals of their obligation to comply with the provisions of section 2718(e) of the Public Health Service Act and provided guidelines for its implementation. We stated that hospitals are required to either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice) or their policies for allowing the public to view a list of those charges in response to an inquiry.

We encouraged hospitals to undertake efforts to engage in consumer friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals. We also stated that we expect that

hospitals will update the information at least annually, or more often as appropriate, to reflect current charges. We further noted that we are confident that hospital compliance with this statutory transparency requirement will greatly improve the public accessibility of charge information. Finally, we stated that we would continue to review and post relevant charge data in a consumer-friendly way, as we previously have done by posting hospital and physician charge information on the CMS website.

In the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20548 and 20549), we indicated that we are concerned that challenges continue to exist for patients due to insufficient price transparency. Such challenges include patients being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients being surprised by facility fees and physician fees for emergency department visits. We also are concerned that chargemaster data are not helpful to patients for determining what they are likely to pay for a particular service or hospital stay. In order to promote greater price transparency for patients, we stated that we are considering ways to improve the accessibility and usability of the charge information that hospitals are required to disclose under section 2718(e) of the Public Health Service Act.

Therefore, as one step to further improve the public accessibility of charge information, effective January 1, 2019, we announced the update to our guidelines to require hospitals to make available a list of their current standard charges via the Internet in a machine readable format and to update this information at least annually, or more

often as appropriate. 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.

We note that it was sometimes difficult to determine when certain commenters who submitted comments on the FY 2019 IPPS/LTCH PPS proposed rule were responding to the broader price transparency request for information (RFI) and when they were responding specifically to the updated guidelines. To the extent we believed that a comment addressed the updated guidelines, we summarized it below. Comments on the broader price transparency initiative and suggestions for additional future actions that we may take with the guidelines, including enforcement actions, will be addressed in future rulemaking.

Comment: Many commenters addressed the announcement of the CMS update to guidelines on price transparency. Some of these commenters supported the update and indicated that many hospitals already make their standard charges available voluntarily or under applicable State law.

Response: We appreciate the support from some commenters regarding our updated guidelines and agree that many hospitals already make their standard charges publicly available either voluntarily or under applicable State law. For example, the 2014 American Hospital Association State Transparency Survey data indicated that 35 States required hospitals to release information on some charges and 7 States relied on voluntary disclosure of charge data (http://www.ahacommunityconnections.org/content/14transparency-trendwatch.pdf). We also appreciate the public support for hospitals to undertake efforts to engage in

consumer friendly communication to help patients understand what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare costs for similar services across hospitals. Improving the public accessibility to charge information is one aspect of our broader price transparency initiative.

Comment: Some commenters stated that the information contained in the chargemaster would not be useful to patients and would only increase confusion, as it would not inform them of their out-of-pocket costs for a particular service. The commenters stated that the chargemaster typically contains terms that are difficult for patients to understand, does not depict negotiated discounts with insurers, and lacks contextual information that patients would need. To the extent that such information would be published in a payer-specific manner, the commenters stated that such information is proprietary and confidential, and that publishing this information could undermine competition. Some commenters stated that certain hospitals are already providing patients with cost estimates that are specific to the payer and the patient's circumstances, and suggested that hospitals be required to provide this type of information instead. Other commenters noted programs by specific hospitals, including web-based tools, which enable patients to estimate their out-of-pocket costs. Other commenters suggested that CMS focus on "shoppable" health care services that can typically be scheduled in advance. Some commenters suggested that CMS conduct further research and work with stakeholders to determine the best approach to making information available to consumers.

Response: We disagree with commenters that the information contained in the chargemaster would not be useful to patients. As pointed out by commenters, many hospitals have price transparency initiatives beyond the provision of the chargemaster and we encourage hospitals to provide context surrounding the chargemaster information. We note that we are not requiring at this time that any information be published in a payer-specific manner, and we disagree that transparent charge information undermines competition. We agree that hospitals should and can provide information on "shoppable" health care services that can typically be scheduled in advance. However, nothing in our guidelines precludes a hospital from providing this information to patients and the public. We also agree with commenters that CMS should continue to work with stakeholders to determine the best approach to making price transparency information available to consumers and we intend to do so. One step in that process is the broad request for information from the public that CMS is currently making.

We acknowledge that providing patients with more specific information on their potential financial liability is needed and commend the hospitals that already do so. However, we believe that this more specific need does not justify a delay in the provision of chargemaster information to the public. We note that making charge information more easily accessible to patients and the public does not preclude hospitals from taking additional steps or continuing to provide the information they currently provide.

Comment: Many commenters explained that, for insured patients, payers are a better source of information about the cost of care and should be the primary source of information for out-of-pocket costs for patients. Some commenters stated that payers can

provide the information that patients require without compromising competition among providers. Other commenters suggested that payers and providers work together to make this information more accessible to patients. Some commenters noted that payers can provide information as to whether patients have met the plan deductible or out-of-pocket spending limits and what their cost-sharing will be. One commenter suggested requiring insurance companies to provide cost calculators or other tools that patients can use to calculate costs specific to their situation. For uninsured patients, commenters noted that many patients receive free or discounted care through the hospital's charity care policies.

Response: With respect to the commenters who indicated that, for insured patients, payers are a better source of information about the cost of care and should be the primary source of information for out-of-pocket costs for patients, we note that nothing in our guidelines precludes hospitals and payers from working together to provide information on out-of-pocket costs for patients and to improve price transparency for patients. We also recognize that sometimes uninsured patients receive free or discounted care through a hospital's charity care policies and again commend hospitals for those policies. Nothing in our guidelines precludes a hospital from providing charity care to uninsured patients.

Comment: Several commenters expressed concern about the updated guidelines conflicting with State requirements and increasing administrative burden if hospitals are required to report charge information in multiple incongruent ways. Commenters stated that CMS should not require hospitals to duplicate or replace existing publically available resources and that the updated requirement would significantly increase provider burden

to provide information that is not useful to patients. Other commenters noted that some State efforts are already providing patients with much more information than they could obtain from a chargemaster, and suggested that CMS instead encourage State level price transparency efforts.

Response: We encourage State efforts in the area of price transparency. As noted earlier, we commend the many hospitals that already make their standard charges publicly available either voluntarily or under applicable State law. This demonstrates that the disclosure of standard charges under our updated guidelines can exist in a complementary manner with State regulatory initiatives.

Comment: Some commenters stated that the definition of standard charges is unclear, as hospitals often have many negotiated rates for the same service. The commenters identified several terms, "charges", "payments", "cost", and "prices", that, according to the commenters, can have different meanings but are often used interchangeably. The commenters believed that, absent a standard definition of these terms, patients could not make accurate comparisons between hospitals.

Response: As noted earlier, we are not at this time requiring payer-specific information under our guidelines, and our updated guidelines are unchanged in this area compared to the prior guidelines. The new guidelines, when compared to the prior guidelines, merely require that this information be made available via the Internet in a machine readable format and that hospitals update this information at least annually, or more often as appropriate.

Comment: A few commenters expressed concern that patients may forgo needed care if they were informed of the charges in advance. Other commenters noted that price information in the absence of quality information can be misleading to patients in a variety of ways.

Response: We disagree that patients may forgo needed care if they were informed of the charges in advance if that information is placed in the proper context by hospitals. We agree with the commenters that price information and quality information are both important to provide to patients. We note that nothing precludes hospitals or other entities from incorporating quality information such as the publicly available CMS Hospital Compare quality information found on the website at: https://www.medicare.gov/hospitalcompare/search.html.

After consideration of the public comments we received, we currently do not believe there is a need to further update our guidelines beyond the updated guidelines that we previously announced would be effective January 1, 2019, which are that hospitals' list of standard charges be made available to the public via the Internet in a machine readable format and that hospitals update this information at least annually, or more often as appropriate.

XI. Revisions Regarding Physician Certification and Recertification of Claims

Our Medicare regulations at 42 CFR 424.11, which implement sections 1814(a)(2) and 1835(a)(2) of the Act, specify the requirements for physician statements that certify and periodically recertify as to the medical necessity of certain types of covered services provided to Medicare beneficiaries. The regulation provision under