HOSPITAL PRICE TRANSPARENCY

REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY

2022

OFFICE OF THE SECRETARY OF
HEALTH AND HUMAN RESOURCES

PREFACE

The Office of the Secretary of Health and Human Resources (OSHHR) is submitting this report in response to the legislative mandate in Chapter 297 of the 2022 Acts of Assembly, which directed OSHHR to "develop recommendations for implementation of this act, including any regulatory changes that may be necessary for implementation of this act." The legislative mandate requires OSHHR to submit the report of findings and recommendations "to the Governor and the Chairmen of the Senate Committees on Education and Health and Finance and Appropriations and the House Committees on Appropriations and Health, Welfare and Institutions by November 1, 2022."

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EXECUTIVE SUMMARY

The General Assembly directed the Secretary of Health and Human Resources (SHHR) to "develop recommendations for implementation of [Chapter 297 of the 2020 Acts of Assembly], including any regulatory changes that may be necessary for implementation of this act, and shall report his recommendations to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022." The Office of the Secretary of Health and Human Resources (OSHHR) convened two meetings in September of 2022, during which several informational presentations were given and robust debate ensued amongst the assembled stakeholders. OSHHR developed the following recommendations.

RECOMMENDATIONS

Legislative. Implementation of any of the recommendations below would require the General Assembly to either amend the Code of Virginia or to amend Chapter 2 of the 2022 Acts of Assembly, Special Session I (Appropriations Act). The legislative recommendation receiving unanimous support of study contributors is Recommendation 3.

1. The Virginia Department of Health (VDH) should have sufficient resources to monitor compliance.

2. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and the hospital fails to submit or comply with an acceptable plan of correction (PoC),[1] the State Health Commissioner should have the authority to impose civil monetary penalties (CMPs) on a hospital in amounts commensurate with the CMPs for failure to comply with the federal hospital price transparency requirements.

3. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and the hospital fails to submit or comply with an acceptable PoC, the State Health Commissioner should have the authority to impose a directed PoC.[2]

4. In addition to administrative enforcement by VDH, subsection A of Va. Code § 59.1-200 and subsection A of Va. Code 32.1-137.05 should be amended to state that a violation of the Virginia hospital price transparency is a prohibited act under the Virginia Consumer Protection Act of 1977 (§ 59.1-196 *et seq.* of the Code of Virginia).

[1] A PoC is developed by the noncompliant health care provider to detail its planned methods to correct violations and date on which such corrections are expected to be completed, all of which is subject to approval by the regulatory body before it can be implemented.

[2] A directed PoC is developed by the regulatory body instead of the noncompliant health care provider, and details the methods by which the noncompliant health care provider must correct violations and date on which such corrections must be completed.

Regulatory. Implementation of any of the recommendations below would require the State Board of Health (Board) to initiate one or more regulatory actions under the Virginia Administrative Process Act. The regulatory recommendations receiving unanimous support of study contributors are Recommendations 1, 3, and 7. Recommendation 6 received unanimous support for the provision of notice to a hospital of alleged noncompliance, but did not receive unanimous support for publication of notice. Unanimous support of study contributors on Recommendation 2 is contingent on the U.S. Centers for Medicare and Medicaid Services (CMS) concurring in the determination outpatients hospitals in Virginia to meet the definition of "hospital" in 45 CFR § 180.20.

1. The Board should adopt the federal minimums for machine-readable files found in 45 CFR § 180.50 in its hospital regulations.

2. Outpatient hospitals should be subject to Virginia's hospital price transparency requirements.

3. Hospitals should be required to display the gross charge, negotiated charge, and discounted cash price in the machine-readable file as U.S. dollars when the charge or cash price has been calculated as a percentage of Medicare or Medicaid rates.

4. "Items and services" should include medication that the hospital customarily provides as part of, or in conjunction with, a service.

5. Hospitals should be required to provide the link to the webpage where their machine-readable files are located to Virginia Health Information (VHI).[3]

6. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement, VDH should provide notice to the hospital of the alleged noncompliance and publish determinations of noncompliance on its website.

7. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and after providing notice, VDH should require the hospital to submit an acceptable PoC.

Operational. Implementation of any of the recommendations below would require neither a legislative act nor regulatory action, but require changes to the operations of VDH. The operational recommendation receiving unanimous support of study contributors is Recommendation 1. Recommendation 2 received unanimous support for which agencies would be responsible for compliance monitoring, but did not receive unanimous support for publication of determinations of noncompliance. Unanimous support of study contributors on Recommendations 3 and 7 are contingent on CMS concurring in the determination outpatients hospitals in Virginia to meet the definition of "hospital" in 45 CFR § 180.20.

1. Links to each hospital's webpage for the machine-readable file should be provided by VHI on each hospital's already-existing VHI webpage.

2. CMS and VDH should be responsible for compliance monitoring, and VDH should make public determinations of noncompliance.

[3] VHI is a nonprofit data services organization that VDH has contracted with pursuant to Va. Code §§ 32.1-23.4 and 32.1-276.2 *et seq*. to collect data for, amongst a number of programs, the prescription drug price transparency program, All-Payer Claims Database, the Patient Level Data System, and service utilization and charity care for the certificate of public need program.

3. VDH and VHI should compile a list of all currently licensed outpatient hospitals and conduct outreach to each facility in advance of July 1, 2023, but no later than March 30, 2023, to inform the outpatient hospitals of the applicability of Chapter 297 of the 2022 Acts of Assembly to their facility.

4. VHI should publish instructions on its website on how a consumer/patient can view the contents of machine-readable file, including recommended free software to open the file.

5. VDH should be directed to create an off-site inspection process to monitor compliance with Virginia's hospital price transparency requirement.

6. VDH should report to CMS any hospital that has been subject to enforcement action for failing to meet a Virginia hospital price transparency requirement that is identical or substantially equivalent to a federal hospital price transparency requirement.

7. VDH should not assess compliance of outpatient hospitals with the Virginia hospital price transparency until January 1, 2024.

INTRODUCTION

STUDY MANDATE

Chapter 297 of the 2022 Acts of Assembly created new requirements related to hospital price transparency that will be effective on July 1, 2023. In the third enactment clause of the act, the General Assembly directed the Secretary of Health and Human Resources (SHHR) to "develop recommendations for implementation of this act, including any regulatory changes that may be necessary for implementation…" (Appendix A).

STUDY ACTIVITIES

In response to the legislative mandate, the Office of Secretary of Health and Human Resources (OSHHR) met with the patron of Chapter 297 of the 2022 Acts of Assembly, interested and affected stakeholders, and staff from the Virginia Department of Health (VDH), representing a broad range of perspectives and expertise. OSHHR held two meetings during 2022: September 7 and September 30.

SEPTEMBER 7 MEETING

OSHHR, along with the assembled stakeholders and VDH staff, reviewed the legislative mandate and discussed the scope of the work. VDH gave a presentation about the federal hospital price transparency requirements and the forthcoming Virginia hospital price transparency requirements, as well as early observations VDH had made regarding the availability and completeness of Virginia hospitals' pricing information. The meeting transitioned to a roundtable discussions about the stakeholders' experience regarding implementation of the federal hospital price transparency requirements, what potential recommendations might include, and perspective on each stakeholder on those potentialities.

SEPTEMBER 30 MEETING

OSHHR met with the assembled stakeholders and VDH staff to review potential recommendations that had been developed during the prior meeting. OSHHR started with reviewing the recommendations that appeared to have unanimous support. The discussion then moved to discussing recommendations suggested at the prior meeting or developed based on the prior meeting's discussion. Stakeholders were given the opportunity to opine on each potential recommendation if they wished.

WRITTEN COMMENT

Stakeholders were given the opportunity to provide written comment and potential recommendations to OSHHR's consideration after the September 7 meeting; these comments are reproduced in full in Appendix E. Stakeholders were given another opportunity to provide written comment after the September 30 meeting; these comments are likewise reproduced in full in Appendix F.

REPORT OUTLINE

Following the discussion of the study mandate, the report provides an overview of what is a hospital for the purposes of price transparency, the federal hospital price transparency requirements, and the forthcoming Virginia hospital price transparency requirements. The report discusses the differences in current enforcement options between the federal government and Virginia, as well as other implementation challenges identified. The report concludes with the recommendations, grouped according to the method by which they may be implemented.

PRICE TRANSPARENCY REQUIREMENTS FOR HOSPITALS

WHAT IS A HOSPITAL?

Discussions with stakeholders, VDH staff, and staff at the U.S. Centers for Medicare and Medicaid Services (CMS) uncovered the issue that what constitutes a "hospital" for the purposes of price transparency is not well understood by licensed Virginia hospitals. For the purposes of state licensure, Va. Code § 32.1-123 defines a hospital as "any facility licensed pursuant to [Article 1 (§ 32.1-123 *et seq.*) of Chapter 5 of Title 32.1 of the Code of Virginia] in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals..." Further, Va. Code § 32.1-127(B)(3) authorizes the State Board of Health (Board) to promulgate regulations that "classify hospitals…by type of specialty or service and may provide for licensing hospitals…by bed capacity and by type of specialty or service"; the Board has exercised this discretionary regulatory authority to create the three classifications of hospital. 12VAC5-410-10 states, in relevant part:[1]

> As used in [12VAC5-410-10 *et seq.*], the following words and terms shall have the following meanings unless the context clearly indicates otherwise:
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> "General hospital" means institutions as defined by § 32.1-123 of the Code of Virginia with an organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services, dentist services and continuous nursing services, to provide diagnosis and treatment for patients who have a variety of medical and dental conditions that may require various types of care, such as medical, surgical, and maternity.
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> "Outpatient hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that primarily provide facilities for the performance of surgical procedures on outpatients. Such patients may require treatment in a medical environment exceeding the normal capability found in a physician's office, but do not require inpatient hospitalization.
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> "Rural hospital" means any general hospital in a county classified by the federal Office of Management and Budget (OMB) as rural, any hospital designated as a critical access hospital, any general hospital that is eligible to receive funds under the federal Small Rural Hospital Improvement Grant Program, or any general hospital that notifies the commissioner of its desire to retain its rural status when that hospital is in a county reclassified by the OMB as a metropolitan statistical area as of June 6, 2003.

Separate from state licensure is federal certification for participation in Medicare and Medicaid under Titles XVIII and XIX of the Social Security Act, which are voluntary programs; certification means that a facility has met the applicable conditions of participation (CoPs) and conditions for coverage (CfCs), which are located in Title 42 of the Code of Federal Regulations and are promulgated by the CMS. For the purposes of the Social Security Act, a hospital has to provide services to inpatients[2] and 24-hour nursing service;[3] a critical access

[1] Certain eligible general hospitals may also be certified by the State Health Commissioner as critical access hospitals under Virginia's rural health care plan. *See* Va. Code §§ 32.1-122.07 and 32.1-125.3.
[2] 42 U.S.C. § 1395x(e)(1).
[3] 42 U.S.C. § 1395x(e)(5).

hospital (CAH) is required to be designated as a CAH by the jurisdiction in which it is located.[4] Every licensed general hospital in Virginia is federally certified as either a hospital or a CAH. However, licensed outpatient hospitals in Virginia are not eligible to be federally certified as hospitals or CAHS, but rather as ambulatory surgical centers (ASCs), which CMS defines as "any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission" and requires that the entity "have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of [42 C.F.R. Part 416]."[5] Nearly all licensed outpatient hospitals in Virginia are federally certified as ASCs.[6,7]

What complicates this is that the federal hospital price transparency law (discussed below in the "Federal Hospital Price Transparency" section)—despite being promulgated by CMS—does not use CMS's definition of "hospital" from Title 42 of the Code of Federal Regulations. Because the federal hospital price transparency rule was authorized under the Public Health Services Act and not the Social Security Act, CMS was not obliged to use the definition of hospital in the Social Security Act. Instead, for the purposes of price transparency under federal law, CMS defined "hospital" as:[8]

> … an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. For purposes of this definition, a State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Because most ASCs are licensed as outpatient hospitals in Virginia, the practical effect is that the federal hospital price transparency rules applies to them[9]--and as discussed in "Virginia Hospital Price Transparency" section, VDH is obligated to use this same definition for the new hospital price transparency requirements that will be effective on July 1, 2023.[10] Additionally, because this definition is tied to a jurisdiction's licensing of a facility, a facility's certification status under Medicare or Medicaid is irrelevant; this means that any licensed outpatient hospital in Virginia that has opted to not be certified as an ASC is still expected to comply.

FEDERAL HOSPITAL PRICE TRANSPARENCY

CORE REQUIREMENTS

The Patient Protection and Affordable Care Act[11] amended the Public Health Services Act to create 42 U.S.C. § 300gg-18(b) and (e), which state, in relevant part:

> (b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—
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> * * *

[4] 42 U.S.C. § 1395i-4(e).
[5] 42 C.F.R § 416.2.
[6] As of October 20, 2022, there are 67 licensed outpatient hospitals in the Commonwealth, of which one is not certified as an ASC.
[7] As of October 20, 2022, there is one ASC that is not licensed as a hospital because it does not meet the definition of an outpatient hospital.
[8] 42 C.F.R. § 180.20.
[9] CMS confirmed this to VDH staff in a videotelephonic meeting on September 28, 2022.
[10] *See* the first and second enactment clauses of Chapter 297 (2022 Acts of Assembly).
[11] As amended by the Health Care and Education Reconciliation Act of 2010.

> (3) ENFORCEMENT.—The Secretary [of Health and Human Services] shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.
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> (e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

In response to these new mandates, CMS created Part 180 in Title 45 of the Code of Federal Regulations (Appendix C). It requires hospitals to provide a machine-readable file containing a list of all standard charges for all items and services and consumer-friendly list of standard charges for a limited set of shoppable services;[12] hospitals are permitted to substitute the consumer-friendly list for an internet-based price estimator tool.[13,14] For each item and service in the machine-readable file, a hospital must provide:[15]

- A description;
- The gross charge in inpatient and outpatient settings, as may be applicable;
- Payer-specific negotiated charge in inpatient and outpatient settings, as may be applicable, with each payer-specific negotiated charge clearly associated with third party payer's name and plan;
- The de-identified minimum negotiated charge in inpatient and outpatient settings, as may be applicable;
- The de-identified maximum negotiated charge in inpatient and outpatient settings, as may be applicable;
- The discounted cash price in inpatient and outpatient settings, as may be applicable; and
- Any code used by the hospital for purposes of accounting or billing, including:
    - The Current Procedural Terminology (CPT) code;
    - The Healthcare Common Procedure Coding System (HCPCS) code;
    - The Diagnosis Related Group (DRG);
    - The National Drug Code (NDC); or
    - Other common payer identifier.

CMS further requires that the information be published in a single, [16] digitally-searchable[17] machine-readable file that is updated at least annually, with the date that the data was most recently updated clearly indicated either within the file itself or otherwise clearly associated with the file,[18] and prominently displayed[19] on a publicly available website.[20] CMS also prescribes the format of the machine-readable file's name as

[12] 45 C.F.R. § 180.40.

[13] 45 C.F.R. § 180.60(a)(2).

[14] The consumer-friendly list of standard charges and the alternative price estimator tool were not incorporated into Virginia law by Chapter 297 (2022 Acts of Assembly), so discussion of provisions related to these requirement are outside the scope of this report.

[15] 45 C.F.R. § 180.50(b).

[16] 45 C.F.R. § 180.50(c).

[17] 45 C.F.R. § 180.50(d)(4).

[18] 45 C.F.R. § 180.50(e).

[19] 45 C.F.R. § 180.50(d)(2).

[20] 45 C.F.R. § 180.50(d)(1).

<ein>_<hospitalname>_standardcharges.[json|xml|csv][21,22] CMS included in its regulations minimum accessibility standards for the machine-readable file to include:[23]

- The absence of barriers;
- Free of charge;
- Without having to establish a user account or password;
- Without having to submit personal identifying information; and
- Accessibility by automated searches and direct file downloads through a link posted on the website.

ENFORCEMENT

While VDH is the state survey agency for Virginia,[24] the activities it conducts on behalf of CMS are limited to federal certification activities under the Social Security Act and as described above in the "Core Requirements" section, the federal hospital price transparency requirements were promulgated under the Public Health Services Act. Therefore, CMS retains all authority for the federal hospital price transparency rules and VDH has no federal role in either monitoring compliance or enforcement-related activities. CMS announced that its enforcement would begin January 1, 2021.[25] CMS has outlined the general order of enforcement proceedings as follows:[26]

- Provide a written warning notice to the hospital of the specific violations;
- Request a corrective action plan (CAP) if noncompliance constitutes a material violation of one or more requirements; and
- Impose a civil monetary penalty (CMP).

The CMPs specified in 45 CFR § 180.90 will typically be imposed only after CMS has identified a hospital as noncompliant and that hospital has either failed to submit a corrective action plan or failed to comply with its corrective action plan.[27,28] CMS created a CMP schedule that is based on a maximum daily dollar amount scaled according to a hospital's bed count, as specified in 45 CFR § 180.90:

> (c) Amount of the civil monetary penalty.
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> (2) CMS determines the daily dollar amount for a civil monetary penalty for which a hospital may be subject as follows:
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> * * *
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> 1. Beginning January 1, 2022, for each day a hospital is determined by CMS to be out of compliance:

[21] 45 C.F.R. § 180.50(d)(5).
[22] The information to be provided at "<ein>" is the hospital's employer identification number that is issued by the Internal Revenue Service.
[23] 45 C.F.R. § 180.50(d)(3).
[24] CMS is authorized by the Social Security Act to "make an agreement with any State which is able and willing to do so under which the services of the State health agency…will be utilized by him for the purpose of determining whether an institution therein…or whether an agency therein…" complies with the CoPs and CfCs. VDH is the only Virginia state agency authorized to enter into such a contract with CMS, pursuant to Va. Code § 32.1-137.
[25] U.S. Centers for Medicare and Medicaid Services, *Hospital Price Transparency Frequently Asked Questions (FAQs)*, May 6, 2022, at 2, https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf.
[26] *Id.*, at 21.
[27] *Id.*
[28] 45 C.F.R. § 180.90(a).

> (A) For a hospital with a number of beds equal to or less than 30, the maximum daily dollar civil monetary penalty amount to which it may be subject is $300, even if the hospital is in violation of multiple discrete requirements of this part.
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> (B) For a hospital with at least 31 and up to and including 550 beds, the maximum daily dollar civil monetary penalty amount to which it may be subject is the number of beds times $10, even if the hospital is in violation of multiple discrete requirements of this part.
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> (C) For a hospital with a number of beds greater than 550, the maximum daily dollar civil monetary penalty amount to which it may be subject is $5,500, even if the hospital is in violation of multiple discrete requirements of this part.
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> (3) The amount of the civil monetary penalty will be adjusted annually using the multiplier determined by OMB for annually adjusting civil monetary penalty amounts under part 102 of this title.

In June 2022, CMS announced imposition of CMPs on two Georgia hospitals, Northside Hospital Atlanta (NHA) in the amount of $883,180[29] and Northside Hospital Cherokee (NHC) in the amount of $214,320.[30] CMS had determined that NHA and NHC were noncompliant because they had both failed to:[31,32]

- Make public the standard charges applicable to each location of the hospital operating under a single license when those locations have different charges;
- Make public a machine-readable file containing a list of all standard charges for all items and services, specifically supplies, room and board, use of the facility and other items generally described as facility fees;
- Publish the required information for all items and services in a single digital file that is in a machine-readable format;
- Follow the naming convention specified by CMS for the machine-readable file; and
- Display the consumer-friendly shoppable services in a prominent manner that identifies the hospital location with which the information is associated.

NHA and NHC both further compound this situation by failing to submit a CAP when requested by CMS—NHC ignored one request[33] and NHA ignored two requests.[34] When CMS attempted to provide technical assistance to the hospitals, the hospitals "confirmed that the previous violations had not been

[29] This reflects a CMP of $36,300 for noncompliance in 2021 ($300 per day of noncompliance from September 2, 2021 through December 31, 2021 pursuant to 45 C.F.R. § 180.90(c)(1)) combined with CMP of $846,880 ($10 per each of its 536 beds per day of noncompliance from January 1, 2022 up to and including June 7, 2022).

[30] This reflects a CMP of $34,200 for noncompliance in 2021 ($300 per day of noncompliance from September 9, 2021 through December 31, 2021 pursuant to 45 C.F.R. § 180.90(c)(1)) combined with CMP of $180,120 ($10 per each of its 114 beds per day of noncompliance from January 1, 2022 up to and including June 7, 2022).

[31] Letter from John Pilotte, Director, Performance-Based Payment Policy Group, U.S. Centers for Medicare and Medicaid Services, to Robert Quattrocchi, President/Chief Executive Officer, Northside Hospital Atlanta (Jun. 7, 2022), https://www.cms.gov/files/document/notice-imposition-cmp-northside-hospital-atlanta-6-7-22finalredacted.pdf.

[32] Letter from John Pilotte, Director, Performance-Based Payment Policy Group, U.S. Centers for Medicare and Medicaid Services, to William Hayes, Chief Executive Officer, Northside Hospital Cherokee (Jun. 7, 2022), https://www.cms.gov/files/document/notice-imposition-cmp-northside-hospital-cherokee-6-7-22finalredacted.pdf.

[33] *Id.* at 3.

[34] Letter from Pilotte to Quattrocchi at 3.

corrected and, in fact, the hospital system had intentionally removed all previously posted pricing files."[35,36] Both hospitals then failed to submit a CAP when requested by CMS for a final time.[37]

Because CMS only publishes information about noncompliant hospitals who are assessed CMPs, information is not available about the total number of hospitals whose compliance has been reviewed by CMS and how many of those hospitals were determined to be noncompliant.[38]

VIRGINIA HOSPITAL PRICE TRANSPARENCY

CORE REQUIREMENTS

The first enactment clause of Chapter 297 of the 2022 Acts of Assembly amended Va. Code § 32.1-137.05 to add a new subsection A that states:

> Every hospital shall make available to the public on its website a machine-readable file containing a list of all standard charges for all items and services provided by the hospital in accordance with 45 C.F.R. § 180.50, as amended. As used in this subsection, "hospital," "items and services," "machine-readable," and "standard charge" have the same meaning as set forth in 45 C.F.R. § 180.20.

Because the legislation pulls in the federal requirements at 45 C.F.R. §§ 180.20 and 180.50, the requirements for the machine-readable file described above will be a part of Virginia law.

ENFORCEMENT

In its second enactment clause, Chapter 297 of the 2022 Acts of Assembly delays the effective date of the amendments to Va. Code § 32.1-137.05 to July 1, 2023. Consequently, VDH cannot monitor compliance or engage in any enforcement activity with respect to the state hospital price transparency requirements until on or after that date. As the majority of current hospital licensing requirements concern quality of care, compliance is monitored through on-site inspections[39] to investigate complaints from the public and routine inspections that occur "periodically, but not less often than biennially."[40] Because inspections have historically been conducted on-site, VDH does not have an off-site inspection procedure. Monitoring compliance for price transparency would very likely not require any on-site inspection, as the required file must be available on the internet and its conformity to the requirements could be verified off-site; similarly, any resulting enforcement activities for noncompliant hospitals would be largely, if not entirely, off-site.

However, VDH faces a major hurdle with inspections that do not involve complaints, regardless of whether they occur on-site or off-site. Va. Code § 32.1-126(B) prohibits VDH from inspecting a hospital:

> …until all other hospitals…have also been inspected, unless the additional inspections are (i) necessary to follow up on a preoperational inspection or one or more violations; (ii) required by a uniformly applied risk-based schedule established by [VDH]; (iii) necessary to investigate a complaint regarding the hospital…; or (iv) otherwise deemed necessary by the [State Health] Commissioner or his designee to protect the health and safety of the public.

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[35] *Id.*; Letter from Pilotte to Hayes at 3.
[36] *Id.*
[37] *Id.*
[38] VDH has filed a request for records for this information with CMS under the federal Freedom of Information Act (FOIA), but has not yet received a response.
[39] Va. Code § 32.1-123 defines inspection to mean "all surveys, inspections, investigations and other procedures necessary for [VDH] to perform in order to carry out various obligations imposed on the Board or Commissioner by applicable state and federal laws and regulations."
[40] Va. Code § 32.1-126(B).

Routine off-site inspections of the machine-readable file would not meet the conditions described in clauses (i) and (iii) above. It is also unclear if these inspections would meet the standard of being "necessary…to protect the health and safety of the public"[41] as described in clause (iv) above; such a determination would very likely require VDH to seek legal advice from the Office of the Attorney General (OAG).[42] That leaves VDH with clause (ii)'s risk-based schedule, which VDH currently has not established. While one could be developed, it is unclear if such a schedule could be used to create an inspection that only reviews a subset of hospital licensing requirements, so it too would require VDH to consult the OAG. CMS did share that the bulk of its compliance reviews for the federal hospital price transparency requirements originated from consumer complaints; if VDH likewise experiences complaint volumes, then development of a risk-based schedule would be a lower priority since VDH can utilize clause (iii) above to initiate an inspection. VDH would still need to develop an off-site inspection procedure for the new state hospital price transparency requirements, regardless of which clause in Va. Code § 32.1-126(B) is utilized.

Like CMS, VDH does provide notice to hospitals when VDH determines that they are noncompliant with hospital licensing requirements. At present, VDH may utilize the following options if a hospital is determined to be noncompliant with any hospital licensing requirement, including the forthcoming state hospital price transparency requirements:

- Request a plan of correction (PoC);[43],[44]
- Suspend the hospital's license;[45] or
- Revoke the hospital's license.[46]

VDH can find no record of any hospital having its license suspended or revoked and has exclusively utilized PoCs when a hospital has been noncompliant with state licensing statutes or regulations. Unlike other agencies within the Health and Human Resources Secretariat, VDH has no other enforcement options that it can exercise on its own authority for violations of either state hospital price transparency requirements or quality of care standards. Its only remaining option is to seek a judicially-imposed remedy—and even then, civil remedies are limited to injunctions or writs of mandamus.[47,48]

Compare this with regulatory boards within the Virginia Department of Health Professions (DHP), which have the authority to impose a CMP of up to $5,000 per violation,[49] place a licensee "on probation with such terms as it may deem appropriate,"[50] or issue a restricted license subject to terms and conditions[51] in addition to the ability to suspend or revoke a license. Similarly, the Department of Social Services (DSS) can place licensees on probation,[52] mandate training for the licensee or its employees,[53] and impose CMPs "for each day [the licensee] is or was out of compliance…not exceed $10,000…in any 12-month period"[54]—again, in addition to the ability to suspend or revoke a license. For some provider types in the Medicare and Medicaid programs,

[41] *Id.*
[42] Pursuant to Va. Code § 32.1-28, the OAG is counsel to both the Board and the State Health Commissioner.
[43] 12VAC5-410-150.
[44] A PoC is analogous to a CAP and does not materially differ from a CAP.
[45] Va. Code § 32.1-135(A).
[46] *Id.*
[47] Va. Code § 32.1-27(B).
[48] If a hospital continues to be noncompliant by refusing to obey an injunction or writ of mandamus, VDH may request that the court impose a CMP to be determined by the court, which cannot "exceed $25,000 for each violation," though the court is not obligated to grant VDH's request. Va. Code § 32.1-27(C).
[49] Va. Code § 54.1-2401.
[50] Va. Code § 54.1-2400(10).
[51] *Id.*
[52] Va. Code § 63.2-1709.2(B)(1).
[53] Va. Code § 63.2-1709.2(B)(3).
[54] Va. Code § 63.2-1709.2(B)(4).

CMS also has expanded enforcement options like directed PoCs.[55] Normally, a PoC is developed by the noncompliant provider to detail its planned methods to correct violations and date on which such corrections are expected to be completed, all of which is subject to approval by CMS[56] before it can be implemented. A directed PoC has those same elements, but the plan is instead developed by either CMS or the state survey agency. Directed PoCs straddle the line between VDH's existing PoC enforcement option and the options that agencies like DHP and DSS have to impose terms and conditions on its licensees or mandate that its licensees take certain actions.

Additional enforcement options for VDH would require the Code of Virginia to be amended, and the General Assembly can choose to make these options exclusive to state hospital price transparency or broaden their applicability to all hospital licensing requirements such as quality of care like it has done for DSS, DHP, and many other agencies.[57] The General Assembly has created requirement-specific enforcement options in the past. For example, Chapters 1080 and 1081 of the 2020 Acts of Assembly authorizes the State Health Commissioner to impose a CMP "in an amount not to exceed $1,000 per violation" if the State Health Commissioner substantiates a report from State Corporation Commission that a medical care facility has engaged in a pattern of balance billing violations. Similarly, Chapter 304 of the 2021 Acts of Assembly, Special Session I authorizes the State Health Commissioner to impose a CMP "not to exceed $2,500 per day" on any health carrier, pharmacy benefits manager, wholesale distributor, or manufacturer that fails to comply with the prescription drug price transparency requirements.

At present, VDH has a resource need equal to one full-time equivalent (FTE) for the purpose to monitoring compliance with state hospital price transparency requirements, reviewing PoCs, and monitoring PoC implementation; this resource need is not expected to increase if the General Assembly were to grant the State Health Commissioner the authority to impose directed PoCs only for noncompliance with state hospital price transparency requirements. However, if the General Assembly were to allow directed PoCs be imposed for all hospital licensing noncompliance or to grant the State Health Commissioner the authority to assess CMPs—either just for noncompliance with state hospital price transparency requirements or for all hospital licensing noncompliance—then the total resource need would increase to three FTEs, in anticipation that hospitals would be more likely to contest either findings of noncompliance or imposition of administrative sanctions through the Virginia Administrative Process Act.[58] Two FTEs would be needed to coordinate adjudication, provide respondents with the due process prescribed, and monitor compliance with administrative sanctions.

It is important to note that VDH is entirely reliant on general fund appropriations to keep the hospital licensure program afloat because hospital licensure fees have not changed in 43 years.[59] Unlike other licensing programs, the Board[60] does not have the authority to set licensing fees for hospitals and currently must use statutorily prescribed fee amounts, which places the licensing program and its oversight functions under financial strain. The current fee schedule for annual license renewal is based on patient bed capacity, but is not to exceed $500. In 1979, this fee schedule nearly supported the entire cost of the licensure and inspection program. However, due to the rate ($1.50 per bed) and the cap placed within the statute ($500),[61] the revenues collected from hospitals during licensure and renewal are no longer adequate to cover the expenditures of the licensing program. Va. Code § 32.1-130 has never been amended to either give the Board the authority to set the fees or simply to increase the fee amounts, in recognition of the additional costs incurred by the licensure and inspection program as a result of legislative mandates and Virginia-specific requirements for hospitals that

[55] Directed PoCs are an enforcement option that CMS may utilize for noncompliant skilled nursing facilities and nursing facilities.
[56] This approval authority is delegated to state survey agencies like VDH.
[57] *See* Va. Code §§ 37.2-419, 54.1-201, 54.1-202, and 54.1-4413.4.
[58] Va. Code § 2.2-4000 *et seq*.
[59] Chapter 711 of the 1979 Acts of the Assembly.
[60] Pursuant to Va. Code § 32.1-12, the Board, not VDH, has the authority to promulgate regulations, which would include regulations establishing and assessing fees for licensure if such regulatory authority were granted.
[61] The fee schedule prescribed by Va. Code § 32.1-130 applies to nursing homes as well as hospitals.

were enacted after 1979. Therefore, the funding for any resources to support enforcement of state hospital price transparency requirements would require the General Assembly to make additional general fund appropriations, to allow the Board to set hospital licensure fees and then authorize nongeneral fund appropriations from those collected fees,[62] or some combination of the two.

OBSERVATIONS ABOUT MACHINE-READABLE FILES IN VIRGINIA

As part of this study, OSHHR requested VDH staff select an anonymized sample of Virginia hospitals' websites, locate their machine-readable files, and provide observations from the perspective of an average consumer. VDH reported that some hospital websites were less navigable than others in that some had complex menus that made it difficult to know what the right webpage was and that some placed the link in the webpage's footer instead of any menu; some websites also put the machine-readable files on webpages that were not where staff anticipated based on the webpages' title. VDH staff also observed that some machine-readable files appeared to be missing update dates entirely or appeared to have not been updated annually. Filenames did not appear to match CMS's requirements. The content and layout of the machine-readable files also varied between hospitals, with VDH staff observing that medication did not appear to be consistently included, that some hospitals displayed prices as a percentage of Medicare or Medicaid rates, and that it was difficult to compare prices across hospitals because of different codes and descriptions being used. VDH staff also noted that some file types, like JSON, are much harder to use than others, though CMS does allow for those file types. VDH staff encountered the most difficulty in finding machine-readable files from licensed outpatient hospitals; as noted above in the "What is a Hospital?" section, this may be due to outpatient hospitals being unaware or confused about the applicability of the federal hospital price transparency rule.

For consumers interested in finding hospital-related data, hospitals in Virginia already provide myriad data to VDH through mandatory data submissions to Virginia Health Information (VHI).[63] For each hospital, VHI creates a webpage on its website that summarizes:

- General information;
- Efficiency indicators;
- Financial information; and
- Outpatient tests and surgery reports.

VHI also provides information about patient satisfaction and service lines for general hospitals. The general information includes both a basic set of information and additional information that the hospital has provided. Some hospitals have voluntarily provided to VHI links to their facility's financial assistance webpage[64] and at least one hospital[65] has provided a link to its price transparency webpage. However, due to the voluntary nature of the information provided, the information is inconsistent between hospitals and some hospitals provide no additional information at all.

OBSERVATIONS ABOUT NON-ADMINISTRATIVE ENFORCEMENT

While the federal hospital price transparency rule is enforced via CMS and the forthcoming state hospital price transparency will be enforced by VDH as a consequence of the requirements being placed in the hospital licensing provisions of Article 1 (§ 32.1-123 *et seq.*) of Chapter 5 of Title 32.1 of the Code of Virginia,

[62] Because the bulk of fee collection happens in the middle of the state fiscal year when hospitals renew their licenses in November and December, VDH would at a minimum need general fund appropriations for state fiscal year 2024 as there would be insufficient nongeneral funds at the start of state fiscal year 2024 to support one or more FTEs.

[63] VHI is a nonprofit data services organization that VDH has contracted with pursuant to Va. Code §§ 32.1-23.4 and 32.1-276.2 *et seq*. to collect data for, amongst a number of programs, the prescription drug price transparency program, All-Payer Claims Database, the Patient Level Data System, and service utilization and charity care for the certificate of public need program.

[64] *See*, e.g., Buchanan General Hospital, https://www.vhi.org/Buchanan%20General%20Hospital.html?tab=&?=h7487/

[65] *See*, e.g., VCU Medical Center, https://www.vhi.org/VCU%20Medical%20Center.html?tab=&?=h1009/

policymakers may create other enforcement mechanisms to be utilized by individuals or by other state agencies, which can be separate from or in lieu of enforcement by an administrative agency like VDH. The Virginia Consumer Protection Act of 1977 (§ 59.1-196 *et seq.*) of the Code of Virginia is intended "to promote fair and ethical standards of dealings between suppliers and the consuming public"[66] by providing remedies through individual action for damages[67] and action to enjoin by the Attorney General, the attorney for the Commonwealth, or the attorney for a county, city, or town.[68] The Virginia Consumer Protection Act of 1977 lists over 70 different prohibited practices, one of which includes violating minimum requirements for nursing home and certified nursing facility advertisements[69] found in Article 1 of Chapter 5 of Title 32.1 of the Code of Virginia—the same article in which the Virginia hospital price transparency requirement is also found.

Another example of multiple enforcement mechanisms can be found in Va. Code § 6.2-2023, which authorizes a person to file civil suit against an agency providing debt management plans if that agency has violated certain state laws[70] and the person has suffered a loss because of that violation. This private right of action is not the exclusive remedy for a violation by an agency providing debt management plans, as the State Corporation Commission (SCC) remains empowered to revoke or suspend a license,[71] issue a cease and desist order,[72] impose civil penalties,[73] or refer the matter to the OAG;[74] similarly, upon referral from the SCC, the OAG can seek an injunction, damages, and other court-ordered relief like restitution[75] against an agency providing debt management plans. Article 1 (§ 32.1-123 *et seq.*) of Chapter 5 of Title 32.1 of the Code of Virginia has its own example of private right of action in Va. Code §§ 32.1-134.1 and 32.1-134.4. These statutes authorize physicians, podiatrists, and certified nurse midwives to file civil suit for an injunction if a hospital violates statutory provisions related to clinical privileges or staff membership. These private rights of action do differ slightly from the SCC example since Va. Code §§ 32.1-134.1 and 32.1-134.4 explicitly state that a hospital's violation of statutory provisions regarding clinical privileges or staff membership cannot be used as ground by the State Health Commissioner for the suspension or revocation of the hospital's license, but all other enforcement options remain available as the existence of a private right of action "shall not be deemed to impair or affect any other right or remedy."

Other states have utilized private rights of action to create state remedies for noncompliance with federal requirements. At this time, the State of Colorado has chosen to not create its own state hospital price transparency requirements like Virginia; it did, however, create a private right of action that allowed a patient or patient's guarantors to seek relief if a Colorado hospital filed a collection action against them and they believed the hospital was not in material compliance with the federal hospital price transparency requirements on the date care was provided to the patient (Appendix D).[76] Because there is no analogous state hospital price transparency requirement to enforce and CMS has not delegated the authority for federal enforcement to state survey agencies, there is no administrative action that could be taken by the Colorado Department of Public Health and Environment.[77] Therefore, a private right of action is presently the only option Colorado patients or patient guarantors have to compel compliance at the state level in that jurisdiction.

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[66] Va. Code § 59.1-197.
[67] Va. Code § 59.1-204.
[68] Va. Code § 59.1-203.
[69] Va. Code § 32.1-126(E).
[70] Specifically, Chapter 20 (§ 6.2-2000 *et seq.*) of Subtitle III of Title 6.2 of the Code of Virginia.
[71] Va. Code § 6.2-2018(A)(2).
[72] Va. Code § 6.2-2019.
[73] Va. Code § 6.2-2021.
[74] Va. Code § 6.2-2404(A).
[75] *Id*; Va. Code § 6.2-2404(B).
[76] 2022 Colorado Session Laws, Chapter 447.
[77] At present, the Colorado Department of Public Health and Environment is entirely outside the compliance monitoring and enforcement framework for hospital price transparency, as material compliance is determined by a judge or jury through the private right of action; OSHHR was not able to establish the admissibility of or evidentiary weight given to *(footnote continued)*

RECOMMENDATIONS

The recommendations below are grouped by the likeliest method by which they could be accomplished, if they are adopted, with unanimity of support by the study contributors noted including whether support was unanimous in part or if unanimous support was contingent on other external factors.

LEGISLATIVE

The legislative recommendation receiving unanimous support of study contributors is Recommendation 3.

1. VDH should have sufficient resources to monitor compliance.

2. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and the hospital fails to submit or comply with an acceptable PoC, the State Health Commissioner should have the authority to impose CMPs on a hospital in amounts commensurate with the CMPs for failure to comply with the federal hospital price transparency requirements.

3. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and the hospital fails to submit or comply with an acceptable PoC, the State Health Commissioner should have the authority to impose a directed PoC.

4. In addition to administrative enforcement by VDH, subsection A of Va. Code § 59.1-200 and subsection A of Va. Code 32.1-137.05 should be amended to state that a violation of the Virginia hospital price transparency is a prohibited act under the Virginia Consumer Protection Act of 1977 (§ 59.1-196 *et seq.* of the Code of Virginia).

REGULATORY

The regulatory recommendations receiving unanimous support of study contributors are Recommendations 1, 3, and 7. Recommendation 6 received unanimous support for the provision of notice to a hospital of alleged noncompliance, but did not receive unanimous support for publication of notice. Unanimous support of study contributors on Recommendation 2 is contingent on CMS concurring in the determination outpatients hospitals in Virginia to meet the definition of "hospital" in 45 CFR § 180.20.

1. The Board should adopt the federal minimums for machine-readable files found in 45 CFR § 180.50 in its hospital regulations.

2. Outpatient hospitals should be subject to Virginia's hospital price transparency requirements.

3. Hospitals should be required to display the gross charge, negotiated charge, and discounted cash price in the machine-readable file as U.S. dollars when the charge or cash price has been calculated as a percentage of Medicare or Medicaid rates.[78]

4. "Items and services" should include medication that the hospital customarily provides as part of, or in conjunction with, a service.

CMS's determination that a Colorado hospital was noncompliant on or about the date care had been provided to the patient.

[78] U.S. Centers for Medicare and Medicaid Services, *Hospital Price Transparency Frequently Asked Questions (FAQs)*, May 6, 2022, at 10, https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf.

5. Hospitals should be required to provide the link to the webpage where their machine-readable files are located to VHI.

6. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement, VDH should provide notice to the hospital of the alleged noncompliance and publish determinations of noncompliance on its website.

7. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and after providing notice, VDH should require the hospital to submit an acceptable PoC.

OPERATIONAL

The operational recommendation receiving unanimous support of study contributors is Recommendation 1. Recommendation 2 received unanimous support for which agencies would be responsible for compliance monitoring, but did not receive unanimous support for publication of determinations of noncompliance. Unanimous support of study contributors on Recommendations 3 and 7 are contingent on CMS concurring in the determination outpatients hospitals in Virginia to meet the definition of "hospital" in 45 CFR § 180.20.

1. Links to each hospital's webpage for the machine-readable file should be provided by VHI on each hospital's already-existing VHI webpage.

2. CMS and VDH should be responsible for compliance monitoring, and VDH should make public determinations of noncompliance.

3. VDH and VHI should compile a list of all currently licensed outpatient hospitals and conduct outreach to each facility in advance of July 1, 2023, but no later than March 30, 2023, to inform the outpatient hospitals of the applicability of Chapter 297 of the 2022 Acts of Assembly to their facility.

4. VHI should publish instructions on its website on how a consumer/patient can view the contents of machine-readable file, including recommended free software to open the file.

5. VDH should be directed to create an off-site inspection process to monitor compliance with Virginia's hospital price transparency requirement.

6. VDH should report to CMS any hospital that has been subject to enforcement action for failing to meet a Virginia hospital price transparency requirement that is identical or substantially equivalent to a federal hospital price transparency requirement.

7. VDH should not assess compliance of outpatient hospitals with the Virginia hospital price transparency until January 1, 2024.

APPENDIX A – CHAPTER 297 OF THE 2022 ACTS OF ASSEMBLY

VIRGINIA ACTS OF ASSEMBLY -- 2022 SESSION

CHAPTER 297

An Act to amend and reenact § 32.1-137.05 of the Code of Virginia, relating to hospitals; price transparency.

[H 481]

Approved April 11, 2022

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-137.05 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-137.05. Information regarding standard charges; advance estimate of patient payment amount for elective procedure, test, or service.

A. Every hospital shall make available to the public on its website a machine-readable file containing a list of all standard charges for all items and services provided by the hospital in accordance with 45 C.F.R. § 180.50, as amended. As used in this subsection, "hospital," "items and services," "machine-readable," and "standard charge" have the same meaning as set forth in 45 C.F.R. § 180.20.

B. Every hospital shall, upon request of a patient scheduled to receive an elective procedure, test, or service to be performed by the hospital, or upon request of such patient's legally authorized representative, made no less than three days in advance of the date on which such elective procedure, test, or service is scheduled to be performed, furnish the patient with an estimate of the payment amount for which the participant will be responsible for such elective procedure, test, or service. Every hospital shall provide written information about the patient's ability to request an estimate of the payment amount pursuant to this section. Such written information shall be posted conspicuously in public areas of the hospital, including admissions or registration areas, and included on any website maintained by the hospital.

2. That the provisions of the first enactment of this act shall become effective on July 1, 2023.

3. That the Secretary of Health and Human Resources shall develop recommendations for implementation of this act, including any regulatory changes that may be necessary for implementation of this act, and shall report his recommendations to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022.

APPENDIX B – ACRONYMS AND ABBREVIATIONS

This is a listing of the acronyms and abbreviations appearing throughout the report and its appendices.

Appropriations Act – the enacted biennial budget for Virginia; for the current biennium, Chapter 2 of the 2022 Acts of Assembly, Special Session I

ASC – ambulatory surgical center

Board – State Board of Health

CAH – critical access hospital

CAP – corrective action plan

CfC – conditions for coverage

CMP – civil monetary penalty

CMS – U.S. Centers for Medicare and Medicaid Services

CoP – condition of participation

CPT – Current Procedural Terminology

DHP – Virginia Department of Health Professions

DRG – Diagnosis Related Group

DSS – Virginia Department of Social Services

HCPCS – Healthcare Common Procedure Coding System

NHA – Northside Hospital Atlanta

NHC – Northside Hospital Cherokee

NDC – National Drug Code

OAG – Office of the Attorney General

OSHHR – Office of the Secretary of Health and Human Resources

SCC – State Corporation Commission

SHHR – Secretary of Health and Human Resources

VDH – Virginia Department of Health

VHI – Virginia Health Information

APPENDIX C – 45 CFR PART 180

This content is from the eCFR and is authoritative but unofficial.

Title 45 - Public Welfare
Subtitle A - Department of Health and Human Services
Subchapter E - Price Transparency

PART 180 - HOSPITAL PRICE TRANSPARENCY

Authority: 42 U.S.C. 300gg-18, 42 U.S.C. 1302.

Source: 84 FR 65602, Nov. 27, 2019, unless otherwise noted.

Subpart A - General Provisions

§ 180.10 Basis and scope.

This part implements section 2718(e) of the Public Health Service (PHS) Act, which requires each hospital operating within the United States, for each year, to establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups (DRGs) established under section 1886(d)(4) of the Social Security Act. This part also implements section 2718(b)(3) of the PHS Act, to the extent that section authorizes CMS to promulgate regulations for enforcing section 2718(e). This part also implements section 1102(a) of the Social Security Act, which authorizes the Secretary to make and publish rules and regulations, not inconsistent with that Act, as may be necessary to the efficient administration of the functions for which the Secretary is charged under that Act.

§ 180.20 Definitions.

The following definitions apply to this part, unless specified otherwise:

Ancillary service means an item or service a hospital customarily provides as part of or in conjunction with a shoppable primary service.

Chargemaster (Charge Description Master or CDM) means the list of all individual items and services maintained by a hospital for which the hospital has established a charge.

De-identified maximum negotiated charge means the highest charge that a hospital has negotiated with all third party payers for an item or service.

De-identified minimum negotiated charge means the lowest charge that a hospital has negotiated with all third party payers for an item or service.

Discounted cash price means the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.

Gross charge means the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.

Hospital means an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. For purposes of this definition, a State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Items and services means all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge. Examples include, but are not limited to, the following:

(1) Supplies and procedures.

(2) Room and board.

(3) Use of the facility and other items (generally described as facility fees).

(4) Services of employed physicians and non-physician practitioners (generally reflected as professional charges).

(5) Any other items or services for which a hospital has established a standard charge.

Machine-readable format means a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and .CSV formats.

Payer-specific negotiated charge means the charge that a hospital has negotiated with a third party payer for an item or service.

Service package means an aggregation of individual items and services into a single service with a single charge.

Shoppable service means a service that can be scheduled by a healthcare consumer in advance.

Standard charge means the regular rate established by the hospital for an item or service provided to a specific group of paying patients. This includes all of the following as defined under this section:

(1) Gross charge.

(2) Payer-specific negotiated charge.

(3) De-identified minimum negotiated charge.

(4) De-identified maximum negotiated charge.

(5) Discounted cash price.

State forensic hospital means a public psychiatric hospital that provides treatment for individuals who are in the custody of penal authorities.

Third party payer means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service.

[84 FR 65602, Nov. 27, 2019, as amended at 86 FR 63998, Nov. 16, 2021]

§ 180.30 Applicability.

(a) ***General applicability.*** Except as provided in paragraph (b) of this section, the requirements of this part apply to hospitals as defined at § 180.20.

(b) ***Exception.*** Federal and State hospitals are deemed by CMS to be in compliance with the requirements of this part including but not limited to:

(1) Federally owned hospital facilities, including facilities operated by the U.S. Department of Veterans Affairs and Military Treatment Facilities operated by the U.S. Department of Defense.

(2) Hospitals operated by an Indian Health Program as defined in section 4(12) of the Indian Health Care Improvement Act.

(3) State forensic hospitals that provide treatment exclusively to individuals who are in the custody of penal authorities.

(c) ***Online availability.*** Unless otherwise stated, hospital charge information must be made public electronically via the internet.

[84 FR 65602, Nov. 27, 2019, as amended at 86 FR 63998, Nov. 16, 2021]

Subpart B - Public Disclosure Requirements

§ 180.40 General requirements.

A hospital must make public the following:

(a) A machine-readable file containing a list of all standard charges for all items and services as provided in § 180.50.

(b) A consumer-friendly list of standard charges for a limited set of shoppable services as provided in § 180.60.

§ 180.50 Requirements for making public hospital standard charges for all items and services.

(a) ***General rules.***

(1) A hospital must establish, update, and make public a list of all standard charges for all items and services online in the form and manner specified in this section.

(2) Each hospital location operating under a single hospital license (or approval) that has a different set of standard charges than the other location(s) operating under the same hospital license (or approval) must separately make public the standard charges applicable to that location.

(b) ***Required data elements.*** A hospital must include all of the following corresponding data elements in its list of standard charges, as applicable:

(1) Description of each item or service provided by the hospital.

(2) Gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(3) Payer-specific negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each payer-specific negotiated charge must be clearly associated with the name of the third party payer and plan.

(4) De-identified minimum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(5) De-identified maximum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(6) Discounted cash price that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(7) Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifier.

(c) ***Format.*** The information described in paragraph (b) of this section must be published in a single digital file that is in a machine-readable format.

(d) ***Location and accessibility.***

(1) A hospital must select a publicly available website for purposes of making public the standard charge information required under paragraph (b) of this section.

(2) The standard charge information must be displayed in a prominent manner and clearly identified with the hospital location with which the standard charge information is associated.

(3) The hospital must ensure that the standard charge information is easily accessible, without barriers, including but not limited to ensuring the information is accessible:

(i) Free of charge;

(ii) Without having to establish a user account or password;

(iii) Without having to submit personal identifying information (PII); and

(iv) To automated searches and direct file downloads through a link posted on a publicly available website.

(4) The digital file and standard charge information contained in that file must be digitally searchable.

(5) The file must use the following naming convention specified by CMS, specifically: <ein>_<hospital-name>_standardcharges.[json|xml|csv].

(e) ***Frequency of updates.*** The hospital must update the standard charge information described in paragraph (b) of this section at least once annually. The hospital must clearly indicate the date that the standard charge data was most recently updated, either within the file itself or otherwise clearly associated with the file.

[84 FR 65602, Nov. 27, 2019, as amended at 86 FR 63998, Nov. 16, 2021]

§ 180.60 Requirements for displaying shoppable services in a consumer-friendly manner.

(a) ***General rules.***

(1) A hospital must make public the standard charges identified in paragraphs (b)(3) through (6) of this section, for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.

(i) In selecting a shoppable service for purposes of this section, a hospital must consider the rate at which it provides and bills for that shoppable service.

(ii) If a hospital does not provide 300 shoppable services, the hospital must make public the information specified in paragraph (b) of this section for as many shoppable services as it provides.

(2) A hospital is deemed by CMS to meet the requirements of this section if the hospital maintains an internet-based price estimator tool which meets the following requirements.

(i) Provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.

(ii) Allows healthcare 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.

(iii) Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password.

(b) ***Required data elements.*** A hospital must include, as applicable, all of the following corresponding data elements when displaying its standard charges (identified in paragraphs (b)(3) through (6) of this section) for its list of shoppable services selected under paragraph (a)(1) of this section:

(1) A plain-language description of each shoppable service.

(2) An indicator when one or more of the CMS-specified shoppable services are not offered by the hospital.

(3) The payer-specific negotiated charge that applies to each shoppable service (and to each ancillary service, as applicable). Each list of payer-specific negotiated charges must be clearly associated with the name of the third party payer and plan.

(4) The discounted cash price that applies to each shoppable service (and corresponding ancillary services, as applicable). If the hospital does not offer a discounted cash price for one or more shoppable services (or corresponding ancillary services), the hospital must list its undiscounted gross charge for the shoppable service (and corresponding ancillary services, as applicable).

(5) The de-identified minimum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).

(6) The de-identified maximum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).

(7) The location at which the shoppable service is provided, including whether the standard charges identified in paragraphs (b)(3) through (6) of this section for the shoppable service apply at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both.

(8) Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, as applicable, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), or other common service billing code.

(c) ***Format.*** A hospital has discretion to choose a format for making public the information described in paragraph (b) of this section online.

(d) ***Location and accessibility of online data.***

(1) A hospital must select an appropriate publicly available internet location for purposes of making public the information described in paragraph (b) of this section.

(2) The information must be displayed in a prominent manner that identifies the hospital location with which the information is associated.

(3) The shoppable services information must be easily accessible, without barriers, including but not limited to ensuring the information is:

(i) Free of charge.

(ii) Accessible without having to register or establish a user account or password.

(iii) Accessible without having to submit personal identifying information (PII).

(iv) Searchable by service description, billing code, and payer.

(e) ***Frequency.*** The hospital must update the standard charge information described in paragraph (b) of this section at least once annually. The hospital must clearly indicate the date that the information was most recently updated.

Subpart C - Monitoring and Penalties for Noncompliance

§ 180.70 Monitoring and enforcement.

(a) ***Monitoring.***

(1) CMS evaluates whether a hospital has complied with the requirements under §§ 180.40, 180.50, and 180.60.

(2) CMS may use methods to monitor and assess hospital compliance with the requirements under this part, including, but not limited to, the following, as appropriate:

(i) CMS' evaluation of complaints made by individuals or entities to CMS.

(ii) CMS review of individuals' or entities' analysis of noncompliance.

(iii) CMS audit of hospitals' websites.

(b) ***Actions to address hospital noncompliance.*** If CMS concludes that the hospital is noncompliant with one or more of the requirements of § 180.40, § 180.50, or § 180.60, CMS may take any of the following actions, which generally, but not necessarily, will occur in the following order:

(1) Provide a written warning notice to the hospital of the specific violation(s).

(2) Request a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements, according to § 180.80.

(3) Impose a civil monetary penalty on the hospital and publicize the penalty on a CMS website according to § 180.90 if the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan.

§ 180.80 Corrective action plans.

(a) ***Material violations requiring a corrective action plan.*** CMS determines if a hospital's noncompliance with the requirements of this part constitutes material violation(s) requiring a corrective action plan. A material violation may include, but is not limited to, the following:

(1) A hospital's failure to make public its standard charges required by § 180.40.

(2) A hospital's failure to make public its standard charges in the form and manner required under §§ 180.50 and 180.60.

(b) ***Notice of violation.*** CMS may request that a hospital submit a corrective action plan, specified in a notice of violation issued by CMS to a hospital.

(c) ***Compliance with corrective action plan requests and corrective actions.***

(1) A hospital required to submit a corrective action plan must do so, in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital and must comply with the requirements of the corrective action plan.

(2) A hospital's corrective action plan must specify elements including, but not limited to:

(i) The corrective actions or processes the hospital will take to address the deficiency or deficiencies identified by CMS.

(ii) The timeframe by which the hospital will complete the corrective action.

(3) A corrective action plan is subject to CMS review and approval.

(4) After CMS' review and approval of a hospital's corrective action plan, CMS may monitor and evaluate the hospital's compliance with the corrective actions.

(d) ***Noncompliance with corrective action plan requests and requirements.***

(1) A hospital's failure to respond to CMS' request to submit a corrective action plan includes failure to submit a corrective action plan in the form, manner, or by the deadline, specified in a notice of violation issued by CMS to the hospital.

(2) A hospital's failure to comply with the requirements of a corrective action plan includes failure to correct violation(s) within the specified timeframes.

§ 180.90 Civil monetary penalties.

(a) ***Basis for imposing civil monetary penalties.*** CMS may impose a civil monetary penalty on a hospital identified as noncompliant according to § 180.70, and that fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan as described in § 180.80(d).

(b) ***Notice of imposition of a civil monetary penalty.***

(1) If CMS imposes a penalty in accordance with this part, CMS provides a written notice of imposition of a civil monetary penalty to the hospital via certified mail or another form of traceable carrier.

(2) This notice to the hospital may include, but is not limited to, the following:

(i) The basis for the hospital's noncompliance, including, but not limited to, the following:

(A) CMS' determination as to which requirement(s) the hospital has violated.

(B) The hospital's failure to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan, as described in § 180.80(d).

(ii) CMS' determination as to the effective date for the violation(s). This date is the latest date of the following:

(A) The first day the hospital is required to meet the requirements of this part.

(B) If a hospital previously met the requirements of this part but did not update the information annually as required, the date 12 months after the date of the last annual update specified in information posted by the hospital.

(C) A date determined by CMS, such as one resulting from monitoring activities specified in § 180.70, or development of a corrective action plan as specified in § 180.80.

(iii) The amount of the penalty as of the date of the notice.

(iv) A statement that a civil monetary penalty may continue to be imposed for continuing violation(s).

(v) Payment instructions.

(vi) Intent to publicize the hospital's noncompliance and CMS' determination to impose a civil monetary penalty on the hospital for noncompliance with the requirements of this part by posting the notice of imposition of a civil monetary penalty on a CMS website.

(vii) A statement of the hospital's right to a hearing according to subpart D of this part.

(viii) A statement that the hospital's failure to request a hearing within 30 calendar days of the issuance of the notice permits the imposition of the penalty, and any subsequent penalties pursuant to continuing violations, without right of appeal in accordance with § 180.110.

(3) If the civil monetary penalty is upheld, in part, by a final and binding decision according to subpart D of this part, CMS will issue a modified notice of imposition of a civil monetary penalty, to conform to the adjudicated finding.

(c) ***Amount of the civil monetary penalty.***

(1) CMS may impose a civil monetary penalty upon a hospital for a violation of each requirement of this part.

(2) CMS determines the daily dollar amount for a civil monetary penalty for which a hospital may be subject as follows:

(i) For each day during Calendar Year 2021 that a hospital is determined by CMS to be out of compliance, the maximum daily dollar amount for a civil monetary penalty to which the hospital may be subject is $300. Even if the hospital is in violation of multiple discrete requirements of this part, the maximum total sum that a single hospital may be assessed per day is $300.

(ii) Beginning January 1, 2022, for each day a hospital is determined by CMS to be out of compliance:

(A) For a hospital with a number of beds equal to or less than 30, the maximum daily dollar civil monetary penalty amount to which it may be subject is $300, even if the hospital is in violation of multiple discrete requirements of this part.

(B) For a hospital with at least 31 and up to and including 550 beds, the maximum daily dollar civil monetary penalty amount to which it may be subject is the number of beds times $10, even if the hospital is in violation of multiple discrete requirements of this part.

(C) For a hospital with a number of beds greater than 550, the maximum daily dollar civil monetary penalty amount to which it may be subject is $5,500, even if the hospital is in violation of multiple discrete requirements of this part.

(D)

(1) CMS will use the most recently available, finalized Medicare hospital cost report to determine the number of beds for a Medicare-enrolled hospital, for purposes of determining the maximum daily dollar civil monetary penalty amount under paragraph (c)(2) of this section.

(2) If the number of beds for the hospital cannot be determined according to paragraph (c)(2)(ii)(D)*(1)* of this section, CMS will request that the hospital provide documentation of its number of beds, in a form and manner and by the deadline prescribed by CMS in a written notice provided to the hospital. Should the hospital fail to provide CMS with this documentation in the prescribed form and manner, and by the specified deadline, CMS will impose on the hospital the maximum daily dollar civil monetary penalty amount according to paragraph (c)(2)(ii)(C) of this section.

(3) The amount of the civil monetary penalty will be adjusted annually using the multiplier determined by OMB for annually adjusting civil monetary penalty amounts under part 102 of this title.

(d) ***Timing of payment of civil monetary penalty.***

(1) A hospital must pay the civil monetary penalty in full within 60 calendar days after the date of the notice of imposition of a civil monetary penalty from CMS under paragraph (b) of this section.

(2) In the event a hospital requests a hearing, pursuant to subpart D of this part, the hospital must pay the amount in full within 60 calendar days after the date of a final and binding decision, according to subpart D of this part, to uphold, in whole or in part, the civil monetary penalty.

(3) If the 60th calendar day described in paragraphs (d)(1) and (2) of this section is a weekend or a Federal holiday, then the timeframe is extended until the end of the next business day.

(e) ***Posting of notice.***

(1) CMS will post the notice of imposition of a civil monetary penalty described in paragraphs (b) and (f) of this section on a CMS website.

(2) In the event that a hospital elects to request a hearing, pursuant to subpart D of this part:

(i) CMS will indicate in its posting, under paragraph (e)(1) of this section, that the civil monetary penalty is under review.

(ii) If the civil monetary penalty is upheld, in whole, by a final and binding decision according to subpart D of this part, CMS will maintain the posting of the notice of imposition of a civil monetary penalty on a CMS website.

(iii) If the civil monetary penalty is upheld, in part, by a final and binding decision according to subpart D of this part, CMS will issue a modified notice of imposition of a civil monetary penalty according to paragraph (b)(3) of this section, to conform to the adjudicated finding. CMS will make this modified notice public on a CMS website.

(iv) If the civil monetary penalty is overturned in full by a final and binding decision according to subpart D of this part, CMS will remove the notice of imposition of a civil monetary penalty from a CMS website.

(f) ***Continuing violations.*** CMS may issue subsequent notice(s) of imposition of a civil monetary penalty, according to paragraph (b) of this section, that result from the same instance(s) of noncompliance.

[84 FR 65602, Nov. 27, 2019, as amended at 86 FR 63998, Nov. 16, 2021]

Subpart D - Appeals of Civil Monetary Penalties

§ 180.100 Appeal of penalty.

(a) A hospital upon which CMS has imposed a penalty under this part may appeal that penalty in accordance with subpart D of part 150 of this title, except as specified in paragraph (b) of this section.

(b) For purposes of applying subpart D of part 150 of this title to appeals of civil monetary penalties under this part:

(1) Civil money penalty means a civil monetary penalty according to § 180.90.

(2) Respondent means a hospital that received a notice of imposition of a civil monetary penalty according to § 180.90(b).

(3) References to a notice of assessment or proposed assessment, or notice of proposed determination of civil monetary penalties, are considered to be references to the notice of imposition of a civil monetary penalty specified in § 180.90(b).

(4) Under § 150.417(b) of this title, in deciding whether the amount of a civil money penalty is reasonable, the ALJ may only consider evidence of record relating to the following:

(i) The hospital's posting(s) of its standard charges, if available.

(ii) Material the hospital timely previously submitted to CMS (including with respect to corrective actions and corrective action plans).

(iii) Material CMS used to monitor and assess the hospital's compliance according to § 180.70(a)(2).

(5) The ALJ's consideration of evidence of acts other than those at issue in the instant case under § 150.445(g) of this title does not apply.

§ 180.110 Failure to request a hearing.

(a) If a hospital does not request a hearing within 30 calendar days of the issuance of the notice of imposition of a civil monetary penalty described in § 180.90(b), CMS may impose the civil monetary penalty indicated in such notice and may impose additional penalties pursuant to continuing violations according to § 180.90(f) without right of appeal in accordance with this part.

(1) If the 30th calendar day described in this paragraph (a) is a weekend or a Federal holiday, then the timeframe is extended until the end of the next business day.

(2) [Reserved]

(b) The hospital has no right to appeal a penalty with respect to which it has not requested a hearing in accordance with § 150.405 of this title, unless the hospital can show good cause, as determined at § 150.405(b) of this title, for failing to timely exercise its right to a hearing.

APPENDIX D – 2022 COLORADO SESSION LAWS, CHAPTER 447

CHAPTER 447

HEALTH AND ENVIRONMENT

HOUSE BILL 22-1285

BY REPRESENTATIVE(S) Neville and Esgar, Daugherty, Amabile, Bernett, Bird, Boesenecker, Carver, Duran, Herod, Jodeh, Kennedy, Kipp, Lindsay, Lontine, McCluskie, McCormick, Michaelson Jenet, Ortiz, Pico, Roberts, Sirota, Snyder, Titone, Valdez A., Van Winkle, Weissman, Garnett, Baisley, Exum, Geitner, Luck, Pelton, Sandridge, Valdez D., Van Beber, Williams, Young;
also SENATOR(S) Moreno and Cooke, Bridges, Buckner, Coram, Danielson, Donovan, Fields, Ginal, Gonzales, Hinrichsen, Holbert, Jaquez Lewis, Kolker, Lee, Pettersen, Priola, Rankin, Rodriguez, Scott, Sonnenberg, Story, Winter, Woodward, Zenzinger, Fenberg.

AN ACT

CONCERNING A PROHIBITION AGAINST A HOSPITAL TAKING CERTAIN DEBT COLLECTION ACTIONS AGAINST A PATIENT IF THE HOSPITAL IS NOT IN COMPLIANCE WITH HOSPITAL PRICE TRANSPARENCY LAWS.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** part 8 to article 3 of title 25 as follows:

PART 8
CONSUMER PROTECTION RELATING TO HOSPITAL PRICE TRANSPARENCY

25-3-801. Legislative declaration. (1) THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

(a) SECTION 1001 OF THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010", PUB.L. 111-148, AS AMENDED BY SECTION 10101 OF THE "HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010", PUB.L. 111-152, AMENDED TITLE XXVII OF THE "PUBLIC HEALTH SERVICE ACT", PUB.L. 78-410, IN PART, BY ADDING A NEW SECTION 2718(e), REQUIRING, IN PART, THAT EACH HOSPITAL OPERATING WITHIN THE UNITED STATES ESTABLISH, UPDATE, AND MAKE PUBLIC A LIST OF THE HOSPITAL'S STANDARD CHARGES FOR THE ITEMS AND SERVICES THAT THE HOSPITAL PROVIDES;

———

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(b) EFFECTIVE JANUARY 1, 2021, THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES PUBLISHED THE FINAL RULE TO IMPLEMENT THE LAW, CODIFIED AT 45 CFR 180;

(c) IN ITS SUMMARY OF THE FINAL RULE, CMS STATES THAT INFORMATION ON HOSPITAL STANDARD CHARGES IS NECESSARY FOR THE PUBLIC TO "MAKE MORE INFORMED DECISIONS ABOUT THEIR CARE" AND THAT THE "IMPACT OF THESE FINAL POLICIES WILL HELP TO INCREASE MARKET COMPETITION, AND ULTIMATELY DRIVE DOWN THE COST OF HEALTH CARE SERVICES, MAKING THEM MORE AFFORDABLE FOR ALL PATIENTS";

(d) ON JULY 9, 2021, PRESIDENT BIDEN, BUILDING UPON EFFORTS OF PAST PRESIDENTS, ISSUED THE "EXECUTIVE ORDER ON PROMOTING COMPETITION IN THE AMERICAN ECONOMY", DIRECTING THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES TO SUPPORT NEW AND EXISTING PRICE TRANSPARENCY INITIATIVES FOR HOSPITALS;

(e) HEALTH-CARE PRICE TRANSPARENCY IS IN THE BEST INTEREST OF ALL COLORADANS, INCLUDING:

(I) THE STATE GOVERNMENT, WHICH PURCHASES HEALTH-CARE SERVICES FOR ALMOST A QUARTER OF ALL COLORADANS;

(II) COLORADO BUSINESSES, WHICH FUND EMPLOYEE MEDICAL EXPENSES; AND

(III) COLORADO RESIDENTS, WHO ULTIMATELY BEAR THE BRUNT OF HIGH HEALTH-CARE COSTS IN THE FORM OF HIGHER TAXES, LOWER WAGES, AND RESIDENTS' OWN OUT-OF-POCKET SPENDING;

(f) MOREOVER, HEALTH-CARE PRICES IN COLORADO ARE AMONG THE HIGHEST IN THE NATION;

(g) HOWEVER, NOT ALL COLORADO HOSPITALS ARE IN COMPLIANCE WITH ALL OF THE DISCLOSURE REQUIREMENTS UNDER FEDERAL LAW AND OTHER STATE LAWS GOVERNING HEALTH-CARE PRICE TRANSPARENCY; AND

(h) THIS LACK OF COMPLIANCE WITH HEALTH-CARE PRICE TRANSPARENCY LAWS BY COLORADO HOSPITALS DECREASES THE LIKELIHOOD THAT COLORADO CONSUMERS WILL BE FULLY AWARE OF AFFORDABLE HEALTH-CARE OPTIONS BEFORE PURCHASING ITEMS AND SERVICES FROM HOSPITALS, PLACING HEALTH-CARE CONSUMERS AT GREATER RISK OF COLLECTION ACTIONS AND OTHER ADVERSE ACTIONS RELATING TO UNPAID MEDICAL BILLS.

(2) THEREFORE, THE GENERAL ASSEMBLY FINDS AND DECLARES THAT IT IS IMPERATIVE TO PROTECT COLORADO HEALTH-CARE CONSUMERS FROM COLLECTION ACTIONS AND OTHER ADVERSE ACTIONS TAKEN BY COLORADO HOSPITALS DURING THE TIME WHEN THE HOSPITAL WAS NOT IN MATERIAL COMPLIANCE WITH HOSPITAL PRICE TRANSPARENCY LAWS INTENDED TO PROTECT HEALTH-CARE CONSUMERS.

25-3-802. Definitions. AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "COLLECTION ACTION" MEANS ANY OF THE FOLLOWING ACTIONS TAKEN WITH RESPECT TO A DEBT FOR ITEMS AND SERVICES THAT WERE PURCHASED FROM OR PROVIDED TO A PATIENT BY A HOSPITAL ON A DATE DURING WHICH THE HOSPITAL WAS NOT IN MATERIAL COMPLIANCE WITH HOSPITAL PRICE TRANSPARENCY LAWS:

(a) ATTEMPTING TO COLLECT A DEBT FROM A PATIENT OR PATIENT GUARANTOR BY REFERRING THE DEBT, DIRECTLY OR INDIRECTLY, TO A DEBT COLLECTOR, A COLLECTION AGENCY, OR OTHER THIRD PARTY RETAINED BY OR ON BEHALF OF THE HOSPITAL;

(b) SUING THE PATIENT OR PATIENT GUARANTOR, OR ENFORCING AN ARBITRATION OR MEDIATION CLAUSE IN ANY HOSPITAL DOCUMENTS INCLUDING CONTRACTS, AGREEMENTS, STATEMENTS, OR BILLS; OR

(c) DIRECTLY OR INDIRECTLY CAUSING A REPORT TO BE MADE TO A CONSUMER REPORTING AGENCY.

(2) (a) "COLLECTION AGENCY" MEANS ANY:

(I) PERSON WHO ENGAGES IN A BUSINESS THE PRINCIPAL PURPOSE OF WHICH IS THE COLLECTION OF DEBTS; OR

(II) PERSON WHO:

(A) REGULARLY COLLECTS OR ATTEMPTS TO COLLECT, DIRECTLY OR INDIRECTLY, DEBTS OWED OR DUE OR ASSERTED TO BE OWED OR DUE TO ANOTHER;

(B) TAKES ASSIGNMENT OF DEBTS FOR COLLECTION PURPOSES;

(C) DIRECTLY OR INDIRECTLY SOLICITS FOR COLLECTION DEBTS OWED OR DUE OR ASSERTED TO BE OWED OR DUE TO ANOTHER; OR

(D) COLLECTS DEBT FOR THE DEPARTMENT OF PERSONNEL.

(b) "COLLECTION AGENCY" DOES NOT INCLUDE:

(I) ANY OFFICER OR EMPLOYEE OF A CREDITOR WHILE, IN THE NAME OF THE CREDITOR, COLLECTING DEBTS FOR SUCH CREDITOR;

(II) ANY PERSON WHILE ACTING AS A COLLECTION AGENCY FOR ANOTHER PERSON, BOTH OF WHOM ARE RELATED BY COMMON OWNERSHIP OR AFFILIATED BY CORPORATE CONTROL, IF THE PERSON ACTING AS A COLLECTION AGENCY DOES SO ONLY FOR CREDITORS TO WHOM IT IS SO RELATED OR AFFILIATED AND IF THE PRINCIPAL BUSINESS OF THE PERSON IS NOT THE COLLECTION OF DEBTS;

(III) ANY OFFICER OR EMPLOYEE OF THE UNITED STATES OR ANY STATE TO THE EXTENT THAT COLLECTING OR ATTEMPTING TO COLLECT ANY DEBT IS IN THE PERFORMANCE OF THE OFFICER'S OR EMPLOYEE'S OFFICIAL DUTIES;

(IV) ANY PERSON WHILE SERVING OR ATTEMPTING TO SERVE LEGAL PROCESS ON ANY OTHER PERSON IN CONNECTION WITH THE JUDICIAL ENFORCEMENT OF ANY

DEBT;

(V) ANY DEBT-MANAGEMENT SERVICES PROVIDER OPERATING IN COMPLIANCE WITH OR EXEMPT FROM THE "UNIFORM DEBT-MANAGEMENT SERVICES ACT", PART 2 OF ARTICLE 19 OF TITLE 5;

(VI) ANY PERSON COLLECTING OR ATTEMPTING TO COLLECT ANY DEBT OWED OR DUE OR ASSERTED TO BE OWED OR DUE ANOTHER TO THE EXTENT THAT:

(A) THE ACTIVITY IS INCIDENTAL TO A BONA FIDE FIDUCIARY OBLIGATION OR A BONA FIDE ESCROW ARRANGEMENT;

(B) THE ACTIVITY CONCERNS A DEBT THAT WAS EXTENDED BY THE PERSON;

(C) THE ACTIVITY CONCERNS A DEBT THAT WAS NOT IN DEFAULT AT THE TIME IT WAS OBTAINED BY THE PERSON; OR

(D) THE ACTIVITY CONCERNS A DEBT OBTAINED BY THE PERSON AS A SECURED PARTY IN A COMMERCIAL CREDIT TRANSACTION INVOLVING THE CREDITOR;

(VII) ANY PERSON WHOSE PRINCIPAL BUSINESS IS THE MAKING OF LOANS OR THE SERVICING OF DEBT NOT IN DEFAULT AND WHO ACTS AS A LOAN CORRESPONDENT, SELLER AND SERVICER FOR THE OWNER, OR HOLDER OF A DEBT THAT IS SECURED BY A DEED OF TRUST ON REAL PROPERTY WHETHER OR NOT THE DEBT IS ALSO SECURED BY AN INTEREST IN PERSONAL PROPERTY;

(VIII) A LIMITED GAMING OR RACING LICENSEE ACTING PURSUANT TO ARTICLE 33 OF TITLE 44.

(c) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (2)(b) OF THIS SECTION, "COLLECTION AGENCY" INCLUDES ANY PERSON WHO, IN THE PROCESS OF COLLECTING THE PERSON'S OWN DEBTS, USES ANOTHER NAME THAT WOULD INDICATE THAT A THIRD PERSON IS COLLECTING OR ATTEMPTING TO COLLECT SUCH DEBTS.

(3) (a) "CONSUMER REPORTING AGENCY" MEANS ANY PERSON THAT, FOR MONETARY FEES, DUES, OR ON A COOPERATIVE NONPROFIT BASIS, REGULARLY ENGAGES, IN WHOLE OR IN PART, IN THE PRACTICE OF ASSEMBLING OR EVALUATING CONSUMER CREDIT INFORMATION OR OTHER INFORMATION ON CONSUMERS FOR THE PURPOSE OF FURNISHING CONSUMER REPORTS TO THIRD PARTIES. "CONSUMER REPORTING AGENCY" INCLUDES ANY PERSON DEFINED IN 15 U.S.C. SEC. 1681a (f) OR SECTION 5-18-103 (4).

(b) "CONSUMER REPORTING AGENCY" DOES NOT INCLUDE ANY BUSINESS ENTITY THAT PROVIDES CHECK VERIFICATION OR CHECK GUARANTEE SERVICES ONLY.

(4) (a) "DEBT" MEANS ANY OBLIGATION OR ALLEGED OBLIGATION OF A CONSUMER TO PAY MONEY ARISING OUT OF A TRANSACTION, WHETHER OR NOT THE OBLIGATION HAS BEEN REDUCED TO JUDGMENT.

(b) "DEBT" DOES NOT INCLUDE A DEBT FOR BUSINESS, INVESTMENT, COMMERCIAL,

OR AGRICULTURAL PURPOSES OR A DEBT INCURRED BY A BUSINESS.

(5) "DEBT COLLECTOR" MEANS ANY PERSON EMPLOYED OR ENGAGED BY A COLLECTION AGENCY TO PERFORM THE COLLECTION OF DEBTS OWED OR DUE OR ASSERTED TO BE OWED OR DUE TO ANOTHER.

(6) "FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES" OR "CMS" MEANS THE CENTER FOR MEDICARE AND MEDICAID SERVICES IN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(7) "HOSPITAL" MEANS, CONSISTENT WITH 45 CFR 180.20, A HOSPITAL:

(a) LICENSED OR CERTIFIED BY THE DEPARTMENT PURSUANT TO SECTION 25-1.5-103 (1)(a); OR

(b) APPROVED BY THE DEPARTMENT AS MEETING THE STANDARDS ESTABLISHED FOR LICENSING A HOSPITAL.

(8) "HOSPITAL PRICE TRANSPARENCY LAWS" MEANS SECTION 2718(e) OF THE "PUBLIC HEALTH SERVICE (PHS) ACT", PUB.L. 78-410, AS AMENDED, AND RULES ADOPTED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES IMPLEMENTING SECTION 2718(e).

(9) "ITEMS AND SERVICES" OR "ITEMS OR SERVICES" MEANS "ITEMS AND SERVICES" AS DEFINED IN 45 CFR 180.20.

25-3-803. Failure to comply with hospital price transparency laws - prohibiting collection of debt - penalty. (1) (a) EXCEPT AS PROVIDED IN SUBSECTION (1)(b) OF THIS SECTION, ON AND AFTER THE EFFECTIVE DATE OF THIS SECTION, A HOSPITAL THAT IS NOT IN MATERIAL COMPLIANCE WITH HOSPITAL PRICE TRANSPARENCY LAWS ON THE DATE THAT ITEMS OR SERVICES ARE PURCHASED FROM OR PROVIDED TO A PATIENT BY THE HOSPITAL SHALL NOT INITIATE OR PURSUE A COLLECTION ACTION AGAINST THE PATIENT OR PATIENT GUARANTOR FOR A DEBT OWED FOR THE ITEMS OR SERVICES.

(b) THIS PART 8 APPLIES, ON AND AFTER FEBRUARY 15, 2023, TO CRITICAL ACCESS HOSPITALS LICENSED AND CERTIFIED BY THE DEPARTMENT PURSUANT TO 42 CFR 485 SUBPART F.

(2) IF A PATIENT BELIEVES THAT A HOSPITAL WAS NOT IN MATERIAL COMPLIANCE WITH HOSPITAL PRICE TRANSPARENCY LAWS ON A DATE ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION THAT ITEMS OR SERVICES WERE PURCHASED BY OR PROVIDED TO THE PATIENT, AND THE HOSPITAL TAKES A COLLECTION ACTION AGAINST THE PATIENT OR PATIENT GUARANTOR, THE PATIENT OR PATIENT GUARANTOR MAY FILE SUIT TO DETERMINE IF THE HOSPITAL WAS MATERIALLY OUT OF COMPLIANCE WITH THE HOSPITAL PRICE TRANSPARENCY LAWS AND RULES AND REGULATIONS ON THE DATE OF SERVICE, AND THE NONCOMPLIANCE IS RELATED TO THE ITEMS OR SERVICES. THE HOSPITAL SHALL NOT TAKE A COLLECTION ACTION AGAINST THE PATIENT OR PATIENT GUARANTOR WHILE THE LAWSUIT IS PENDING.

(3) A HOSPITAL THAT HAS BEEN FOUND BY A JUDGE OR JURY, CONSIDERING

COMPLIANCE STANDARDS ISSUED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, TO BE MATERIALLY OUT OF COMPLIANCE WITH HOSPITAL PRICE TRANSPARENCY LAWS AND RULES AND REGULATIONS:

(a) SHALL REFUND THE PAYER ANY AMOUNT OF THE DEBT THE PAYER HAS PAID AND SHALL PAY A PENALTY TO THE PATIENT OR PATIENT GUARANTOR IN AN AMOUNT EQUAL TO THE TOTAL AMOUNT OF THE DEBT;

(b) SHALL DISMISS OR CAUSE TO BE DISMISSED ANY COURT ACTION WITH PREJUDICE AND PAY ANY ATTORNEY FEES AND COSTS INCURRED BY THE PATIENT OR PATIENT GUARANTOR RELATING TO THE ACTION; AND

(c) REMOVE OR CAUSE TO BE REMOVED FROM THE PATIENT'S OR PATIENT GUARANTOR'S CREDIT REPORT ANY REPORT MADE TO A CONSUMER REPORTING AGENCY RELATING TO THE DEBT.

(4) NOTHING IN THIS PART 8:

(a) PROHIBITS A HOSPITAL FROM BILLING A PATIENT, PATIENT GUARANTOR, OR THIRD-PARTY PAYER, INCLUDING HEALTH INSURER, FOR ITEMS OR SERVICES PROVIDED TO THE PATIENT; OR

(b) REQUIRES A HOSPITAL TO REFUND ANY PAYMENT MADE TO THE HOSPITAL FOR ITEMS OR SERVICES PROVIDED TO THE PATIENT, SO LONG AS NO COLLECTION ACTION IS TAKEN IN VIOLATION OF THIS PART 8.

SECTION 2. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2022 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Approved: June 8, 2022

APPENDIX E – STUDY CONTRIBUTORS' WRITTEN COMMENTS PRIOR TO SEPTEMBER 30, 2022 MEETING

Study contributors were offered the opportunity to provide written comment for the consideration of OSHHR prior to the September 30, 2022 meeting.

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PATIENTRIGHTSADVOCATE.ORG

My name is Ilaria Santangelo. I am the director of research at Patient Rights Advocate. I helped create the recent Hospital Price Transparency Compliance Report, which found that 16 percent of hospitals nationwide were complying with the federal price transparency rule. Virginia is looking at 20% percent compliance. Thank you to the hospitals that have come into compliance this go around and the hospitals that are actively trying.

By law, hospitals must post all prices upfront, clearly and completely, by payer and plan, including cash prices.

Only when consumers can shop and compare prices before they receive care, and see that an MRI can cost $300 or $3,000, can they make the best purchasing decisions for their health and their wealth. It is still difficult for patients in Virginia to do this.

I would like to ask the group and Deputy Secretary of Health James Williams to consider additional implementation guidance and regulatory requirements to H481 such as:

- Requiring hospitals to upload data to a government server to make it available from a central repository;
- Require hospitals to submit to the Dept. the URL where the required data resides;
- Require data submissions (or publications) to be accompanied by an attestation of truth and accuracy from an officer of the hospital;
- Authorize the state to aggregate hospitals' data to make it available via a gov't website;
- Prohibit access limitations (such as pop-up disclaimers or CAPTCHA or any barriers to entry);
- Establish data standards
- And use existing licensure authority to set up an enforcement framework to ensure compliance.

H.B. 481 is critical to all healthcare consumers – it protects Virginia patients from unforeseen financial ruin from medical debt. If they can't see prices upfront, how can they be expected to pay a bill they never saw coming?

Anthem BCBS MCD		
Service Description	Coding	Rate
Behavioral Health		102% of MCD
Other Inpatient		102% of MCD
Other Outpatient		100% of MCD
Rehab		102% of MCD
Transplant		102% of MCD
Anthem BCBS MCR		
Service Description	Coding	Rate
Covered Inpatient Services		100% of MCR
Inpatient Acute		103% of MCR
Other Outpatient		101.5% of MCR
Anthem COMM		
Service Description	Coding	Rate
Agent Therapy		$1,136.00
All Other Lab/Rad Services		50% of BC
Allergy Testing		$726.75
Ambulance		70.8% of BC
Angioplasty	CPT/HCPC 92986, 92987, 92990	$7,383.25
Angioplasty	CPT/HCPC C9600-C9608	$40,564.00
Angioplasty	CPT/HCPC 92928-92929, 92933-92934, 92937-92938, 92941, 92943-92944, 37215-37216	$14,278.50
Angioplasty	CPT/HCPC 92920-92921, 92924-92925	$11,774.50
Angioplasty	CPT/HCPC 92997-92998	$7,383.25
Audiology		$500.50
Behavioral Health	MS-DRG 876, 880-887, 894-897	$1,376.75
Cardiac Cath	CPT/HCPC 93451-93464, 93530-93533	$12,120.25
Cardiac Rehab		$123.75
Cardiac Stress Test		$946.75
Cardiology	MS-DRG 246, 247	$36,405.75
Cardiology	MS-DRG 287	$22,600.00
Cardiology		$929.50
Cardiovascular	CPT/HCPC 93650, 93653-93657	$11,021.25
Cardiovascular	CPT/HCPC 93580-93581	$14,272.75
Cardiovascular Surgery	MS-DRG 233, 234	$75,652.50
Cardiovascular Surgery	MS-DRG 235, 236	$56,978.00
Chemotherapy		$5,958.25
CT		$751.50

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Parham Doctors' Hospital
Location: Richmond, VA
Downloaded: 07/11/2022

Reason: Standard charges file fails to provide adequate pricing information for major payer negotiated rates as well as de-identified min/max charges; has non-searchable incomplete, overbroad or inapplicable descriptions; contains calculation instructions in place of numerical prices in negotiated rates, minimum and maximum fields, and non-searchable code ranges.

1

CDM / DRG Code		Description	HCPCS Code	Charge	Aetna Medicaid	Aetna Medicare	Anthem Medicaid	Anthem Medicare	Humana Medicare	Magellan Medicaid	Magellan Medicare	Optima Medicaid	Optima Medicare	United Medicaid	United Medicare	Va Premier Medicaid	Va Premier Medicare
AM000008		TRANSPORT REVERSE PER 30MIN		$121	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000001		ANES LOCAL PUDENDAL		$576	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000021		ANESTHESIA TIME 1/2 HR LVL 1		$1,212	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000022		ANESTHESIA TIME 1/2 HR LVL 2		$1,490	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000023		ANESTHESIA TIME 1/2 HR LVL 3		$1,761	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000024		ANESTHESIA TIME 1/2 HR LVL 4		$2,089	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000025		ANESTHESIA TIME 1/2 HR LVL 5		$2,202	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000026		ANESTHESIA TIME 1/2 HR LVL 6		$1,212	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000028		MOD SED SAME PHYS/QHP 5 OR GREATER	99152	$279	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000029		MOD SED SAME PHYS/QHP EA	99153	$279	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000030		MOD SED OTH PHYS/QHP GREATER 5 YRS	99155	$279	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000031		MOD SED OTH PHYS/QHP 5 OR LESS YRS	99156	$279	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000032		MOD SED OTHER PHYS/QHP EA	99157	$279	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AN000033		MOD SEDAT ENDO SERVICE GREARTER THN 5YRS	G0500	$173	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS
AU000030		AUD SCREEN PURE TONE AIR ONLY	92551	$158	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	100% of Medicare IPPS/OPPS	105% of Medicaid IP/OP Rates	105% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	102% of Medicare IPPS/OPPS	103% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS	100% of Medicaid IP/OP Rates	100% of Medicare IPPS/OPPS

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VCU Medical Center
Location: Richmond, VA
Downloaded: 05/29/2022

Reason: Standard Charges File omits the discounted cash price, the de-identified minimum and maximum charges, and negotiated rates and fails to adequately identify specific plans for all commercial payers.

2

Code	Procedure Desc	NDC	Rev Code	IP Price	OP Price	<Self-pay>	AETNA [101101]	BLUE CROSS [100101]	CIGNA [103101]	MEDICAL MUTUAL OF OHIO [1162]	UNITED HEALTHCARE [107101]	Min	Max	AARP MEDICARE COMPLETE [2119]	BLUE CROSS MEDICARE [2115]	CCCP MEDICARE [2195]	HUMANA MEDICARE [2116]	VA MEDICARE [2101]	AETNA BETTER HEALTH OF VA [3189]	BLUE CROSS MEDICAID [3128]	CCCP MEDICAID [3202]	OPTIMA MEDICAID [3117]	VIRGINIA PREMIER MEDICAID [3119]
	RM PRIVATE		0110 - ROOM &	546	546	327.6	416.6	0	415.505	191.1	0	0	416.6										
	RM PRIVATE G'		0111 - ROOM &	546	546	327.6	416.6	0	415.505	191.1	0	0	416.6										
	RM PRIVATE OI		0112 - ROOM &	546	546	327.6	416.6	0	415.505	191.1	0	0	416.6										
	RM PRIVATE PE		0113 - ROOM &	546	546	327.6	416.6	0	415.505	191.1	0	0	416.6										
	RM PRIVATE PS		0114 - ROOM &	1286	1286	771.6	981.22	0	978.645	450.1	0	0	981.22										
	RM PRIVATE OI		0117 - ROOM &	546	546	327.6	416.6	0	415.505	191.1	0	0	416.6										
	RM SEMIPRIVA		0120 - ROOM &	546	546	327.6	416.6	0	415.505	191.1	0	0	416.6										
	RM SEMIPRIVA		0122 - ROOM &	496	496	297.6	378.45	0	377.455	173.6	0	0	378.45										
	RM SEMIPRIVA		0123 - ROOM &	527	527	316.2	402.1	0	401.045	184.45	0	0	402.1										
	RM SEMIPRIVA		0124 - ROOM &	1238	1238	742.8	944.59	0	942.12	433.3	0	0	944.59										
	RM STERILE IS		0164 - ROOM &	496	496	297.6	378.45	0	377.455	173.6	0	0	378.45										
	RM NURSERY \		0171 - NURSER	455	455	273	347.17	0	346.255	159.25	0	0	347.17										
	RM NURSERY (		0172 - NURSER	1036	1036	621.6	790.47	0	788.395	362.6	0	0	790.47										
	RM NURSERY S		0173 - NURSER	1420	1420	852	1083.46	0	1080.62	497	0	0	1083.46										
	RM NURSERY I		0174 - NURSER	4743	4743	2845.8	3618.91	0	3609.425	1660.05	0	0	3618.91										
	RM INTENSIVE		0200 - INTENSI	3152	3152	1891.2	2404.98	0	2398.67	1103.2	0	0	2404.98										
	RM ICU SURGI(		0201 - INTENSI	3152	3152	1891.2	2404.98	0	2398.67	1103.2	0	0	2404.98										
	RM ICU PEDIAT		0203 - INTENSI	3152	3152	1891.2	2404.98	0	2398.67	1103.2	0	0	2404.98										
	RM ICU INTERN		0206 - INTENSI	1757	1757	1054.2	1340.59	0	1337.075	614.95	0	0	1340.59										
	RM CCU GENEI		0210 - CORONA	3152	3152	1891.2	2404.98	0	2398.67	1103.2	0	0	2404.98										
	RM CCU STEPI		0214 - CORONA	546	546	327.6	416.6	0	415.505	191.1	0	0	416.6										
	ALPRAZOLAM (		0250 - PHARMA	16	16	9.6	12.21	10.37	12.175	5.6	11.49	5.6	12.21										
	CHLORAL HYDI		0250 - PHARMA	17	17	10.2	12.97	11.02	12.935	5.95	12.21	5.95	12.97										
	LIDO/EPI 1%/1		0250 - PHARMA	5	6	3.6	4.58	3.89	4.565	2.1	4.31	2.1	4.58										
	LIDOCAINE 1%		0250 - PHARMA	5	5	3	3.82	3.24	3.805	1.75	3.59	1.75	3.82										
	PTCH FBRN SE		0250 - PHARMA	2289	2289	1373.4	1746.51	1483.27	1741.93	801.15	1643.5	801.15	1746.51										
	PTCH FBRN SE		0250 - PHARMA	3902	3902	2341.2	2977.23	2528.5	2969.42	1365.7	2801.64	1365.7	2977.23										
	SOD BICARB 1I		0250 - PHARMA	91	95	57	72.49	61.56	72.295	33.25	68.21	33.25	72.49										
	0.9NS 100ML IV		0258 - PHARMA	83	83	49.8	63.33	53.78	63.165	29.05	59.59	29.05	63.33										
	D5/0.2NS 500MI		0258 - PHARMA	61	61	36.6	46.54	39.53	46.42	21.35	43.8	21.35	46.54										
	SOL INJ 5% D/0		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D 10%		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D 10%		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D 5% 1		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D 5% 1		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D 5% 2		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D 5% L		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D 5% L		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D 5% L		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D10 LF		0258 - PHARMA	290.5	290.5	174.3	221.65	188.24	221.075	101.68	208.58	101.68	221.65										
	SOL INJ D5 SOI		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D5% S		0258 - PHARMA	290.5	290.5	174.3	221.65	188.24	221.075	101.68	208.58	101.68	221.65										
	SOL INJ D5%S(		0258 - PHARMA	290.5	290.5	174.3	221.65	188.24	221.075	101.68	208.58	101.68	221.65										
	SOL INJ D545N		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ D5LR L		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ L R VIA		0258 - PHARMA	290.5	290.5	174.3	221.65	188.24	221.075	101.68	208.58	101.68	221.65										
	SOL INJ LR 100		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ NACL (		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ RINGE		0258 - PHARMA	290.5	290.5	174.3	221.65	188.24	221.075	101.68	208.58	101.68	221.65										
	SOL INJ SOD C		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ SOD C		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ SOD C		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ SOD C		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ SOD C		0258 - PHARMA	6	6	3.6	4.58	3.89	4.565	2.1	4.31	2.1	4.58										
	SOL INJ SOD C		0258 - PHARMA	290.5	290.5	174.3	221.65	188.24	221.075	101.68	208.58	101.68	221.65										
	SOL INJ SOD C		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ SOD C		0258 - PHARMA	269.5	269.5	161.7	205.63	174.64	205.09	94.33	193.5	94.33	205.63										
	SOL INJ STRL H		0258 - PHARMA	290.5	290.5	174.3	221.65	188.24	221.075	101.68	208.58	101.68	221.65										
	SOL NACL 0.9%		0258 - PHARMA	8	8	4.8	6.1	5.18	6.09	2.8	5.74	2.8	6.1										
	ABD PLLW HIP		0270 - MEDICAL	66	66	39.6	50.36	42.77	50.225	23.1	47.39	23.1	50.36										
	ABD PLLW HIP		0270 - MEDICAL	94	94	56.4	71.72	60.91	71.535	32.9	67.49	32.9	71.72										
	ABD PLLW HIP		0270 - MEDICAL	106	106	63.6	80.88	68.69	80.665	37.1	76.11	37.1	80.88										
	ABD PLLW HIP		0270 - MEDICAL	68	68	40.8	51.88	44.06	51.75	23.8	48.82	23.8	51.88										
	ABD PLLW HIP		0270 - MEDICAL	319	319	191.4	243.4	206.71	242.76	111.65	229.04	111.65	243.4										
	ABD PLLW HIP		0270 - MEDICAL	88	88	52.8	67.14	57.02	66.97	30.8	63.18	30.8	67.14										
	ABD PLLW HIP		0270 - MEDICAL	90	90	54	68.67	58.32	68.49	31.5	64.62	31.5	68.67										
	ABD PLLW SHL		0270 - MEDICAL	198	198	118.8	151.07	128.3	150.68	69.3	142.16	69.3	151.07										
	ABD PLLW SHL		0270 - MEDICAL	203	203	121.8	154.89	131.54	154.485	71.05	145.75	71.05	154.89										
	ABD PLLW SHL		0270 - MEDICAL	282	282	169.2	215.17	182.74	214.6	98.7	202.48	98.7	215.17										
	ABD PLLW SHL		0270 - MEDICAL	151	151	90.6	115.21	97.85	114.91	52.85	108.42	52.85	115.21										
	ADPT CBL CAR		0270 - MEDICAL	867	867	520.2	661.52	561.82	659.785	303.45	622.51	303.45	661.52										
	ADPT DEFIB MI		0270 - MEDICAL	340	340	204	259.42	220.32	258.74	119	244.12	119	259.42										
	ADPT DUAL FL(		0270 - MEDICAL	15	15	9	11.45	9.72	11.415	5.25	10.77	5.25	11.45										
	AIRWY BINASL		0270 - MEDICAL	31	31	18.6	23.65	20.09	23.59	10.85	22.26	10.85	23.65										

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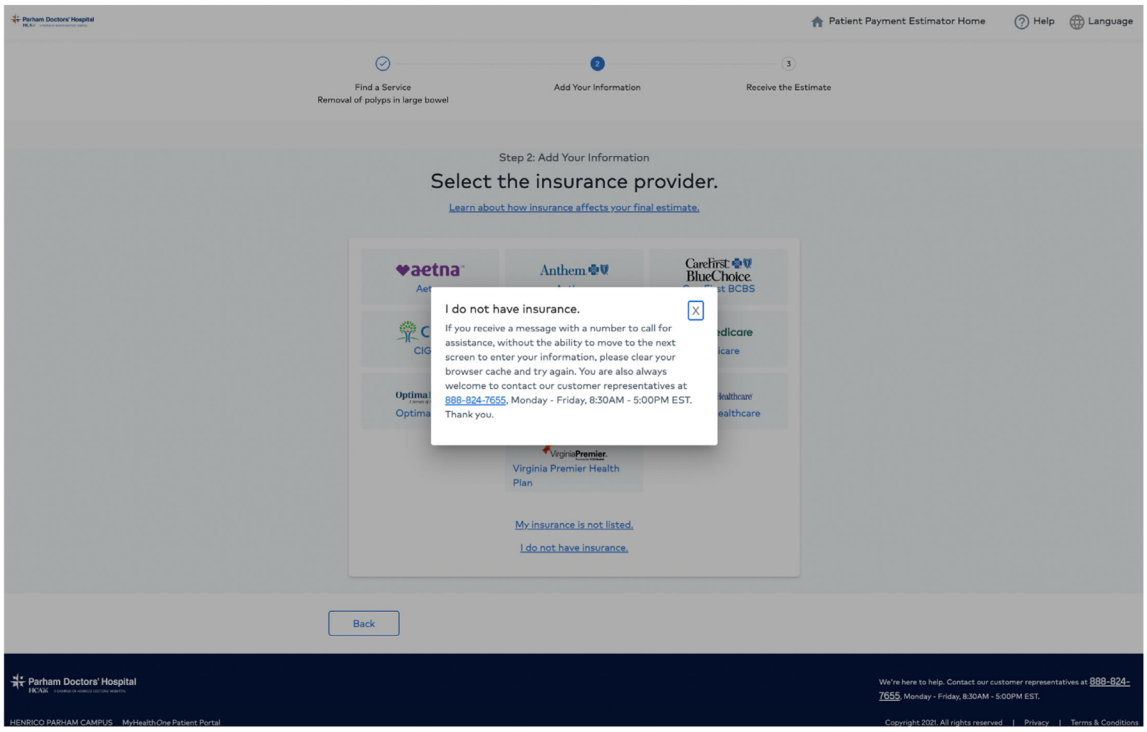
Noncompliant Hospital: Bon Secours Richmond Community Hospital
Location: Richmond, VA
Download Date: 07/01/2022
Reason: Standard Charges File fails to provide an adequate amount of negotiated rates and fails to adequately identify specific plans for all commercial payers.

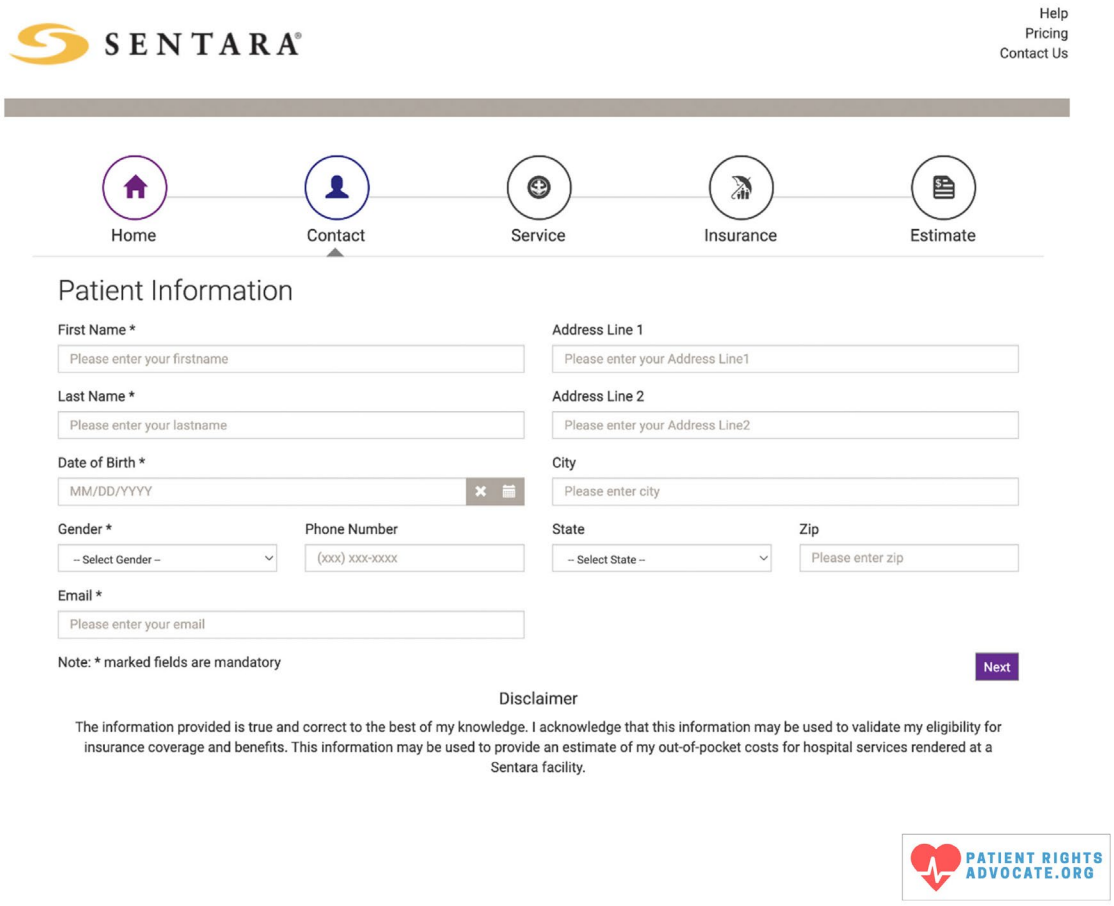
3



PATIENT RIGHTS ADVOCATE.ORG

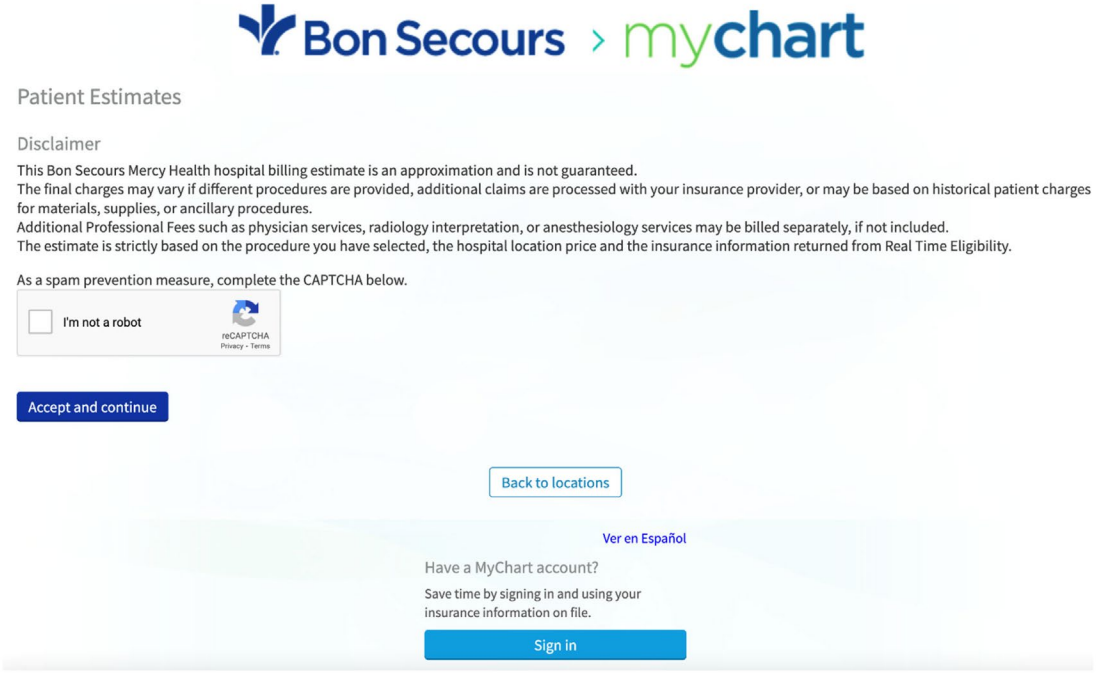
Parham Doctors' Hospital - Richmond, VA
Checked: 09/02/2022

4



Sentara Halifax Regional Hospital - South Boston, VA
Checked: 09/02/2022

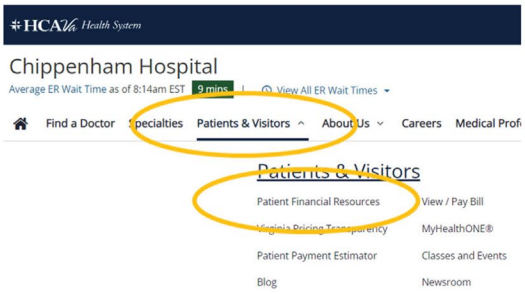
5

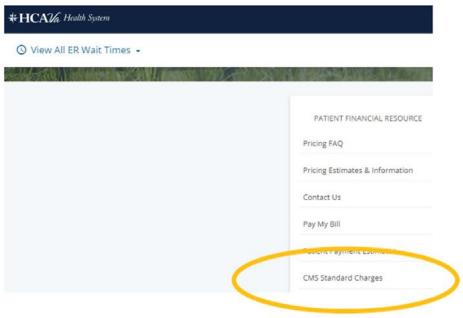


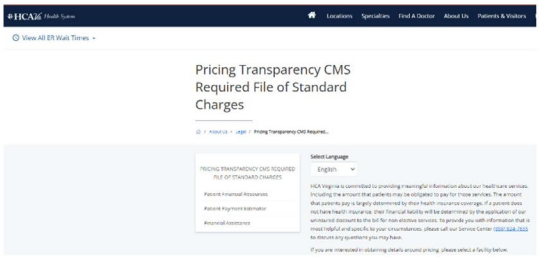
PATIENT RIGHTS ADVOCATE.ORG

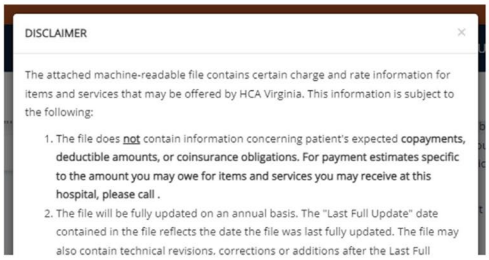
Richmond Community Hospital - Richmond, VA
Checked: 09/02/2022

6









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Chippenham Medical Center - Richmond, VA
Checked: 09/06/2022

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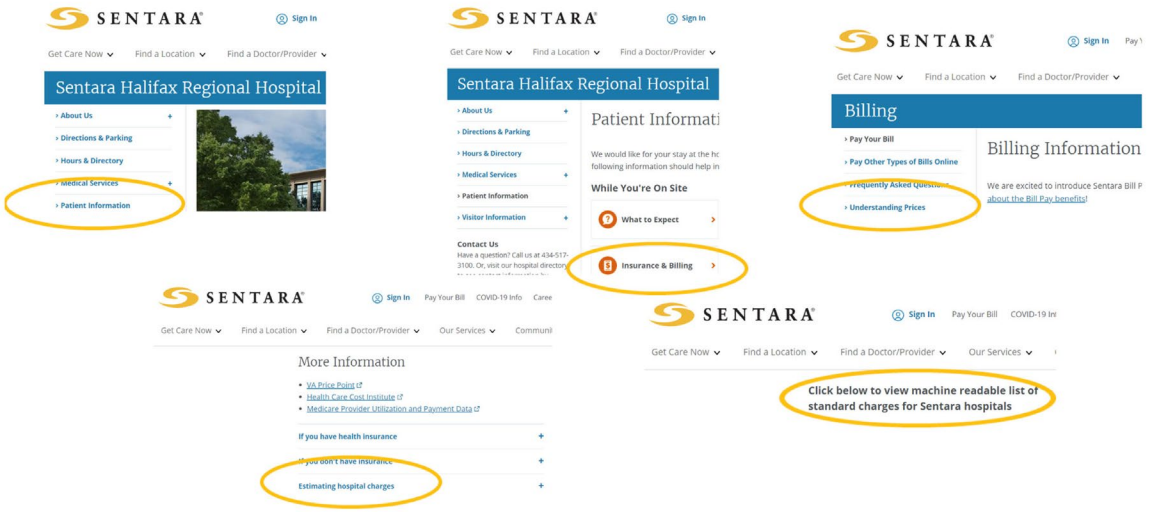

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Checked: 9/06/2022

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Patient Pricing Information

Bon Secours is happy to provide information on anticipated charges for services most frequently provided at our hospital facilities. Using the links below, you can visit your individual hospital facility to learn more about common charges.

Last Updated 1/1/2022

Richmond Community Hospital - Richmond, VA
Checked: 09/06/2022

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PATIENTRIGHTSADVOCATE.ORG AND POWER TO THE PATIENTS (JOINT COMMENT)

September 28, 2022

Mr. John Littel, Secretary, Health and Human Services
Mr. James Williams, Deputy Secretary, Health and Human Resources
Ms. Kimberly Beazley, Director, Office of Licensure and Certification
Ms. Ruthanne Risser, Deputy Director, Office of Licensure and Certification
Ms. Rebekah E. Allen, Senior Policy Analyst, Office of Licensure and Certification
Virginia Department of Health
1111 East Broad Street
Richmond, VA 23219

RE: Implementation Recommendations for Chapter 297 (2022 Acts of Assembly)

Dear Secretary Littel, Deputy Secretary Williams, Ms. Beazley, Ms. Risser, and Ms. Allen:

As you look for ways to best implement the state hospital price transparency law for the Commonwealth of Virginia (Chapter 297 — 2022 Acts of Assembly), we appreciate the opportunity to offer our insights and recommendations. We are writing here to represent two national nonprofit advocacy groups, PatientRightsAdvocate.org and Power to the Patients. Our organizations are joined in our commitment to ensuring that all Americans realize their right to know the price of their healthcare up front, that they have clear unfettered access to actual prices, and that by having this information they will be empowered to shop and compare prices to find the most affordable care, ultimately lowering the costs of care and coverage.

This access to accurate, upfront hospital prices is essential for the physical and financial wellbeing of all Virginians, and it is on track to be realized, thanks to the state hospital price transparency law set to take effect next July. However, it will not successfully happen without your thoughtful, diligent implementation, and fortification of this important statute.

As you move forward to recommend ways to implement, apply and fortify this statute, we encourage you to include the following regulatory provisions:

- Require hospitals to upload data to a government server so it is available from a central repository.
- Require hospitals to submit to the Department of Health the URL where their required data resides.
- Require the chief officer responsible for the hospital's pricing data, such as the CEO or CFO, to provide an attestation of truth and accuracy along with the data submitted.
- Authorize the state to aggregate hospitals' data to make it available through a government website.
- Prohibit any interference or limitation to access of online pricing data, including but not limited to pop-up disclaimers or CAPTCHA.
- Establish uniform data standards, so all hospital pricing data follows a consistent format across hospitals.
- Use existing licensure authority to set up an enforcement framework to ensure compliance.

As a nation divided on many issues, we can all agree that preying on anyone who is sick and injured for excessive financial gain is shameful. However, that's business as usual for many hospitals across America. Virginia is no exception. For instance, in one five-year span, Mary Washington Hospital, in Fredericksburg, sued over 20,000 patients for unpaid bills – in a town of only 28,000 residents. The hospital also put liens on patients' houses and garnished their wages when they lacked the ability to pay bills they could not have foreseen. Mary Washington Hospital did this to one of its own employees, a single mom named Wanda.

Perhaps you read the two *New York Times* stories that came out last week, bringing more hospital injustices to light. One story called out Providence Health System, one of the country's biggest nonprofit health systems, for hounding patients who, based on state law, were financially eligible for free charitable care to pay their hospital bills.

A second story outed Bon Secours, another large nonprofit health system with many hospitals in Virginia, for using an under-resourced hospital in a poor black community in Richmond to basically launder money. Bon Secours exploited a federal program allowing the hospital to buy drugs at a greatly reduced price and sell them for full price, *up to eight times more*. Rather than direct those profits to benefit their underserved patients as intended, the health system pocketed the substantial gains. Even worse, our most recent Hospital Price Transparency Compliance Report found that none of 33 Bon Secours' hospitals reviewed were in compliance with the federal price transparency rule.

These abuses of our most vulnerable citizens must stop. How you implement Chapter 297 (2022 Acts of Assembly) will make a difference. This statute, if effectively implemented and enforced, will empower patients to know prices before they get care, and before they get a surprise bill they could not foresee let alone afford. By introducing price competition, it will drive the down the cost of care, which would also reduce the price of coverage. Lower costs of care and coverage will open the way for greater access to care, and lessen the inequities. Once prices are revealed, hospitals will no longer be able to keep patients in the dark creating a perfect breeding ground for price gouging, and for the extreme price variations that commonly exist within and among hospitals.

Once prices are accessible, predatory hospital behaviors will stop. Patients will be able to see that a C-section could cost $6,000 or $60,000 at the same hospital depending on their plan. Virginians would also know that if they got a colonoscopy from Dr. Keith Berger, a gastroenterologist in Virginia Beach, the price would be $775 if they went to his independent clinic or $4,000 if he performed the same procedure, using identical equipment, across the street at the hospital. That wouldn't be the case for long once price competition exposes these differences and creates a functional market, where health-care purchasers buy care based on price, quality and value.

Done right and done well, this law will make sure that all Virginia hospitals obey the federal hospital price transparency rule, and not twenty percent, as our most recent compliance report found when it assessed 45 Virginia hospitals. Fortunately, thanks to bold legislation from Virginia lawmakers, that's about to change.

Finally, enforcement works. We encourage Virginia to make this law meaningful by asserting its authority to enforce compliance. When the federal government finally fined the first two of thousands of noncompliant hospitals, hitting two Atlanta hospitals with a total of over $1 million in penalties, the hospitals not only quickly fell into compliance, but they also posted files that are exemplary models of what transparent prices should look like. It can be done.

Thank you for working to improve the physical and financial health of all Virginians, and for taking a pioneering role in what will be a transformative change in the great Commonwealth of Virginia, and beyond.

Sincerely,

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Founder and Chairman
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Marni J. Carey
President
Power to the Patients
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VERSAN CONSULTING

Comments from Christin Deacon, Esq., *Principal and Founder of VerSan Consulting, Former Assistant Director of Health Benefits, Department of Treasury, State of New Jersey, Special Assistant Counsel to Governor Chris Christie, and Deputy Attorney General, State of New Jersey*

As the former chief administrators for the State and School Health Benefits Programs for over 800,000 public sector workers in New Jersey, I have a unique perspective on the role that the hospital transparency can have to positively impact public sector workers and taxpayers in Virginia. While Virginia is slightly better than NJ's 15% compliance with approximately 20% or 1 in 5 hospitals currently compliant with federal law, this willful non-compliance is harmful not only to the individual consumer, but VA taxpayers that fund public sector worker healthcare costs. COVA currently spends approximately $1.4 Billion on the State Health Plan, covering about 100k lives (as of 2021), with the employer/state funding approximately 86% of the total costs. COVA experienced a $49M loss in 2021, after gains ranging from $40M to $130M for the prior four years.*

The most recent Rand study shows that Virginia ranks 16th in hospital spending (1 being the most expensive), with an average commercial paid amount of 279% of CMS as a relative price index. Note that relatively efficient hospitals should be able to break even at around 100% to 115% of Medicare rates, give or take. Your state health plans pay commercial rates, and so this should be of great concern to members of this body, the legislature, and taxpayers.

Hospital Transparency Data, if available, would enable the State and local governments, as purchasers of healthcare for its public sector employees, to know the prices that they are paying, evaluate them for reasonableness, and ensure that the billions of dollars that are being spent through third party administrator contracts are indeed paying the contracted price. For example, the State plan's primary carrier is Anthem Blue Cross Blue Shield and the prices for all Anthem negotiated rates at the hospitals your state employees frequent should be publicly available to you. This would not only enable your OPM to actually engage in contract oversight and compliance, but it might present opportunities to direct contract with your hospitals and other provider systems that would no doubt lead to substantial savings – 5,10, 15 and in some case 30+ percent in savings have been realized by negotiating directly with hospital systems for contracted rates.

While consumers certainly have a legal right and interest in hospital transparency data, the State as a purchaser has both the legal obligation and opportunity to leverage this data for the benefit of the taxpayers – who are the ultimate consumers of healthcare. Do not let the hospitals tell you that consumers will not use this information, or that it is without utility because of the complexity. The State is a sophisticated purchaser and has a vested interest in knowing the price it pays. As a steward of taxpayer dollars and trusted partner to its public sector employees as the provider of this important benefit, the State has a legal and moral imperative to ensure that the hospitals that are operating within its borders are not flouting their legal and ethical obligations.

Sincerest Regards,

Chris E. Deacon

*COVA Health Benefits Annual Report 2021

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

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SENT VIA EMAIL (Rebekah.allen@vdh.virginia.gov)

September 28, 2022

Ms. Rebekah E. Allen, J.D.
Senior Policy Analyst
Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

RE: **Comment on Recommendations of Chapter 297 (2022 Acts of Assembly) Study/Hospital Price Transparency**

Dear Ms. Allen,

On behalf of the Virginia Hospital & Healthcare Association (VHHA), please accept these comments submitted in response to the recommendations introduced following the September 7, 2022, meeting of the Chapter 297 (2022 Acts of Assembly) Study workgroup on hospital price transparency (the "Workgroup"). As explained more fully below, VHHA is generally supportive of the first two recommendations, partially agrees with the third recommendation, and disagrees with the fourth and fifth recommendations.

Recommendation 1: Virginia should adopt the federal minimums for machine-readable files found in 45 C.F.R. § 180.50.

As reflected in the minutes from the September 7, 2022, meeting of the Workgroup, VHHA supports adopting recommendations that align with the federal requirements. This is consistent with the text of the statute: "[e]very hospital shall make available to the public on its website a machine-readable file containing a list of all standard charges for all items and services provided by the hospital *in accordance with* 45 C.F.R. § 180.50, as amended. As used in this subsection, 'hospital,' 'items and services,' 'machine-readable,' and 'standard charge' *have the same meaning as set forth in* 45 C.F.R. § 180.20." This establishes that for purposes of Virginia Code § 32.1-137.05.A, if a hospital is compliant with the minimum federal requirements at 45 C.F.R. § 180.50, then it is compliant with state law. This should not be interpreted to authorize Virginia Department of Health (VDH) to establish additional requirements that are not included in the minimum federal requirements at 45 C.F.R. § 180.50.

Any VDH interpretation of what constitutes federal minimum requirements should conform to Centers for Medicare & Medicaid Services' (CMS) interpretation, including federal law and corresponding regulations, and should be informed by applicable CMS guidance, including CMS Hospital Price Transparency Frequently Asked Questions (FAQs), as may be updated from time to time.[1]

[1] *See* https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf.

Recommendation 2: Links to each hospital's webpage for the machine-readable file should be provided by Virginia Health Information (VHI) on each hospital's already-existing VHI webpage.

VHHA supports this recommendation as this information is already publicly available. As we indicated in the September 7, 2022, meeting of the Workgroup, VHHA has already taken steps to ensure that the public has access to this information in a central location. The VHHA website includes a webpage that provides Hospital Price Transparency Links and Financial Assistance Policies for all Virginia hospitals. The webpage allows the user to filter the links by region and by health system. The link for each hospital also provides a drop-down list of links for the Financial Assistance Link, Machine Readable File Link, and Price Estimator Tool Link. This webpage replaced VHHA's PricePoint website that was operated from 2006 through 2022, providing charge information and comparison tools for all Virginia hospitals. These voluntary efforts demonstrate our ongoing commitment to transparency and enhancing public understanding of the health care delivery system in Virginia.

Recommendation 3: The Centers for Medicare and Medicaid Services and the Virginia Department of Health (VDH) should be responsible for compliance monitoring, and VDH should publish information about noncompliance on its website.

VHHA partially supports this recommendation. VHHA agrees that CMS and VDH should be responsible for compliance monitoring. Consistent with our comments in response to Recommendation 1, any VDH interpretation of what constitutes federal minimum requirements should conform to CMS's interpretation, including federal law and corresponding regulations, and should be informed by applicable CMS guidance.

As it relates to publishing information about noncompliance, any complaint, finding of non-compliance, orders for plan of correction, or other compliance and enforcement activity by VDH should be processed and managed by VDH in the same manner as compliance and enforcement activity conducted for any other VDH requirement for licensure of hospitals under the hospital licensure code at Chapter 5, Article 1 of the Code of Virginia and corresponding regulations at Title 12, Agency 5, Chapter 410, Parts I through III of the Virginia Administrative Code regarding hospital licensure and inspection. We do not agree that VDH should publish information about noncompliance with the hospital price transparency requirements at 45 C.F.R. § 180.50 or Virginia Code § 32.1-137.05.A on its website. VDH does not publish on its websites any information about noncompliance by a hospital with any requirement for licensure of hospitals under the hospital licensure code, or any complaints for noncompliance. Possible non-compliance with 45 C.F.R. § 180.50 or Virginia Code § 32.1-137.05 should not be treated any differently.

Recommendation 4: Outpatient surgical hospitals should be subject to Virginia's hospital price transparency requirements.

VHHA does not support this recommendation. In the September 7, 2022, meeting of the Workgroup, VDH presented information on the definition of "hospital" found at Virginia Code § 32.1-123 which means "any facility licensed pursuant to [Article I of Chapter 5 of Title 32.1] in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or non-surgical, for two or more nonrelated individuals including hospitals known by varying nomenclature or designation such as . . . *outpatient surgical*, . . . *hospitals*." VDH also

presented information on the definition of "hospital" for purposes of 45 C.F.R. § 180.50, which "means an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing."[2]

Given these definitions, we understand the logic of how VDH has arrived at its conclusion that an outpatient surgical hospital is considered a hospital for purposes of Virginia law, but we do not agree with the conclusion that an outpatient surgical hospital should therefore be regarded as a "hospital" for purposes of 45 C.F.R. § 180.50. The Final Rule for Price Transparency Requirements for Hospitals to Make Standard Charges Public (the "Final Rule")[3] includes a number of statements that, when read in context, indicate that outpatient surgical hospitals should not be subject to the minimum federal requirements at 45 C.F.R. § 180.50.

A common definition of "hospital" used by CMS is found at § 1861 (e) of the Social Security Act (42 U.S.C. 1395x (e)) which means an institution that "is primarily engaged in providing . . . *to inpatients* (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons . . [and] provides *24-hour nursing service*." This is essentially the definition of what constitutes a hospital for purposes of Medicare participation. It is comparable in nature and scope to a "general hospital" in Virginia hospital licensure regulations, which is defined as "institutions as defined by § 32.1-123 of the Code of Virginia . . . with permanent facilities that include *inpatient* beds."[4]

In the Final Rule, CMS elected to limit the definition of "hospital" to track the licensing requirements at § 1861 (e)(7) to include "an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing." CMS's primary rationale for using this definition is that it applies to "all Medicare-enrolled hospitals" as well as institutions that "might not be considered hospitals for purposes of Medicare participation" (*i.e.*, because it did not want to limit the definition of hospital covered by the hospital price transparency requirements to only those that participate in Medicare).[5]

Consistent with this rationale, CMS goes on to state that "our proposed definition includes each institution that satisfies the definition, regardless of whether that institution is enrolled in Medicare or, if enrolled, regardless of how Medicare designates the institution for its purposes. Thus, we noted that the proposed definition includes critical access hospitals (CAHs), inpatient psychiatric facilities (IPFs), sole community hospitals (SCHs), and inpatient rehabilitation facilities (IRFs), which we previously identified in our guidelines as being hospitals."[6] CMS did not reference ambulatory surgical centers (ASCs) or other non-hospital sites of care in the types of institutions that could be included in the definition of "hospital."

[2] 45 C.F.R. § 180.20.
[3] 84 Fed. Reg. 65524 (Nov. 27, 2019).
[4] 12 VAC 5-410-10.
[5] *See* 84 Fed. Reg. 65530 (discussing definition of "hospital).
[6] *Id.*

In fact, CMS expressly stated that "the proposed definition of 'hospital' did not include entities such as ambulatory surgical centers (ASCs) or other non-hospital sites-of-care from which consumers may seek health care items and services."[7] Several commenters suggested that the proposed definition of hospital is too limited, and suggested that CMS expand the definition to include other providers, such as . . . ASCs." In response, CMS stated that "we do not have the authority to apply the price transparency requirements to non-hospital sites of care" and declined the commenters suggestions.[8]

The discussion of ASCs is relevant because in Virginia, operation of an ASC requires an outpatient surgical hospital license. CMS defers to "States' or localities' hospital licensing standards for the determination of whether an entity falls within the definition of hospital" for purposes of the law and declined to provide an exhaustive list of institution types encompassed within State or locality hospital licensing laws. It also speculates that "healthcare providers such as ASCs . . . would not likely satisfy our specified definition of 'hospital' since they are not likely to be licensed by a State or locality as a hospital."

All of these statements combined lead to the conclusion that CMS did not intend to include ASCs in the definition of hospital for purposes of 45 C.F.R. § 180.50. If it did, it could have specifically included ASCs in the definition of hospital, but it did not. Any suggestion that an outpatient surgical hospital should be included in the definition of hospital for purposes of 45 C.F.R. § 180.50 and subject to the federal minimums for machine-readable files would be inconsistent with CMS's own statements and inconsistent with application of the law in other states.

Ultimately, any determination of whether an outpatient surgical hospital is a hospital for purposes of 45 C.F.R. § 180.50 is a matter of interpretation for CMS. As stated in our comments on Recommendation 1, VDH interpretation must conform with CMS interpretation. Accordingly, if an outpatient surgical hospital that is an ASC is not required by CMS to comply with 45 C.F.R. § 180.50, then VDH cannot require it to comply with Virginia Code § 32.1-137.05.A.

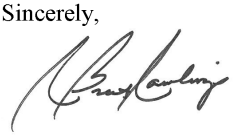
Recommendation 5: VDH and VHI should compile a list of all currently licensed outpatient surgical hospitals and conduct outreach to each facility in advance of July 1, 2023 (no later than March 30, 2023) to inform the outpatient surgical hospitals of the applicability of Chapter 297 (2022 Acts of Assembly) top their facility.

As stated in response to Recommendation 4, we do not believe that 45 C.F.R. § 180.50 and Virginia Code § 32.1-137.05.A are applicable to outpatient surgical hospitals.

[7] *See* 84 Fed. Reg. 65531.
[8] *Id.*

Thank you for your consideration of these comments. Please let us know if we can provide you with any further information on this matter.

Sincerely,



R. Brent Rawlings
Senior Vice President and General Counsel

cc: Mr. James H. Williams, Deputy Secretary of Health and Human Resources
Ms. Julie M. Dime, Vice President of Government Affairs

APPENDIX F – STUDY CONTRIBUTORS' WRITTEN COMMENTS ON POTENTIAL RECOMMENDATIONS

Study contributors were offered the opportunity to provide feedback and suggestions on the potential recommendations after the September 30, 2022 meeting.

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FIRELIGHT HEALTH

October 18, 2022

Rebekah E. Allen, JD
Senior Policy Analyst
Office of the Secretary of Health and Human Resources
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233

RE: Hospital Price Transparency - Supplemental Comments to the September 30, 2022 meeting regarding implementation of Chapter 297 (2022 Acts of Assembly).

Hello Rebekah --

My thanks to you, the Secretary, and Deputy Secretary Williams for the opportunity to have participated in the September 30 meeting relating to Virginia's implementation of hospital price transparency [Chapter 297 (2022 Acts of Assembly)].

During the meeting, Deputy Secretary Williams invited me to submit written comments on the specific issue of widespread omission of prices in many hospital files due to overuse of the notation of 'N/A' (or blank space) in price data fields. The order of magnitude at which I see this issue involves the many hospital downloadable machine-readable files (MRFs) in which 50% or more of the fields for provider-specific negotiated rates contain 'N/A's or blanks, often numbering in the tens of thousands within a single hospital's file.

It's an issue that was observed in a technical experts panel on which I served for the MITRE corporation (convened as part of that organization's contract with CMS). It was also discussed in detail as part of my participation in preparing a bid (ultimately not successful) for a CMS contract to assist the agency in enforcement of the rule.

The bottom line is that CMS' current guidance is too permissive in permitting use of 'N/A's in place of actual prices, and Virginia should improve on this -- and as a result better serve its citizens -- in the area of hospital price transparency.

The current FAQ from CMS (https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf) on pages 8 and 9 contains CMS' advice on the use of 'N/A' notations in

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MRFs. The FAQ essentially suggests that if a hospital has any variability in its price for a given service (e.g. due to use of an 'algorithm' to determine the price), then the hospital may enter 'N/A' in the price field.

It has become all too easy for a hospital to introduce a small amount of variability in its prices and then insert 'N/A's into large portions of its price fields, resulting in a functionally useless file.

To ensure the disclosure of actual, dollar-denominated prices from Virginia hospitals (rather than 'N/A's), I recommend that the Secretary consider the following in order to avoid the ambiguity and risk of manipulation that is inherent in the current CMS FAQ:

1. **'Not Provided' or 'Not Available.'** To make clear when a hospital is not reporting a price for an available item or service from instances where prices are not reported due to services genuinely not provided at the hospital, MRF's should be required to use the notation of 'N/P' for any item or service that is *not provided* at the hospital, and the notation of 'N/A' in the rare cases where a price is truly *not available* for an item or service provided by the hospital. (The latter is expected to be quite rare because if a hospital provides an item or service, one can be certain that somewhere, somehow, it puts a price on it and bills for it.)

2. **No Formulas or Algorithms**. MRFs should contain dollar-denominated numerical prices regardless of whether they are available directly OR indirectly as the result of calculations or algorithms, that the hospital must perform, in order to provide the resulting numerical dollar-amount price value. Particularly in cases where executing an algorithm requires reference to an external schedule or data source (e.g. a worker's compensation schedule, Medicare or Medicaid schedules or any other external data source), it must be incumbent on the hospital to identify the corresponding data in the schedule, execute the hospital's algorithm, and display the resulting price. As an actual example, reporting a price as a "percent of Medicare" should not be permitted. The amounts paid by Medicare to any given hospital may technically be publicly determinable, but recreating each hospital's unique Medicare fee structure -- with Medicare's payment adjustments for academic programs, training, rural, CAH status, local labor costs, and other items -- is not an appropriate burden to place on MRF users. Each hospital is far more efficiently positioned to determine what charges it expects from each payer than any file user could ever be.

3. **Variations in Price**. Where no single numerical value results from an algorithm, then the set of variations should be provided. E.g. if a price depends on any of five degrees of medical severity, then the price for each level of severity should be calculated and provided in the MRF. Other instances of variability are caused by outlier and 'greater of' provisions in payer contracts. Footnotes or explanations in the hospital's file will likely be needed and should be required.

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4. **Most Common Price**. The Secretary may consider an alternative to recommendation #3 above, if variations-in-price rules prove to be problematic (and from my conversations with hospital executives, this will likely be a key battlefield issue). One alternative is to adopt a 'most common price' rule: in instances of overly complex contractual pricing provisions, for which hospitals may insist there is no way to render a 'standard charge', the required displayed charge could be mandated to be the price expected for what the hospital anticipates will be the most common instance of the item or service billed to the relevant payer and plan during the annual reporting period for the MRF. It is likely that hospitals will determine this price based on recent past billing data for the item plus a reasonably anticipated increase.

5. **Bundles and Packages**. Finally, if a hospital asserts that there is no standard charge for an item because it's part of a bundle or package, then the hospital should be required to describe the applicable bundled components and identify the total bundle price.

In summary, the Commonwealth will benefit greatly if its implementation can codify that: (1) 'N/P' must be used if the hospital *does not provide* the item or service, and 'N/A' is reserved for the rare instance of a complete absence of a standard charge; (2) 'standard charges' means the display of dollar-denominated prices regardless of how they are determined or calculated -- whether by amounts on a fee schedule or the hospital's use of algorithms or any other method; and (3) that where the hospital has more than one price for an item, it must display the prices and add a footnote to describe differences, conditions or scenarios that account for each of the prices.

Considering the potential future evolution of hospital MRF's, I believe the issue of variable pricing will be the most significant determinant of the overall success or failure of hospital pricing transparency.

Thank you again for your efforts and dedication to this critical set of healthcare regulations. I am happy to be available for comments, discussion or examples that might be helpful to your process in issuing regulations for this fundamentally transformative aspect of Virginia's healthcare system.

Kind regards,
Jim Jusko
/electronic signature, hand-signed original available upon request/

James A. Jusko, JD
Founder & CEO
FireLight Health

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October 12, 2022

Mr. James Williams, Deputy Secretary, Health and Human Resources
Ms. Kimberly Beazley, Director, Office of Licensure and Certification
Ms. Ruthanne Risser, Deputy Director, Office of Licensure and Certification
Ms. Rebekah E. Allen, Senior Policy Analyst, Office of Licensure and Certification
Virginia Department of Health
109 Governor Street
Richmond, Virginia 23219

RE: Follow-up Comments to Chapter 297 (2022 Acts of Assembly) Workgroup Meeting

Dear Deputy Secretary Williams, Ms. Beazley, Ms. Risser, and Ms. Allen:

We appreciate the time and thoughtful effort you have put toward implementing and refining Virginia's new hospital price transparency law. Thank you for the opportunity to work with you on this important effort. As a result of your diligence, Virginians will soon enjoy the benefits that come with a functional, competitive healthcare market, which will usher in lower prices and greater access to care.

The 19 potential recommendations we discussed in the Workgroup meeting September 30 provide an excellent foundation for the law. PatientRightsAdvocate.org supports all but one of the recommendations. Below for your consideration we have listed our comments that we believe will make certain recommendations more effective. For those recommendations that we suggest strengthening, we offer below, by number, our suggestions:

#2 Links to each hospital's webpage for the machine-readable file should be provided by Virginia Health Information (VHI) on each hospital's already-existing VHI webpage.

PatientRightsAdvocate.org Comment: We suggest that both the VHI and Virginia Department of Health (VDH) websites host a webpage that lists:

- each Virginia hospital by name
- a link to each hospital's standard charges files, and
- the date the files were last updated.

#3 The Centers for Medicare and Medicaid Services and the Virginia Department of Health (VDH) should be responsible for compliance monitoring, and VDH should publish information about noncompliance on its website.

PatientRightsAdvocate.org Comment: To fortify compliance and assure accountability, we encourage you to require hospital CEOs or CFOs to attest to the accuracy and quality of the data at least annually. Such attestations are critical to ensure that hospitals take seriously their obligation to submit accurate, complete data, or face the consequences of lying to the government.

For example, Texas Senate Bill 1137 requires an executive from hospital management to submit a form of attestation verifying the accuracy of the pricing files. If the files contain extensive errors or omissions, the executive could then be accused of fraud. Similarly, hospital executives must submit an attestation to the Centers of Medicare & Medicaid Services (CMS) when filing their Medicare Cost Reports.

#4 Outpatient surgical hospitals should be subject to Virginia's hospital price transparency requirements.

PatientRightsAdvocate.org Comment: To enable a functional, competitive marketplace systemwide in healthcare, we suggest you subject all facilities, including outpatient surgical hospitals, to the price transparency requirements.

#5 VDH and VHI should compile a list of all currently licensed outpatient surgical hospitals and conduct outreach to each facility in advance of July 1, 2023 (no later than March 30, 2023) to inform the outpatient surgical hospitals of the applicability of Chapter 297 (2022 Acts of Assembly) to their facility.

PatientRightsAdvocate.org Comment: We suggest this communication be made sooner, so that outpatient surgical hospitals' (OSH) compliance can be concurrent with that of inpatient hospitals. (See #16.)

#6 Hospitals should be required to show prices in U.S. Dollars. *This is now a unanimous recommendation.*

PatientRightsAdvocate.org Comment: Although now a unanimous recommendation, we strongly support the requirement that all prices be posted in U.S. dollars. This clarification would eliminate the confusing use of percentages and formulas, and the overuse of N/As or blank fields, all of which obfuscate true prices.

To this point, as VDH refines its implementation guidelines regarding pricing, we would further request that the department curtail the abuse of N/As in the machine-readable files, where actual dollar prices belong. Currently, hospitals are taking advantage of an exception CMS allows in its Frequently Asked Questions (FAQ's), which state that if a hospital has any pricing variability for a given service, then it may record an N/A in the price field. As a result, hospitals have exploited what should be a rare exception, and have filled more than 50% of the pricing fields in the standard charges files with N/As, making the files useless and the price transparency effort futile.

As such, we respectfully suggest VDH strengthen its requirements with the following changes:

- If a hospital legitimately cannot provide a price because it does not provide a specific service, it may enter N/P in the pricing field to represent that the service is "not provided."
- If variations in price for a particular service exist due to levels of complexity, often described by levels one through five, then a hospital may list prices for each level. If needed, the hospital may add footnotes for different scenarios, but it may not default to N/A when a price is available. If a hospital can bill for a service, the price is available, making the use of N/A extremely rare.
- If a hospital claims that no price exists because a service is "bundled," then the hospital must post the bundled price as well as individual prices for each component of the deconstructed bundle.

#7 "Items and services" should include medication that the hospital customarily provides as part of, or in conjunction with, a service.

PatientRightsAdvocate.org Comment: National Drug Codes for medications are already required to be included in hospitals' Standard Charges Files (SCF), per the federal price transparency rule. On page 133 of the federal requirement, language mandates that the SCF must include: "Any code used by the hospital

for purposes of accounting or billing for the item or service, including, but not limited to, the CPT code, HCPCS code, DRG, NDC, or other common payer identifier. Revenue code, as applicable." See Exhibit 1 below for the full text of the federal rule.

#8 VHI should publish instructions on its website on how a consumer/patient can view the contents of the machine-readable file, including recommended free software to open the file.

PatientRightsAdvocate.org Comment: If software is not available to convert machine-readable JSON files, we suggest requiring hospitals to post prices in an accessible format, such as .xls or csv files, which are both machine-readable and user-friendly.

#10 VDH should have sufficient resources to monitor compliance.

PatientRightsAdvocate.org Comment: We suggest that VDH hire additional staff positions to conduct enforcement and compliance activities, potentially funded by penalty monies received.

#11 If VDH determines that a hospital is noncompliant with any Virginia Hospital Price Transparency Requirement, VDH should provide notice to the hospital of the alleged noncompliance and publish determinations of noncompliance.

PatientRightsAdvocate.org Comment: We suggest the VDH and WHI make public all noncompliance information and post it on their websites, including:

- the form of material noncompliance,
- the corrective action plan imposed, and
- the timeline in which the hospital must comply.

#12 If VDH determined that a hospital is noncompliant with any Virginia hospital price transparency requirement after pricing notice, VDH should require the hospital to submit an acceptable plan of correction.

PatientRightsAdvocate.org Comment: We suggest implementing strict timelines and enforcement, and that the Corrective Action Plans (CAPs) be made public on the VDH and VHI websites.

#13 If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and the hospital fails to submit an acceptable plan of correction, the State Health Commissioner should have the authority to impose monetary penalties on a hospital in amounts commensurate with federal civil monetary penalties.

PatientRightsAdvocate.org Comment: The issuing of monetary penalties without delay or equivocation is vital to the success of this law. Enforcement at the federal level, though minimal, has proven to work: When CMS fined two hospitals in Georgia for noncompliance, those hospitals not only quickly came into compliance, but they also now have posted files that are shining models of what standard charge files should look like. We suggest that fines be implemented both when hospitals fail to submit an acceptable plan of correction within the specified time frame, or when the hospital fails to follow through on its submitted plan on time.

We further recommend that the health department create a public service campaign to inform and educate consumers of their rights to know prices at both outpatient and inpatient hospitals. VDH can apply the penalty monies it collects toward boosting this awareness campaigns, which could aim to inform hospitals of their legal obligation as well. We are willing to work with the department to help create this outreach.

#14 The State Health Commissioner should have the authority to place a hospital's license on probation if it fails to comply with any Virginia hospital price transparency requirement.

PatientRightsAdvocate.org Comment: The Virginia State Health Commissioner has authority over hospital licensure and a statutory duty to review Virginia hospital compliance along with numerous other statues and regulations.

#16 VDH should not assess compliance of outpatient surgical hospitals with the Virginia hospital price transparency until January 1, 2024.

PatientRightsAdvocate.org Comment: **We do not concur with this recommendation**. We recommend that VDH require Outpatient Surgical Hospitals (OSH's) to conform with Virginia law by the same date that inpatient hospitals must comply: July 1, 2023. We suggest that the VDH notify OSH's without delay that they are indeed considered "hospitals" by definition, and so will be expected to comply with the state law when it takes effect. Not doing so will undermine and delay the spirit of this law which is to make sure all Virginians have ready access to all hospital prices, of which outpatient surgeries is a considerable component. Virginia will not realize the benefits of a competitive healthcare market until all hospitals are actively complying.

#18 Hospitals should be required to provide a link to the webpage where their machine-readable files are located as part of their annual filings to VHI.

PatientRightsAdvocate.org Comment: All Virginia hospitals including outpatient surgical hospitals should submit their machine-readable files as a part of their annual filings with along with attestations verifying the accuracy of the files. Virginia hospitals should also submit their machine-readable files to the State Health Commissioner.

#19 Based on the recently enacted law in Colorado:

a. There should be a prohibition that prevents a hospital that is not in material compliance with Virginia hospital price transparency requirements from initiating or pursuing a collection against a patient or patient guarantor for a debt owed for the items or services;
b. There should be a private right of action for a patient to file suit against a hospital that the patient believes was not in material compliance with Virginia hospital price transparency requirements and that has taken a collection action against that patient or their guarantor;
c. There should be a prohibition that prevents a hospital from taking a collection action against the patient or patient guarantor while a lawsuit under 19(b) is pending; and
d. If a hospital is found by a judge or jury to be materially out of compliance with Virginia hospital price transparency requirements, the hospital should:
i. Refund the payer any amount of the debt the payer paid;
ii. Pay a penalty to the patient or patient guarantor equal to the total amount off the debt;
iii. Dismiss or cause to be dismissed with prejudice any collection action and pay any attorney fees and costs to the patient or patient guarantor; and
iv. Remove or cause to be removed from the patient's or patient guarantor's credit report any report made by the hospital related to the debt.

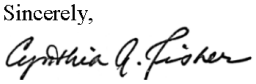
PatientRightsAdvocate.org Comment: We suggest that Virginia follow suit with all aspects of the Colorado law to ensure that patients have recourse when they are not able to price shop and, as a result, get hit with a bill they could not see coming. This change is critically important because the No Surprises Act only allows patients to get an estimate of the price three days prior to a scheduled procedure, a

timeframe which does not allow patients to shop for the best quality of care at the lowest price. An estimate is not a real price and offers no price certainty or guarantee.

Thank you again for this opportunity, and for your careful consideration of this important law and its successful implementation. Congratulations on taking a pioneering role on an initiative that stands to transform and heal our broken health system – not just in Virginia, but nationwide.

Please feel free to contact me if our organization can be of further help.

Sincerely,



Cynthia A. Fisher
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Exhibit 1
Excerpt from the Federal Hospital Price Transparency Rule

services include the following corresponding information, as applicable, for each item and service:

- Description of each item or service (including both individual items and services and service packages).
- The corresponding gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- The corresponding payer-specific negotiated charge that applies to each item or service (including charges for both individual items and services as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each list of payer-specific charges must be clearly associated with the name of the third party payer.
- Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the CPT code, HCPCS code, DRG, NDC, or other common payer identifier.
- Revenue code, as applicable.

We proposed to codify these requirements at proposed new 45 CFR 180.50(b). We stated that we believe that these elements would be necessary to ensure that the public would be able to compare standard charges for the same or similar items and services provided by different hospitals.

We proposed that hospitals associate each standard charge with a CPT or HCPCS code, DRG, NDC, or other common payer identifier, as applicable, because hospitals uniformly understand them and commonly use them for billing items and services

POWER TO THE PATIENTS

October 12, 2022

Mr. James Williams, Deputy Secretary, Health and Human Resources
Ms. Kimberly Beazley, Director, Office of Licensure and Certification
Ms. Ruthanne Risser, Deputy Director, Office of Licensure and Certification
Ms. Rebekah E. Allen, Senior Policy Analyst, Office of Licensure and Certification
Virginia Department of Health
109 Governor Street
Richmond, Virginia 23219

RE: Follow-up Comments to Chapter 297 (2022 Acts of Assembly) Workgroup Meeting

Dear Deputy Secretary Williams, Ms. Beazley, Ms. Risser, and Ms. Allen:

Thank you for your attentiveness and consideration during the September 30 Workgroup session to discuss implementation recommendations for the Virginia Transparency Law. As stakeholders in strong support of this legislation, we at Power to the Patients are submitting here, as requested, specific comments as they relate to the 19 potential recommendations discussed.

To that end, we are in favor of all the recommendations, and only call out here by number the ones we believe would benefit from further refinement and clarification. Thus, please consider the following:

#3 The Centers for Medicare and Medicaid Services and the Virginia Department of Health should be responsible for compliance monitoring, and VDH should publish information about noncompliance on its website.

Although the Virginia Hospital Association has asked that the Virginia law go no further than CMS's efforts, in fact the Commonwealth must strengthen those anemic efforts with stronger interpretation, implementation and enforcement.

We agree that VDH must publicly name on the VHD website the hospitals that are not complying. Further, we believe that compliance will be easier to monitor if all hospitals are required to use a standard VHD-issued template.

As we assess hospital compliance with the federal rule, we have seen that hospitals that are posting prices are using an array of display methods. This lack of uniformity among hospitals presents a new learning curve each time consumers search for prices at a different facility, reinforcing the obfuscation hospitals appear to be employing to keep prices hidden.

By issuing a standard template that all hospitals are required to use when posting their standard charge files, VDH will streamline and simplify the process for consumers trying to shop and compare prices, while making the job of monitoring compliance far easier. Please see the PDF of an exemplary file at the end of this letter to use as a model for a standard template.

#5 VDH and VHI should compile a list of all currently licensed outpatient surgical hospitals and conduct outreach to each facility in advance of July 1, 2023 (no later than March 30, 2023) to inform the outpatient surgical hospitals of the applicability of Chapter 297 (2022 Acts of Assembly) to their facility.

We concur, and recommend that this outreach happen sooner than March 30, 2023, perhaps before the end of this year. This would give OSHs time to comply when inpatient hospitals must comply. (See comment under item #16.) Concurrent compliance would help consumers navigate the new law, as many don't differentiate between inpatient and outpatient care, and won't understand why some hospital prices are available and others are not.

Moreover, bringing outpatient surgical prices into the light sooner has another longer reaching effect. The sooner outpatient surgical centers, including freestanding independent centers, comply the better for all Virginians. Here's why: Independent doctors have long wanted to post their prices, which are universally far lower than their hospital-employed counterparts. However, they fear retaliation from the hospitals. If they cause hospitals to lose business based on price, the hospitals could cancel their privileges at the hospitals. It's well known that hospitals favor their employed physicians, and independent doctors who need hospital privileges must treat with caution.

For example, Dr. Keith Berger, a gastroenterologist in Virginia Beach, performs colonoscopies in his private clinic for $795. At the hospital across the street, he performs the same procedure using identical equipment, and the hospital charges $4,000. Transparency will reveal, and competition will erase, these inequities. Once hospital-owned and freestanding outpatient clinics are required to post prices, independent doctors and clinics will be better insulated against retaliation. Patients will be able to see the value in choosing the lower cost independent provider, which will slow the insidious and detrimental trend of hospital-physician consolidation.

#6 Hospitals should be required to show prices in U.S. Dollars. ***This is now a unanimous recommendation.***

We are pleased to see that this is now a unanimous recommendation. Dollars is clearly the only unit that makes sense for consumers seeking to know prices. N/A is not a price. A percentage is not a price. A formula is not a price. A blank space is not a price.

#7 "Items and services" should include medication that the hospital customarily provides as part of, or in conjunction with, a service.

Since the law's objective is to put in place necessary patient protections, then Virginia must absolutely assure that medications that would ordinarily be part of a treatment or procedure be included in total prices. Such medications would include, but not be limited to, any and all anesthesia provided.

If medication prices are not included, hospitals looking to recoup what they will lose through price transparency will likely look to inflate the prices of any non-protected revenue streams. Pharmaceutical charges would be ripe for price extorsion. We only have to look at the infamous example of Martin Shkreli who took the price of Daraprim, a life-saving drug for immune compromised patients, such as those with HIV or certain cancers, from $13.50 to $750 per tablet overnight. We've also seen Doxycycline jump from $20 a bottle to $1,849 a bottle overnight, and tuberculosis drug Cycloserine skyrocket from $17 per pill to $360. We must prevent that.

#8 VHI should publish instructions on its website on how a consumer/patient can view the contents of a machine-readable file, including recommended free software to open the file.

Making user-friendly software available will be crucial to allow health-care consumers to read machine-readable (JSON) files that they would not otherwise be able to access. Without it, visitors would face yet another barrier to finding prices.

#12 If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and after providing notice, VDH should require the hospital to submit an acceptable plan of correction.

We concur, and would like to add that Virginia should add a timeline for when an accepted plan of correction is due, such as 30 days, and include how quickly the hospital must fulfill its plan. Imposing timelines for noncompliant hospitals to become compliant is imperative, otherwise they will have little incentive.

#13 If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and the hospital fails to submit an acceptable plan of correction, the State Health Commissioner should have the authority to impose monetary penalties on a hospital in amounts commensurate with federal civil monetary penalties.

Noncompliant hospitals should also be subject to dual fines. Hospitals that fail to submit a plan of correction, or that fail to follow that plan within the preset timeframe should be fined to the full extent of state law, that is, an amount equal to the federal civil monetary penalties. Further, they should be reported to the U.S. Department of Health and Human Services, and also subjected to federal fines.

Imposing significant monetary fines is crucial to compliance as demonstrated on the federal level. Hospitals nationwide have largely ignored written warnings. However, the only two hospitals that have been fined to date (Northside Hospital Atlanta and Northside Hospital Cherokee) immediately became fully compliant. Additionally, Virginia could apply penalty revenues toward further supporting the price transparency effort through public awareness campaigns.

Notably, while discussing this recommendation, Ms. Julie Diamond submitted that, in lieu of shopping for prices online at a variety of hospitals well in advance of an elective procedure, as is the spirit and intent of the law, allowing patients to be able to get an estimate three days prior to their scheduled procedure should suffice. While this may lull some into believing this passes as price transparency, it falls far short for several reasons: One, the patient only has access to one price, that provided under his or her insurance plan, and so cannot price compare. Two, in order to get an estimate, the procedure must be scheduled, so patients are already locked in. Third, the quoted amount is just an estimate, which may or may not reflect the final price.

#14 The State Health Commissioner should have the authority to place a hospital's license on probation if it fails to comply with any Virginia hospital price transparency requirement.

We concur. If a hospital continues to flout the laws despite financial penalties and public disgrace, then the state must apply additional penalties, including suspending a hospital's license. Otherwise, these abuses will continue at the expense of patients and further a culture where hospitals conceal prices.

#15 VDH should report to the Centers for Medicare and Medicaid Services any hospital that has been subject to enforcement action for failing to meet Virginia hospital price transparency requirements.

Concur, and respectfully add that, as mentioned under recommendation #13, VDH should further suggest that CMS levy additional fines against the noncompliant institution.

#16 VDH should not assess compliance of outpatient surgical hospitals with the Virginia hospital price transparency until January 1, 2024.

We strongly advise against this delay, and recommend that OSHs be required to comply with the law when it takes effect July 1, 2023. This gives the outpatient centers, all of whom will receive ample notice, plenty of time. Hospitals, including outpatient surgical hospitals, demonstrate daily that they know the prices for all their services and procedures because they have no problem producing bills to patients and insurers. Why would we allow them more time to comply?

Outpatient procedures constitute the majority of care. According to CMS, 70 percent of all surgeries in the U.S. occur in outpatient or ambulatory care settings. Every day that Virginia delays compliance is another day more of its residents incur financial harm. If not all done at once, Virginia still would not have a free market economy for healthcare until 2024. For this to work for the people of Virginia, all hospitals must follow the same set of rules commencing at the same time. Don't subject Virginians to another six months of price gouging.

Finally, we applaud Virginia for taking a pioneering role in supporting health-care price transparency, a widely bipartisan issue surveys show 92% of Americans support. If implemented and enforced well, this law could not only become the keystone legacy for Gov. Youngkin and the Commonwealth of Virginia, but would also allow Virginia to lead the nation in a movement destined to transform health care.

Thank you again for your consideration.

Sincerely,

Marni J. Carey

Marni Jameson Carey
President, Power to the Patients

Kevin Morra

Kevin Morra
Co-founder, Power to the Patients

Electronic signatures, hand-signed available on request

Exhibit 1

VA Exhibit 2
ValleyHealth Shenar

VERSAN CONSULTING

ADDITIONAL COMMENTS AND FOLLOW UP FROM 9/30/2022 MEETING
FROM CHRIS DEACON, VERSAN CONSULTING, LLC

Unanimous Recommendations:

1. Virginia should adopt the federal minimums for machine-readable files found in 45 CFR 180.50.

   AGREED.

2. Links to each hospital's webpage for the machine-readable file should be provided by Virginia Health Information (VHI) on each hospital's already-existing VHI webpage.

   AGREED. VA consumers and payer/purchasers should have confidence that the VHI webpage contains the accurate links for each hospital's MRF data that is subject to the new law.

3. The Centers of Medicare and Medicaid Services and the Virginia Department of Health (VDH) should be responsible for compliance monitoring and VDH should publish information about noncompliance on its website.

   AGREED. Compliance monitoring is a prerequisite to consumer confidence and purchaser confidence in MRF that are available; Non-compliance without monitoring by VDH will erode public trust and consumer confidence in information if/when available.

4. Outpatient surgical hospitals should be subject to Virginia's hospital price transparency requirements.

   AGREED. While VA hospital definition may technically differ from Federal law, the language of the statute should be read broadly to include all facilities that would otherwise be encompassed within the Federal definition and overlapping State definition.

5. VDH and VHI should compile a list of all currently licensed outpatient surgical hospitals and conduct outreach to each facility in advance of July 1, 2023 (no later than March 30, 2023) to inform the outpatient surgical hospitals of the applicability of Chapter 297 (2022 Acts of Assembly) to their facility.

   AGREED. Public Media Service Announcements would also be important given the consumer focus of the statute and need for healthcare purchasers to know about new law and enforcement if it is indeed to be meaningful and impactful.

Non-Unanimous Recommendations:

6. Minimum Data.

Any utilization of NA in Codes should include a legend which sets forth the specific reasons why NA is appropriate. For example, NA1 – no pricing available. NA2 – services not performed, etc. Utilization of blanket NA should be impermissible.

7. NDC Codes.

   AGREED. NDC Codes are imperative as increasing amounts of hospital spend include medical pharmacy.

8. VHI should publish instructions on its website on how a consumer/patient can view the contents of the machine-readable file, including recommended free software to open the file.

   AGREED.

9. VDH should be directed to create an off-site inspection process to monitor compliance with Virginia's hospital price transparency requirement.

   AGREED. Text of Statute Support Compliance.

10. VDH should have sufficient resources to monitor compliance.

    AGREED. Suggest that VDH eventually fund FTE positions with enforcement penalties incurred by Hospitals. FTE justification should also be documented utilizing enforcement success metrics.

11. If VDH determines that a hospital is noncompliant with any Virginia Hospital Price Transparency requirement, VDH should provide notice to the hospital of the alleged noncompliance and publish determinations of noncompliance on its website.

    AGREED. Contrary to the other enforcement actions related to other regulatory provisions cited by the VA hospital association that are not made publicly available, this is a consumer driven statute and therefore, this information should be made public in order to give consumers confidence or notice of compliance, or lack thereof, of this important statutory right.

12. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and after providing notice, VDH should require the hospital to submit an acceptable plan of correction.

    AGREE. Strict Timelines should be in place, with Corrective Action Plan to become a public document. Corrective Action Plan should not negate ability to impose fines, if appropriate.

13. If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and the hospital fails to submit an acceptable plan of

correction, the State Health Commissioner should have the authority to impose monetary penalties on a hospital in amounts commensurate with federal civil monetary penalties.

AGREED. Suggest a presumption of non-compliance with State law if Federal Enforcement by HHC occurs. In addition, fine by one agency shall not preclude fines by another agency, nor shall they be dispositive (i.e., if HHS does not fine State Hospital then that does not preclude or prevent VA State Health Commissioner from their ability to levy monetary penalty).

14. The State Health Commissioner should have the authority to place a hospital's license on probation if it fails to comply with any Virginia hospital price transparency requirement.

AGREED. Licensure is within the jurisdiction of the State Health Commissioner, whose statutory duties include review of VA hospitals' compliance with myriad statutes and regulations intended to protect the public and VA providers. For example:

> 12VAC5-410-70. Request for issuance.
>
> …[B] The renewal of a hospital license shall be conditioned upon the up-to-date payment of any civil penalties owed as a result of willful refusal, failure, or neglect to honor certain conditions established in their award of a Certificate of Public Need pursuant to § 32.1-102.4 of the Code of Virginia.

It is important to note that the criteria listed in 32.1-102.4 for Certificate of Need (CON) include levels of charity care provided (which would necessitate an evaluation of prices), terms of financial assistance policies (also includes billing criteria and processes), and the "…development and operation of primary and specialty medical care services in designated medically underserved areas of the applicant's service area…". See Section 32.1-102.4.

15. VDH should report to the Centers for Medicare and Medicaid Services any hospital that has been subject to enforcement action for failing to meet Virginia hospital price transparency requirements.

AGREED.

16. VDH should not assess compliance of outpatient surgical hospitals with the Virginia hospital price transparency until January 1, 2024.

DISAGREE. July 1, 2023 is an appropriate date. While undertaking the file uploads is laborious, the process should have been well worn given the fact that the Federal Transparency Rules will have been in place for over 36 months. Moreover, all VA Hospitals are keenly aware of the prices and update these prices with network carriers on

an annual basis. Therefore, given the frequency of these ongoing contractual updates, it is not unfair to expect that prices made available to multiple carriers also be made available to the public.

17. Hospitals should be required to provide the link to the webpage where their machine-readable files are located as part of their annual filings to VHI.

    AGREED.

18. Hospitals should be required to submit the machine-readable file to VHI as part of their annual fillings to VHI.

    AGREED. In addition, VA Hospitals should be required to submit the machine-readable file to the State Health Commissioner, in its role as a licensing agent. To limit duplication, VHI could be the recipient of the files with a report of compliance due to the State Health Commissioner.

19. Colorado Law

    NO COMMENT.

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

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SENT VIA EMAIL (Rebekah.allen@vdh.virginia.gov)

October 19, 2022

Rebekah E. Allen, J.D.
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Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

RE: **Comment on Recommendations of Chapter 297 (2022 Acts of Assembly) Study/Hospital Price Transparency**

Dear Ms. Allen,

On behalf of the Virginia Hospital & Healthcare Association (VHHA), please accept these comments submitted in response to the recommendations introduced following the September 30, 2022, meeting of the Chapter 297 (2022 Acts of Assembly) Study workgroup on hospital price transparency (the "Workgroup"). VHHA is generally supportive of, partially agrees with, or disagrees with the recommendations as more fully explained below. These comments supplement the comments VHHA previously submitted on September 28, 2022, regarding recommendations from the September 7, 2022, meeting of the Workgroup.

Recommendation 1: Virginia should adopt the federal minimums for machine-readable files found in 45 C.F.R. § 180.50.

As reflected in the minutes from the September 7, 2022, meeting of the Workgroup, VHHA supports adopting recommendations that align with the federal requirements. This is consistent with the text of the statute: "[e]very hospital shall make available to the public on its website a machine-readable file containing a list of all standard charges for all items and services provided by the hospital *in accordance with* 45 C.F.R. § 180.50, as amended. As used in this subsection, 'hospital,' 'items and services,' 'machine-readable,' and 'standard charge' *have the same meaning as set forth in* 45 C.F.R. § 180.20." This establishes that for purposes of Virginia Code § 32.1-137.05.A, if a hospital is compliant with the federal minimum requirements at 45 C.F.R. § 180.50, then it is compliant with state law. This should not be interpreted to authorize Virginia Department of Health (VDH) to establish additional requirements that are not included in the federal minimum requirements at 45 C.F.R. § 180.50.

Any VDH interpretation of what constitutes federal minimum requirements should conform to Centers for Medicare & Medicaid Services' (CMS) interpretation, including federal law and corresponding regulations, and should be informed by applicable CMS guidance, including CMS

Hospital Price Transparency Frequently Asked Questions (FAQs), as may be updated from time to time.[1]

Recommendation 2: Links to each hospital's webpage for the machine-readable file should be provided by Virginia Health Information (VHI) on each hospital's already-existing VHI webpage.

VHHA supports this recommendation as this information is already publicly available. As we indicated in the September 7, 2022, meeting of the Workgroup, VHHA has already taken steps to ensure that the public has access to this information in a central location. The VHHA website includes a webpage that provides Hospital Price Transparency Links and Financial Assistance Policies for all Virginia hospitals. The webpage allows the user to filter the links by region and by health system. The link for each hospital also provides a drop-down list of links for the Financial Assistance Link, Machine Readable File Link, and Price Estimator Tool Link. This webpage replaced VHHA's PricePoint website that was operated from 2006 through 2022, providing charge information and comparison tools for all Virginia hospitals. These voluntary efforts demonstrate our ongoing commitment to transparency and enhancing public understanding of the health care delivery system in Virginia.

Recommendation 3: The Centers for Medicare and Medicaid Services and the Virginia Department of Health (VDH) should be responsible for compliance monitoring, and VDH should publish information about noncompliance on its website.

VHHA partially supports this recommendation. VHHA agrees that CMS and VDH should be responsible for compliance monitoring. Consistent with our comments in response to Recommendation 1, any VDH interpretation of what constitutes federal minimum requirements should conform to CMS interpretation, including federal law and corresponding regulations, and should be informed by applicable CMS guidance.

As it relates to publishing information about noncompliance, any complaint, finding of non-compliance, orders for plan of correction, or other compliance and enforcement activity by VDH should be processed and managed by VDH in the same manner as compliance and enforcement activity conducted for any other VDH requirement for licensure of hospitals under the hospital licensure code at Chapter 5, Article 1 of the Code of Virginia and corresponding regulations at Title 12, Agency 5, Chapter 410, Parts I through III of the Virginia Administrative Code regarding hospital licensure and inspection. We do not agree that VDH should publish information about noncompliance with the hospital price transparency requirements at 45 C.F.R. § 180.50 or Virginia Code § 32.1-137.05.A on its website. VDH does not publish on its websites any information about noncompliance by a hospital with any requirement for licensure of hospitals under the hospital licensure code, or any complaints for noncompliance. Possible non-compliance with 45 C.F.R. § 180.50 or Virginia Code § 32.1-137.05.A should not be treated any differently.

[1] *See* https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf.

Recommendation 4: Outpatient surgical hospitals should be subject to Virginia's hospital price transparency requirements.

VHHA does not support this recommendation for reasons explained in detail in our September 28, 2022, letter. In reference to the many points raised in that previous letter, we again submit that, ultimately, any determination of whether an outpatient surgical hospital is a hospital for purposes of 45 C.F.R. § 180.50 is a matter of interpretation for CMS. As stated in our comments on Recommendation 1, VDH interpretation must conform with CMS interpretation. Accordingly, if an outpatient surgical hospital that is an ASC is not required by CMS to comply with 45 C.F.R. § 180.50, then VDH cannot require it to comply with Virginia Code § 32.1-137.05.A.

Recommendation 5: VDH and VHI should compile a list of all currently licensed outpatient surgical hospitals and conduct outreach to each facility in advance of July 1, 2023 (no later than March 30, 2023) to inform the outpatient surgical hospitals of the applicability of Chapter 297 (2022 Acts of Assembly) to their facility.

As stated in response to Recommendation 4, we do not believe that 45 C.F.R. § 180.50 and Virginia Code § 32.1-137.05.A are applicable to outpatient surgical hospitals. However, if CMS ultimately determines that an ASC in Virginia is a hospital for purposes of 45 C.F.R. § 180.50, we are in agreement that VDH and VHI should compile a list well in advance of July 1, 2023, and inform each facility of the requirement to comply with Chapter 297 (2022 Acts of Assembly).

Recommendation 6: Hospitals should be required to display prices in the machine-readable file as U.S. dollars (see pg. 10 of the Centers for Medicare and Medicaid Services "Hospital Price Transparency Frequently Asked Questions (FAQs)).

VHHA partially agrees with this recommendation. VHHA agrees that if there is a dollar amount provided in the contract it should be displayed in dollars. However, if the contract, for example, establishes payment at a rate of 50 % of charges, this is an allowable entry per CMS. Under the Technical Clarification question #34 CMS specifically states that the negotiated percentage should be entered as the negotiated rate. If the contracted rate is a percent of the Medicare or Medicaid fee schedule, we agree that this should be converted into a dollar amount per the FAQ document. We disagree with statements made by Workgroup members that "N/A" cannot be used. CMS sanctions the use of "N/A" in multiple places throughout the CMS FAQ document. One common occurrence where the use of "N/A" is required is in instances where hospitals have one tab that includes all of their charges and negotiated rates. This is because inpatient payment rates in contracts are typically based on MS-DRG, APR-DRG, DRG, and at a per diem amount. If all the negotiated rates are on one tab, an insurer that pays a per diem for one item will have "N/A" in all cells that are related to MS-DRG, APR-DRG, and DRG. Outpatient will be similar in nature as health plans may pay by EAPG, APC, RBRVS, percent of charges, or the health plan's own home-grown grouper unique to that health plan. For example, Anthem uses both the Outpatient Hospital Allowance Schedule (OHAS) and Commercial Outpatient Pricing Payment System (COPPS). There is the potential that for a particular hospital that has multiple Anthem plans, one plan may have a contracted rate under OHAS while the other plan has a contracted rate under COPPS. In this case and many others, "N/A" would have to be used in all rows of the fee schedule not being utilized.

Recommendation 7: "Items and services" should include medication that the hospital customarily provides as part of, or in conjunction with, a service.

Any VDH interpretation of what constitutes federal minimum requirements should conform to CMS interpretation, including federal law and corresponding regulations, and should be informed by applicable CMS guidance, including CMS Hospital Price Transparency Frequently Asked Questions (FAQs), as may be updated from time to time. Current regulations and FAQs do not explicitly require that items and services include medication that the hospital customarily provides as part of, or in conjunction with, a service. The FAQs state that "For purposes of complying with the hospital price transparency requirements, items and services are all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit *for which a hospital has established a standard charge*. Examples include supplies and procedures, room and board, and use of the facility and other items (generally described as facility fees), services of employed physicians and non-physician practitioners (generally reflected as professional charges), and any other item or service for which a hospital has established a standard charge." Accordingly, the determination of what items and services, such as medications, must be included is determined by whether the hospital has established a standard charge for such item and service. Under this guidance, it is irrelevant whether that medication is customarily provided as part of, or in conjunction with, a service.

Recommendation 8: VHI should publish instructions on its website on how a consumer/patient can view the contents of machine-readable files, including recommended free software to open the file.

VHHA has no comment on this recommendation, as this directly impacts VHI and their capabilities and willingness to complete this task.

Recommendation 9: VDH should be directed to create an off-site inspection process to monitor compliance with Virginia's hospital price transparency requirement.

VHHA does not support this recommendation. As stated in response to Recommendation 3, any complaint investigation or inspection related to allegations of noncompliance with Va. Code § 38.2-137.05 should be managed in the same manner as any other matter of noncompliance with hospital licensure laws and regulations using the same procedures and remedies as limited by applicable laws and regulations.

Recommendation 10: VDH should have sufficient resources to monitor compliance.

Funding allocation decisions for VDH are made by the Virginia General Assembly. A budget amendment for the corresponding legislation was not submitted, therefore it was not considered by the General Assembly during the legislative session.

Recommendation 11: If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement, VDH should provide notice to the hospital of the alleged noncompliance and publish determinations of noncompliance on its website.

VHHA agrees that VDH should have the ability to notify a hospital if they are deemed to be out of compliance. However, as stated in response to Recommendation 3, VHHA disagrees that VDH should publish determinations of noncompliance on its website. As explained by VDH representatives in the Workgroup, VDH does not publish determinations of noncompliance with hospital licensure laws and regulations. Any noncompliance with Va. Code § 38.2-137.05 should be managed in the same manner as any other matter of noncompliance with hospital licensure laws and regulations using the same procedures and remedies as limited by applicable laws and regulations.

Recommendation 12: If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and after providing notice, VDH should require the hospital to submit an acceptable plan of correction.

As noted previously, any noncompliance with Va. Code § 38.2-137.05 should be managed in the same manner as any other matter of noncompliance with hospital licensure laws and regulations using the same procedures and remedies as limited by applicable laws and regulations.

Recommendation 13: If VDH determines that a hospital is noncompliant with any Virginia hospital price transparency requirement and the hospital fails to submit an acceptable plan of correction, the State Health Commissioner should have the authority to impose monetary penalties on a hospital in amounts commensurate with federal civil monetary penalties.

VHHA does not support this recommendation. As noted previously, any noncompliance with Va. Code § 38.2-137.05 should be managed in the same manner as any other matter of noncompliance with hospital licensure laws and regulations using the same procedures and remedies as limited by applicable laws and regulations. Based upon our interpretation of hospital licensure laws and regulations, the State Health Commissioner does not have the authority to impose monetary penalties on a hospital for failure to comply with a requirement for hospital licensure, including Va. Code § 38.2-137.05, in any amount.

Recommendation 14: The State Health Commissioner should have the authority to place a hospital's license on probation if it fails to comply with any Virginia hospital price transparency requirement.

As noted previously, any noncompliance with Va. Code § 38.2-137.05 should be managed in the same manner as any other matter of noncompliance with hospital licensure laws and regulations using the same procedures and remedies as limited by applicable laws and regulations.

Recommendation 15: VDH should report to the Centers for Medicare and Medicaid Services any hospital that has been subject to enforcement action for failing to meet Virginia hospital price transparency requirements.

VHHA member hospitals are already subject to CMS enforcement mechanisms related to the federal minimum requirements. As was discussed in the Workgroup, CMS regulations and the federal minimum requirements are in Title 45 of the C.F.R. This is separate from Title 42 under which VDH, as the designated state survey agency, has the responsibility to inspect hospitals for compliance with Medicare certification requirements and conditions of participation. Accordingly, based upon our interpretation, there is not an existing notice or reporting responsibility for any state

to CMS for instances of alleged noncompliance with the federal minimum requirements. CMS is the ultimate arbiter of compliance with the federal minimum requirements and as stated previously, any VDH interpretation of what constitutes federal minimum requirements should conform to CMS interpretation, including federal law and corresponding regulations, and should be informed by applicable CMS guidance, including CMS Hospital Price Transparency Frequently Asked Questions (FAQs), as may be updated from time to time. There is nothing preventing VDH or any person or organization from reporting the hospital to CMS if they feel the hospital is noncompliant. CMS has already established a complaint process for this purpose (https://cms.gov1.qualtrics.com/jfe/form/SV_b2fAQwrDLIC7Iyx) and any complaints should be submitted through this existing mechanism.

Recommendation 16: VDH should not assess compliance of outpatient surgical hospitals with the Virginia hospital price transparency requirements until January 1, 2024.

As stated in response to Recommendation 4, we do not believe that 45 C.F.R. § 180.50 and Virginia Code § 32.1-137.05.A are applicable to outpatient surgical hospitals. However, if CMS ultimately determines that an ASC in Virginia is a hospital for purposes of 45 C.F.R. § 180.50 , we are in agreement that VDH should not assess compliance of outpatient surgical hospitals with the federal minimum requirements until January 1, 2024.

Recommendation 17: Hospitals should be required to provide the link to the webpage where their machine-readable files are located as part of their annual filings to VHI.

VHHA does not oppose this recommendation. However, we do not believe the process laid out in the recommendation will be effective in providing the state or the public timely and accurate information. Currently, hospitals file their annual filing to VDH 90 days after the end of their fiscal year and VHI does not update its website until November or December. For hospitals with a December 31st fiscal year end, it could be close to a year later before the VHI website would be updated with the hospital's information. By that time, many of the links could be out of date. An alternative would be for VHI to conduct a separate collection of website links apart from the required annual filing provided the links are posted in a timely manner and not months after being submitted.

Recommendation 18: Hospitals should be required to submit the machine-readable file to VHI as part of their annual filings to VHI.

VHHA disagrees with this recommendation. As stated in response to recommendation 17, this recommendation will not be effective in providing the state or the public timely and accurate information. In addition, the size of these files will make it very difficult for a submission to occur. Further, this is not required nor contemplated as part of the federal minimum requirements, nor was it contemplated within the scope of the state legislation. Again, any VDH interpretation of what constitutes federal minimum requirements should conform to CMS interpretation, including federal law and corresponding regulations, and should be informed by applicable CMS guidance, including CMS Hospital Price Transparency Frequently Asked Questions (FAQs), as may be updated from time to time.

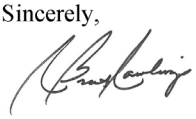
Recommendation 19: Multiple recommendations based on the recently enacted law in Colorado

a. There should be a prohibition that prevents a hospital that is not in material compliance with Virginia hospital price transparency requirements from initiating or pursuing a collection against a patient or patient guarantor for a debt owed for the items or services;
b. There should be a private right of action for a patient to file suit against a hospital that the patient believes was not in material compliance with Virginia hospital price transparency requirements and that has taken a collection action against that patient or their guarantor;
c. There should be a prohibition that prevents a hospital from taking a collection action against the patient or patient guarantor while a lawsuit under 19(b) is pending; and
d. If a hospital is found by a judge or jury to be materially out of compliance with Virginia hospital price transparency requirements, the hospital should:
i. Refund the payer any amount of the debt the payer paid;
ii. Pay a penalty to the patient or patient guarantor equal to the total amount off the debt;
iii. Dismiss or cause to be dismissed with prejudice any collection action and pay any attorney fees and costs to the patient or patient guarantor; and
iv. Remove or cause to be removed from the patient's or patient guarantor's credit report any report made by the hospital related to the debt.

The last set of recommendations is drawn from a recently enacted law in Colorado. VHHA does not support this recommendation. Each of these recommendations go far beyond the legislation that was passed by the General Assembly and for this reason we do not believe that VDH has any authority to include any such requirement in its regulations. Implementation of these requirements will require additional legislation by the General Assembly. Additionally, this is not required nor contemplated as part of the minimum federal requirement. Again, any VDH interpretation of what constitutes federal minimum requirements should conform to CMS interpretation, including federal law and corresponding regulations, and should be informed by applicable CMS guidance, including CMS Hospital Price Transparency Frequently Asked Questions (FAQs), as may be updated from time to time.

Thank you for your consideration of these comments. Please let us know if we can provide you with any further information on this matter.

Sincerely,



R. Brent Rawlings
Senior Vice President and General Counsel

cc: James H. Williams, Deputy Secretary of Health, and Human Resources
Julie M. Dime, Vice President of Government Affairs