FEATURE

It's 2024. Do Patients Know Where Your MRF Is?

Verify compliance with the machine-readable files requirements

By Caroline Znaniec, MBA, MS-HCA, CRIP, CRCR, and Joe O'Malley, CHC

The Hospital Price Transparency Rule was implemented on January 1, 2021, and codified in the Code of Federal Regulations (Title 45, Subtitle A, Subchapter E, Part 180). CMS has finalized new changes to increase standardization of the machine-readable files (MRF) to help deliver on the promise of hospital price transparency. Ensure that your hospital complies to enhance the public's ability to access and aggregate information and streamline CMS's ability to enforce the requirements.

In response to industry members' requests for standardization in reporting, CMS developed a template and encoding requirements for the price transparency data elements. The CY2024 Outpatient Prospective Payment System (CY2024 Final Rule) published November 22, 2023, provides guidance and related implementation (compliance) dates specific to the accessibility, format and structure, and content of the MRF. Exhibit 1 summarizes the compliance dates, which vary by requirement and range from January of 2024 through January of 2025.

Exhibit 1 – Summary of compliance dates

Requirement	Regulation	Implementation (compliance) date
MRF Information		
MRF Date	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
CMS Template Version	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
Hospital Information		
Hospital Name	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Location(s)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Address(es)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Licensure Information	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Standard charges		
Gross Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Discounted Cash	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Payer Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Plan Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Standard Charge Method	45 CFR 180.50(b)(2)(ii)(B)	July 1, 2024
Payer-Specific Negotiated Charge – Dollar Amount	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Percentage	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Algorithm	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Estimated Allowed Amount	45 CFR 180.50(b)(2)(ii)(C)	January 1, 2025
De-identified Minimum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
De-identified Maximum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024

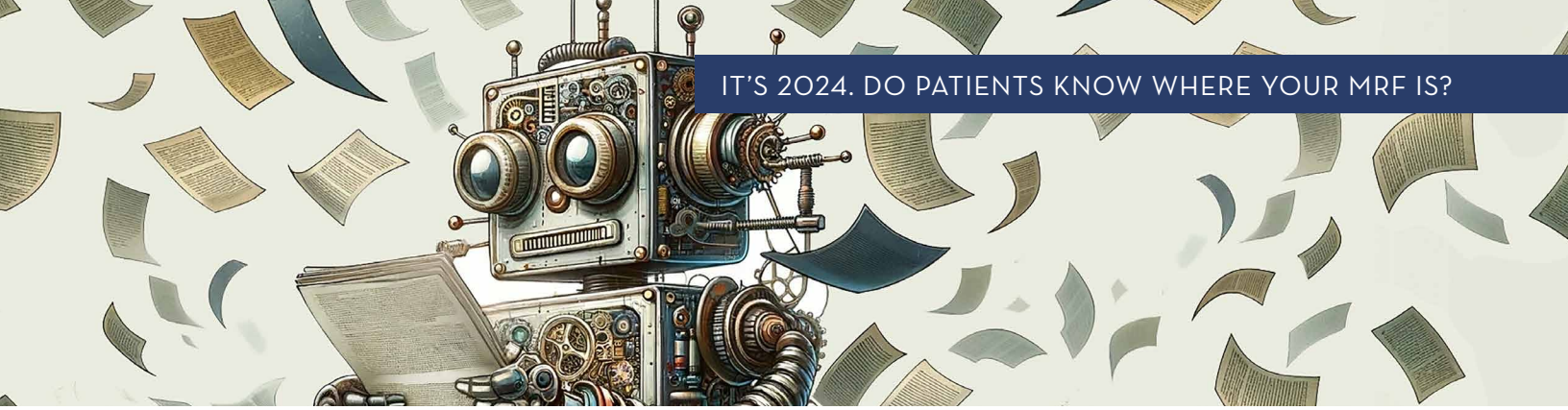

Exhibit 1 – Summary of compliance dates (continued)

Requirement	Regulation	Implementation (compliance) date
Item and service information		
General Description	45 CFR 180.50(b)(2)(iii)(A)	July 1, 2024
Setting	45 CFR 180.50(b)(2)(iii)(B)	July 1, 2024
Drug Unit of Measurement	45 CFR 180.50(b)(2)(iii)(C)	January 1, 2025
Drug Type of Measurement	45 CFR 180.50 (b)(2)(iii)(C)	January 1, 2025
Coding information		
Billing/Accounting Code	45 CFR 180.50(b)(2)(iv)(A)	July 1, 2024
Code Type	45 CFR 180.50(b)(2)(iv)(B)	July 1, 2024
Modifiers	45 CFR 180.50(b)(2)(iv)(C)	January 1, 2025
Other new hospital price transparency requirements		
Good faith effort	45 CFR 180.50(a)(3)(i)	January 1, 2024
Affirmation in the MRF	45 CFR 180.50(a)(3)(ii)	July 1, 2024
.txt file	45 CFR 180.50(d)(6)(i)	January 1, 2024
Footer link	45 CFR 180.50(d)(6)(ii)	January 1, 2024

Accessibility

As of January 1, 2024, a hospital must ensure that its MRF is easily accessible by both the public and by CMS for automated auditing. The new requirements include a .txt file and website footer. A hospital's good faith effort in providing access to its MRF is demonstrated through meeting these requirements together with the publishing of the MRF itself.

.txt file

The .txt file must be placed in the root folder of the website domain that hosts the MRF. The .txt file is a document that provides information specific to the hospital location name, source page URL that hosts the MRF, a direct link to the MRF, and designated point of contact information. To assist hospitals in generating the MRF, CMS provides instructions and a generator tool for document output.

Exhibit 2 – Example .txt file output

```
location-name: ABC Hospital
source-page-url: https://www.abchospital.com/patients-visitors/patient-guide/billing-insurance/cost-of-care/
mrf-url: https://www.abchospital.com/123456789_ABC-Hospital_standardcharges.csv
contact-name: MRF Team
contact-email: MRFTEAM@abchospital.com
```

While a health system may post multiple MRFs on its source page, all locations should be included in the single .txt file document.

Exhibit 3 – Example .txt file output with multiple locations

```
location-name: ABC Hospital
source-page-url: https://www.abchospital.com/patients-visitors/patient-guide/billing-insurance/cost-of-care/
mrf-url: https://www.abchospital.com/123456789_ABC-Hospital_standardcharges.csv
contact-name: MRF Team
contact-email: MRFTEAM@abchospital.com

location-name: CDE Hospital
source-page-url: https://www.abchospital.com/patients-visitors/patient-guide/billing-insurance/cost-of-care/
mrf-url: https://www.abchospital.com/123456789_CDE-Hospital_standardcharges.csv
contact-name: MRF Team
contact-email: MRFTEAM@abchospital.com
```

When multiple locations (e.g., acute care hospital, stand-alone emergency center) share an MRF, a separate entry must be included in the output by location.

Exhibit 4 – Example .txt file output for shared MRF

```
location-name: ABC Hospital
source-page-url: https://www.abchospital.com/patients-visitors/patient-guide/billing-insurance/cost-of-care/
mrf-url: https://www.abchospital.com/123456789_ABC-Hospital_standardcharges.csv
contact-name: MRF Team
contact-email: MRFTEAM@abchospital.com

location-name: ABC Standalone Emergency
source-page-url: https://www.abchospital.com/patients-visitors/patient-guide/billing-insurance/cost-of-care/
mrf-url: https://www.abchospital.com/123456789_ABC-Hospital_standardcharges.csv
contact-name: MRF Team
contact-email: MRFTEAM@abchospital.com
```

Where a hospital uses a vendor to host its MRF, the .txt file should indicate the vendor's source page URL and the MRF URL established by the vendor. The point of contact should reflect the person or team of people that can answer questions regarding the publicly available MRF information.

Website footer

The hospital must provide a link in the footer of its website that is labeled exactly: "Price Transparency." Other variations, such as "Pricing Transparency" or "Hospital Price Transparency," are not acceptable. The footer must link directly to the publicly available webpage that hosts the link to the MRF.

Format and structure

As of July 1, 2024, hospital MRFs must conform to a CMS template layout. The compliance date applies to all hospitals, regardless of their use of prior voluntary templates or last annual update date. For example, if a hospital last updated its MRF in December of 2023, it must comply with the CMS template by July 1, 2024. Hospitals must continue to provide annual updates up to and after the required compliance dates.

CMS has published the template layout in three formats: CSV "Tall," CVS "Wide," and JSON. Hospitals may choose the format for publishing their charges. Within each format, CMS has adopted established standards and industry norms. The requirements include valid types by data element, such as string, date, Enum, numeric and Boolean. Values encoded incorrectly will generate a compliance deficiency. With each template format, CMS provides a README file that lists the valid types by data element, along with additional instructions.

Content

The content for the CMS MRF template resembles much of what has been in place since 2021. The content includes providing item and service descriptions, billing identifiers and standard charges, including gross and discounted cash prices and de-identified minimum and maximum charges. Under the CY2024 Final Rule, additional data elements are included to improve the public's understanding of hospital provider and payer charge methodologies.

Steps for publicizing your hospital charges using a required CMS template layout

1. Identify your hospital and each hospital location that must make available its list of standard charges.
2. Identify each standard charge your hospital has established and its corresponding item or service.
3. Select a required CMS template.
4. Gather and encode your standard charge information in the CMS template.
5. Affirm the accuracy and completeness of your file.
6. Name your MRF according to the CMS naming convention.
7. Validate that you have encoded your data correctly within the CMS template.
8. Post your machine-readable file prominently on a publicly available website.
9. Add the .txt file and footer link.
10. Update your hospital's MRF annually.

Source: https://www.cms.gov/files/document/steps-machine-readable-file.pdf

The data elements provide information that contextualize the standard charges of the hospital. CMS categorizes the data elements into five groups:

1. MRF Information
2. Hospital Information
3. Standard charges
4. Item and service information
5. Coding information

Exhibit 5 summarizes the new data elements as of July 1, 2024. An asterisk indicates a compliance date of January 1, 2025.

Exhibit 5 – New data elements

Category	New data element as of July 1, 2024 (Asterisk indicates required as of January 1, 2025)	Definition and considerations
1. MRF information	MRF date	Provide the calendar date of the last file update.
	CMS template version	CMS template version 2.0.0 is current as of May 2024.
	Affirmation statement	Include a pre-populated statement, written and required by CMS, with a value encoded of "True" or "False" to confirm to the best of the hospital's knowledge that the information provided is true, accurate and complete as of the date of the MRF.
2. Hospital information	Hospital name	Provide the legal name of the hospital.
	Hospital location(s)	Include the unique name of the hospital location(s), absent acronyms. More than one hospital location is included when >1 location is included in the MRF. For example, under a single license a hospital and standalone emergency center share the same standard charges.
	Hospital address(es)	Disclose the geographic address of the corresponding locations.
	Hospital licensure information	Disclose the hospital license and state/territory abbreviation. If the hospital does not have a license (e.g., state-owned hospitals), the field can be left blank. Hospitals without a license number, but with a registry number, may include the registry number as an option, but not required.
3. Standard Charges (Additional data elements including gross charge, discounted cash price, de-identified minimum and maximum charges remain unchanged and are required in the CMS template.)	Standard charge method	Provide the method used to establish the payer-specific negotiated charge. Valid values include: • Case rate • Fee schedule • Per diem • Percent of total billed charges • Other
	Payer-specific negotiated charge – dollar amount	Disclose the charge that a hospital has negotiated with a third-party payer for the corresponding item or service. The value is expressed as a dollar amount without dollar signs or cents when the cents are "00."

Exhibit 5 – New data elements (continued)

Category	New data element as of July 1, 2024 (Asterisk indicates required as of January 1, 2025)	Definition and considerations
3. Standard Charges (continued) (Additional data elements including gross charge, discounted cash price, de-identified minimum and maximum charges remain unchanged and are required in the CMS template.)	Payer-specific negotiated charge – percentage	Complete this when a payer-specific negotiated charge has been established as a percentage and no dollar amount can be calculated. For example, when the negotiated charge is based on the aggregation of charges that may vary by patient (e.g., inpatient stay, surgical procedure). The percentage is provided as a numeric representation and not as a decimal. For example, 65.5 percent is to be entered as 65.5 and not .655. An estimated allowed amount must also be calculated when this type of negotiated charge is encoded.
	Payer-specific negotiated charge – algorithm	Disclose the expressed algorithm that the hospital has negotiated. For example, the adjusted base payment rate indicated in the standard charge/negotiated dollar data element may be further adjusted for additional factors including transfers and outliers. An estimated allowed amount must also be calculated when this type of negotiated charge is encoded.
	Estimated allowed amount*	Provide the average dollar amount that the hospital has historically received from a third-party payer for an item or service. If historic claims history is insufficient to derive the estimated allowed amount, the hospital should encode 999999999 (nine 9s) in the data element value.
	Additional generic notes	Use free text data to explain any of the data, including, for example, blanks due to no applicable data, charity care policies, or other contextual information that aids in the understanding of the standard charges.
	Additional payer-specific notes	Use free text data to explain data in the file that is related to a payer-specific negotiated charge.

Exhibit 5 – New data elements (continued)

Category	New data element as of July 1, 2024 (Asterisk indicates required as of January 1, 2025)	Definition and considerations
4. Item and service information (The General Description data element remains unchanged from prior requirements and is required in the CMS template.)	Setting	Provide Information that indicates the setting of the item or service. Valid values include: • Inpatient • Outpatient • Both
	Drug unit of measure*	Indicate the unit value that corresponds to the established standard charge. For example, an 81mg aspirin unit of measure would be indicated as 1.
	Drug type of measurement*	Disclose the measurement type that corresponds to the established standard charge for drugs as defined by either the National Drug Code or the National Council for Prescription Drug Programs. The measurement aligns to volume measurement and may not correspond with HCPCS (e.g., J-Code) billable units. Valid values include: • GM or GR (grams) • ME (milligrams) • ML (milliliters) • UN (unit) • F2 (international unit) • EA (each) For example, an 81mg aspirin type of measurement would be indicated as UN.
5. Coding information	Billing/accounting code	The code(s) are used by the hospital for purposes of billing or accounting for the item or service. Billing/accounting code greater than one may be associated with an item or service. For example, a payer may require the combination of a revenue code and CPT code for reimbursement.
	Code type	The code type corresponds to the billing/accounting code to indicate the type of code displayed. Valid values include, but are not limited to: • CPT • HCPCS • NDC • MS-DRG • RC
	Modifiers*	Provide any modifier(s) that may change the standard charge that corresponds to hospital items or services. Payment modifiers may include: • Prolonged service–22 • Bilateral procedure–50 • Reduced service–52 • Staged procedure–58

CMS has provided examples of how to complete the CMS template based on common scenarios and continues to add to the scenarios as providers reach out with questions and request further guidance.

CMS scenario examples

Exhibits 6–10 provide examples of CMS scenarios. The data has been transposed from CSV Tall format for illustrative purposes and includes only those data elements with values.

Exhibit 6 – Case rate based on a MS-DRG algorithm

Category	Description
description	Major hip and knee joint replacement or reattachment of lower extremity without mcc
code|1	470
code|1|type	MS-DRG
code|2	175869
code|2|type	LOCAL
setting	inpatient
payer_name	Platform Health Insurance
plan_name	PPO
standard_charge|negotiated_dollar	20000
standard _charge|negotiated_algorithm	The adjusted base payment rate indicated in the standard charge or negotiated dollar data element may be further adjusted for additional factors including transfers and outliers.
estimated_amount	22243.34
standard_charge|methodology	case rate
standard_charge|min	20000
standard_charge|max	20000

Exhibit 7 – Percent of total billed charges

Category	Description
description	Major hip and knee joint replacement or reattachment of lower extremity without mcc
code|1	470
code|1|type	MS-DRG
code|2	175869
code|2|type	LOCAL
setting	inpatient
payer_name	Region Health Insurance
plan_name	HMO
standard_charge|negotiated_percentage	50
estimated_amount	23145.98
standard_charge|methodology	Percent of total billed charges
standard_charge|min	20000
standard_charge|max	20000

Exhibit 8 – Fee schedule: Standard charge is a percent of a common fee schedule and the standard charge dollar amount can be calculated

Category	Description
description	Evaluation of hearing function to determine candidacy for, or postoperative status of, surgically implanted hearing device; first hour
code|1	92626
code|1|type	CPT
setting	outpatient
standard_charge|gross	150
standard_charge|discounted_cash	125
payer_name	Platform Health Insurance
plan_name	PPO
standard_charge|negotiated_dollar	98.98
standard_charge|methodology	fee schedule
standard_charge|min	98.98
standard_charge|max	98.98
additional_generic_notes	110% of the Medicare fee schedule

Exhibit 9 – Fee schedule where the standard charge is a percent of a common fee schedule, and the standard charge dollar amount cannot be calculated

Category	Description
description	Evaluation of hearing function to determine candidacy for, or postoperative status of, surgically implanted hearing device; first hour
code|1	92626
code|1|type	CPT
setting	outpatient
standard_charge|gross	150
standard_charge|discounted_cash	125
payer_name	Region Health Insurance
plan_name	HMO
standard_charge|negotiated_percentage	115
estimated_amount	105.34
standard_charge|methodology	fee schedule
standard_charge|min	98.98
standard_charge|max	98.98
additional_generic_notes	115% of the state's workers' compensation amount

Exhibit 10 – Per diem where the standard charges are for a length of stay of 1–3 days

Category	Description
description	Behavioral health; residential (hospital residential treatment program), without room and board, per diem, days 1–3
code|1	H0017
code|1|type	HCPCS
setting	inpatient
standard_charge|gross	2500
standard_charge|discounted_cash	2250
payer_name	Region Health Insurance
plan_name	HMO
standard_charge|negotiated_dollar	2000
standard_charge|methodology	per diem
standard_charge|min	2000
standard_charge|max	2000

Exhibit 11 – Per diem where the standard charges are for a length of stay of 4–5 days

Category	Description
description	Behavioral health; residential (hospital residential treatment program), without room and board, per diem, days 4–5
code|1	H0017
code|1|type	HCPCS
setting	inpatient
standard_charge|gross	2500
standard_charge|discounted_cash	2250
payer_name	Region Health Insurance
plan_name	HMO
standard_charge|negotiated_dollar	1800
standard_charge|methodology	per diem
standard_charge|min	1800
standard_charge|max	1800
standard_charge|max	98.98

Noncompliance risks are high for hospitals that do not meet accessibility requirements and publish an MRF in the required format.

Audit program considerations

Hospitals at the highest risk of noncompliance include those that do not meet accessibility requirements or do not publish a machine-readable file in the required CMS template format. In establishing your audit work program for hospital price transparency, you can leverage CMS' resources (see sidebar) to understand the full requirements and to align your testing with the highest risks. Further audit steps should include interviews of those stakeholders responsible for both compiling the MRF content and formatting to the new required structure.

Testing should include a comparison to payer contract and reimbursement terms, as well as reconciliation of the chargemaster and other modules that may house charge detail (e.g., room and board tables, pharmacy formularies, supply item masters).

Testing provides confidence in affirming to CMS that "To the best of its knowledge and belief, the hospital has included all applicable standard charge information in accordance with the requirements of 45 CFR 180.50, and the information encoded is true, accurate, and complete as of the date indicated."

Conclusion

Despite challenges and resistance by hospitals, CMS has doubled down on requirements to make MRFs easier to find and use. By working toward pricing transparency compliance, hospitals reduce the risk of monetary fines, public scrutiny and reputational damage, while potentially uncovering charge capture opportunities and increasing the quality and efficiency of their revenue cycle processes. Help your hospitals gain these advantages. **NP**

Resources

- CMS–
  - Resources
  - Hospital Price Transparency Fact Sheet
  - Hospital Price Transparency: Using a CMS Template Layout to Encode Hospital Standard Charge Information
  - Technical Implementation Guide
- Healthcare Financial Management Association – CMS finalizes enhanced hospital price transparency requirements for 2024

Caroline Znaniec, MBA, MS-HCA, CRIP, CRCR, is a Managing Director with Protiviti's Healthcare Business Performance Improvement practice and Provider Operations Solutions leader. She works with healthcare organizations to improve margins through the identification, capture and collection of services. Caroline can be reached at 410-463-9867 and Caroline.Znaniec@protiviti.com.

Joe O'Malley, CHC, is an Associate Director with Protiviti's Healthcare Business Performance Improvement practice, and the Revenue Integrity and Transformation Solutions leader. He works with healthcare organizations to improve upon operational performance to increase net revenue. Joe can be reached at 708-745-1891 and Joe.Omalley@protiviti.com.

I would rather work with five people who really believe in what they are doing ... than five hundred who can't see the point.
- Patrick Dixon, business consultant