Minnesota health care price transparency laws and rules

Minnesota Statutes 2013

62J.81 DISCLOSURE OF PAYMENTS FOR HEALTH CARE SERVICES.

Subdivision 1.**Required disclosure of estimated payment.**

(a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. Health plan companies must allow contracted providers, or their designee, to release this information. If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee intending to receive specific health care services or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.

Subd. 2.**Applicability.** For purposes of this section, "consumer" does not include a medical assistance, MinnesotaCare, or general assistance medical care enrollee, for services covered under those programs.

(First enacted 2004)

62J.82 HOSPITAL INFORMATION REPORTING DISCLOSURE.

Subdivision 1.**Required information.** The Minnesota Hospital Association shall develop a Web-based system, available to the public free of charge, for reporting the following, for Minnesota residents:

(1) hospital-specific performance on the measures of care developed under section 256B.072 for acute myocardial infarction, heart failure, and pneumonia;

(2) by January 1, 2009, hospital-specific performance on the public reporting measures for hospital-acquired infections as published by the National Quality Forum and collected by the Minnesota Hospital Association and Stratis Health in collaboration with infection control practitioners; and

(3) charge information, including, but not limited to, number of discharges, average length of stay, average charge, average charge per day, and median charge, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association.

Subd. 2.**Web site.**

The Web site must provide information that compares hospital-specific data to hospital statewide data. The Web site must be updated annually. The commissioner shall provide a link to this reporting information on the department's Web site.

Subd. 3.**Enforcement.**

The commissioner shall provide a link to this information on the department's Web site. If a hospital does not provide this information to the Minnesota Hospital Association, the commissioner of health may require the hospital to do so in accordance with section 144.55, subdivision 6.

(First enacted 2005)

62J.823 HOSPITAL PRICING TRANSPARENCY.

Subdivision 1.**Short title.** This section may be cited as the Hospital Pricing Transparency Act.

Subd. 2.**Definition.** For the purposes of this section, "estimate" means the actual price expected to be billed to the individual or to the individual's health plan company based on the specific diagnostic-related group code or specific procedure code or codes, reflecting any known discounts the individual would receive.

Subd. 3.**Applicability and scope.** Any hospital, as defined in section 144.696, subdivision 3, and outpatient surgical center, as defined in section 144.696, subdivision 4, shall provide a written estimate of the cost of a specific service or stay upon the request of a patient, doctor, or the patient's representative. The request must include:

(1) the health coverage status of the patient, including the specific health plan or other health coverage under which the patient is enrolled, if any; and

(2) at least one of the following:

(i) the specific diagnostic-related group code;

(ii) the name of the procedure or procedures to be performed;

(iii) the type of treatment to be received; or

(iv) any other information that will allow the hospital or outpatient surgical center to determine the specific diagnostic-related group or procedure code or codes.

Subd. 4.**Estimate.** (a) An estimate provided by the hospital or outpatient surgical center must contain:

(1) the method used to calculate the estimate;

(2) the specific diagnostic-related group or procedure code or codes used to calculate the estimate, and a description of the diagnostic-related group or procedure code or codes that is reasonably understandable to a patient; and

(3) a statement indicating that the estimate, while accurate, may not reflect the actual billed charges and that the final bill may be higher or lower depending on the patient's specific circumstances.

(b) The estimate may be provided in any method that meets the needs of the patient and the hospital or outpatient surgical center, including electronically; however, a paper copy must be provided if specifically requested.

(2006)

62J.83 REDUCED PAYMENT AMOUNTS PERMITTED.

(a) Notwithstanding any provision of chapter 148 or any other provision of law to the contrary, a health care provider may provide care to a patient at a discounted payment amount, including care provided for free.

(b) This section does not apply in a situation in which the discounted payment amount is not permitted under federal law.

(First enacted 2006)

62U.04 PAYMENT REFORM; HEALTH CARE COSTS; QUALITY OUTCOMES.

Subdivision 1.**Development of tools to improve costs and quality outcomes.** The commissioner of health shall develop a plan to create transparent prices, encourage greater provider innovation and collaboration across points on the health continuum in cost-effective, high-quality care delivery, reduce the administrative burden on providers and health plans associated with submitting and processing claims, and provide comparative information to consumers on variation in health care cost and quality across providers.

Subd. 2.**Calculation of health care costs and quality**. The commissioner of health shall develop a uniform method of calculating providers' relative cost of care, defined as a measure of health care spending

including resource use and unit prices, and relative quality of care. In developing this method, the commissioner must address the following issues:

(1) provider attribution of costs and quality;

(2) appropriate adjustment for outlier or catastrophic cases;

(3) appropriate risk adjustment to reflect differences in the demographics and health status across provider patient populations, using generally accepted and transparent risk adjustment methodologies and case mix adjustment;

(4) specific types of providers that should be included in the calculation;

(5) specific types of services that should be included in the calculation;

(6) appropriate adjustment for variation in payment rates;

(7) the appropriate provider level for analysis;

(8) payer mix adjustments, including variation across providers in the percentage of revenue received from government programs; and

(9) other factors that the commissioner and the advisory committee, established under subdivision 3, determine are needed to ensure validity and comparability of the analysis.

Subd. 3.**Provider peer grouping; system development; advisory committee.** (a) The commissioner shall develop a peer grouping system for providers that incorporates both provider risk-adjusted cost of care and quality of care, and for specific conditions as determined by the commissioner. For purposes of the final establishment of the peer grouping system, the commissioner shall not contract with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of the system.

(b) The commissioner shall establish an advisory committee comprised of representatives of health care providers, health plan companies, consumers, state agencies, employers, academic researchers, and organizations that work to improve health care quality in Minnesota. The advisory committee shall meet no fewer than three times per year. The commissioner shall consult with the advisory committee in developing and administering the peer grouping system, including but not limited to the following activities:

(1) establishing peer groups;

(2) selecting quality measures;

(3) recommending thresholds for completeness of data and statistical significance for the purposes of public release of provider peer grouping results;

(4) considering whether adjustments are necessary for facilities that provide medical education, level 1 trauma services, neonatal intensive care, or inpatient psychiatric care;

(5) recommending inclusion or exclusion of other costs; and

(6) adopting patient attribution and quality and cost-scoring methodologies.

Subd. 3a.**Provider peer grouping; dissemination of data to providers.** (a) The commissioner shall disseminate information to providers on their total cost of care, total resource use, total quality of care, and the total care results of the grouping developed under subdivision 3 in comparison to an appropriate peer group. Data used for this analysis must be the most recent data available. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data in order to verify, consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner, the accuracy and representativeness of any analyses or reports and submit comments to the commissioner or initiate an appeal under subdivision 3b. Upon request, providers shall be given any data for which they are the subject of the data. The provider shall have 60 days to review the data for accuracy and initiate an appeal as specified in subdivision 3b.

(b) The commissioner shall disseminate information to providers on their condition-specific cost of care, condition-specific resource use, condition-specific quality of care, and the condition-specific results of the grouping developed under subdivision 3 in comparison to an appropriate peer group. Data used for this analysis must be the most recent data available. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data in order to verify, consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner, the accuracy and representativeness of any analyses or reports, and submit comments to the commissioner or initiate an appeal under subdivision 3b. Upon request, providers shall be given any data for which they are the subject of the data. The provider shall have 60 days to review the data for accuracy and initiate an appeal as specified in subdivision 3b.

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Subd. 3c.**Provider peer grouping; publication of information for the public.** (a) The commissioner may publicly release summary data related to the peer grouping system as long as the data do not contain information or descriptions from which the identity of individual hospitals, clinics, or other providers may be discerned.

(b) The commissioner may publicly release analyses or results related to the peer grouping system that identify hospitals, clinics, or other providers only if the following criteria are met:

(1) the results, data, and summaries, including any graphical depictions of provider performance, have been distributed to providers at least 120 days prior to publication;

(2) the commissioner has provided an opportunity for providers to verify and review data for which the provider is the subject consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner;

(3) the results meet thresholds of validity, reliability, statistical significance, representativeness, and other standards that reflect the recommendations of the advisory committee, established under subdivision 3; and

(4) any public report or other usage of the analyses, reports, or data used by the state clearly notifies consumers about how to use and interpret the results, including any limitations of the data and analyses.

(c) After publishing the first public report, the commissioner shall, no less frequently than annually, publish information on providers' total cost, total resource use, total quality, and the results of the total care portion of the peer grouping process, as well as information on providers' condition-specific cost, condition-specific resource use, and condition-specific quality, and the results of the condition-specific portion of the peer grouping process. The results that are published must be on a risk-adjusted basis, including case mix adjustments.

(d) The commissioner shall convene a work group comprised of representatives of physician clinics, hospitals, their respective statewide associations, and other relevant stakeholder organizations to make recommendations on data to be made available to hospitals and physician clinics to allow for verification of the accuracy and representativeness of the provider peer grouping results.

Subd. 3d.**Provider peer grouping; standards for dissemination and publication.** (a) Prior to disseminating data to providers under subdivision 3a or publishing information under subdivision 3c, the commissioner, in consultation with the advisory committee, shall ensure the scientific and statistical validity and reliability of the results according to the standards described in paragraph (b). If additional time is needed to establish the scientific validity, statistical significance, and reliability of the results, the commissioner may delay the dissemination of data to providers under subdivision 3a, or the publication of information under subdivision 3c.

The commissioner must disseminate the information to providers under subdivision 3a at least 120 days before publishing results under subdivision 3c.

(b) The commissioner's assurance of valid, timely, and reliable clinic and hospital peer grouping performance results shall include, at a minimum, the following:

(1) use of the best available evidence, research, and methodologies; and

(2) establishment of explicit minimum reliability thresholds for both quality and costs developed in collaboration with the subjects of the data and the users of the data, at a level not below nationally accepted standards where such standards exist.

In achieving these thresholds, the commissioner shall not aggregate clinics that are not part of the same system or practice group. The commissioner shall consult with and solicit feedback from the advisory committee and representatives of physician clinics and hospitals during the peer grouping data analysis process to obtain input on the methodological options prior to final analysis and on the design, development, and testing of provider reports.

Subd. 4.**Encounter data.** (a) Beginning July 1, 2009, and every six months thereafter, all health plan companies and third-party administrators shall submit encounter data to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section62J.536.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out its responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

Subd. 5.**Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter, all health plan companies and third-party administrators shall submit data on their contracted prices with health care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. The data shall be submitted in the form and manner specified by the commissioner of health.

(b) The commissioner or the commissioner's designee shall only use the data submitted under this subdivision to carry out its responsibilities under this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may

be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

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Subd. 8.**Provider innovation to reduce health care costs and improve quality.** (a) Nothing in this section shall prohibit group purchasers and health care providers, upon mutual agreement, from entering into arrangements that establish package prices for a comprehensive set of services or separately for the cost of care for specific health conditions in addition to the baskets of care established in section 62U.05, in order to give providers the flexibility to innovate on ways to reduce health care costs while improving overall quality of care and health outcomes.

(b) The commissioner of health may convene working groups of private sector payers and health care providers to discuss and develop new strategies for reforming health care payment systems to promote innovative care delivery that reduces health care costs and improves quality.

Subd. 9.**Uses of information.** For product renewals or for new products that are offered:

(1) the commissioner of management and budget may use the information and methods developed under subdivisions 3 to 3d to strengthen incentives for members of the state employee group insurance program to use high-quality, low-cost providers;

(2) political subdivisions, as defined in section 13.02, subdivision 11, that offer health benefits to their employees may offer plans that differentiate providers on their cost and quality performance and create incentives for members to use better-performing providers;

(3) health plan companies may use the information and methods developed under subdivisions 3 to 3d to develop products that encourage consumers to use high-quality, low-cost providers; and

(4) health plan companies that issue health plans in the individual market or the small employer market may offer at least one health plan that uses the information developed under subdivisions 3 to 3d to establish financial incentives for consumers to choose higher-quality, lower-cost providers through enrollee cost-sharing or selective provider networks.

(First enacted 2008)

62U.05 PROVIDER PRICING FOR BASKETS OF CARE.

Subdivision 1.**Establishment of definitions.** (a) By July 1, 2009, the commissioner of health shall establish uniform definitions for baskets of care beginning with a minimum of seven baskets of care. In selecting health conditions for which baskets of care should be defined, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression. In selecting health conditions, the commissioner shall also consider the prevalence of the health conditions, the cost of treating the health conditions, and the potential for innovations to reduce cost and improve quality.

(b) The commissioner shall convene one or more work groups to assist in establishing these definitions. Each work group shall include members appointed by statewide associations representing relevant health care providers and health plan companies, and organizations that work to improve health care quality in Minnesota.

(c) To the extent possible, the baskets of care must incorporate a patient-directed, decision-making support model.

Subd. 2.**Package prices.** (a) Beginning January 1, 2010, health care providers may establish package prices for the baskets of care defined under subdivision 1.

(b) Beginning January 1, 2010, no health care provider or group of providers that has established a package price for a basket of care under this section shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser. This paragraph applies only to health care services provided to Minnesota residents or to non-Minnesota residents who obtain health insurance through a Minnesota employer. This paragraph does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid

arrangements, workers' compensation, or no-fault automobile insurance. This paragraph does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

Subd. 3.**Quality measurements for baskets of care.** (a) The commissioner shall establish quality measurements for the defined baskets of care by December 31, 2009. The commissioner may contract with an organization that works to improve health care quality to make recommendations about the use of existing measures or establishing new measures where no measures currently exist.

(b) Beginning July 1, 2010, the commissioner or the commissioner's designee shall publish comparative price and quality information on the baskets of care in a manner that is easily accessible and understandable to the public, as this information becomes available.

(First enacted 2008)

Minnesota Administrative Rules

4650.0104 SCOPE; REPORT REQUIREMENTS.

Subpart 1. Scope. All hospitals, psychiatric hospitals, specialized hospitals, and outpatient surgical centers licensed under Minnesota Statutes, sections 144.50 to 144.58, are subject to this chapter.

Subp. 2. Report requirements. A hospital, psychiatric hospital, or specialized hospital shall submit a financial, utilization, and services report as described in part 4650.0112. An outpatient surgical center shall submit a financial, utilization, and services report as described in part 4650.0113. A hospital or outpatient surgical center shall submit an audited annual financial statement as described in part 4650.0110 and a Medicare cost report as described in part 4650.0111.

4650.0110 AUDITED ANNUAL FINANCIAL STATEMENT.

Subpart 1. Reporting requirements. A hospital or outpatient surgical center shall submit an audited annual financial statement, including all notes, footnotes, and auditor's opinion, to the commissioner or the voluntary, nonprofit reporting organization approved by the commissioner.

4650.0111 MEDICARE COST REPORT. A hospital or outpatient surgical center shall submit to the commissioner or the voluntary, nonprofit reporting organization approved by the commissioner a copy of the facility's cost report as filed under United States Social Security Act, title XVIII, stated in Code of Federal Regulations, title 42, section 413.20, and the uniform cost report required under United States Code, title 42, section 1320a. The hospital or outpatient surgical center shall also submit a copy of any supplemental reconciliation schedules tying the financial statement to the cost report.

4650.0112 FINANCIAL, UTILIZATION, AND SERVICES REPORT; HOSPITALS.

Subpart 1. Reporting requirements. A hospital, psychiatric hospital, or specialized hospital shall submit a report including financial, utilization, and services information for the facility's last full and audited accounting period prior to the accounting period during which it submits this report. This period is called the reporting year. A hospital must include the information described in subparts 2, 2a, and 3. A psychiatric hospital or a specialized hospital must include the information described in subparts 2, 2a, and 3, item A, but is not required to report the detailed financial data described in subpart 3, items B to R. Information must be reported according to subpart 1c.

Subp. 1a. Changes in accounting period. If a hospital, psychiatric hospital, or specialized hospital changes its audited accounting period, reports must include financial, utilization, and services information for all time periods. Required information for a period of up to 13 months may be included in one report.

Subp. 1b. Clinic data reporting. If a hospital is not part of a multihospital system, but is affiliated with a clinic as evidenced on the audited annual financial statement, the hospital must separately report the hospital and affiliated clinic information. Reporting affiliated clinic information as specified in subpart 7 fulfills the requirements of chapter 4651 for physicians whose information is included in the clinic reporting.

Subp. 1c. Estimating. Whenever reasonably possible, a hospital, psychiatric hospital, or specialized hospital must report actual numbers in all categories. If it is not reasonably possible for the facility to report actual numbers, the facility may estimate using reasonable methods. Upon request from the commissioner, the facility must provide a written explanation of the method used for the estimate.

Subp. 3. Financial information. Financial information must include:

A. total operating expenses and total operating revenue;

B. management information systems expenses and plant, equipment, and occupancy expenses;

C. total administrative expenses. A hospital licensed for 50 or more beds shall report expenses for each of the following functions: admitting, patient billing, and collection; accounting and financial reporting; quality assurance and utilization management program or activity; community and wellness education; promotion and marketing; taxes, fees, and assessments; malpractice; and other administrative expenses;

D. regulatory and compliance reporting expenses;

E. hospital patient care services charges and other patient care services charges;

F. the sum of hospital patient care services charges and other patient care services charges:

(1) by type of payer;

(2) by inpatient, outpatient, and other patient category;

(3) by outpatient services categories;

(4) for services provided in swing beds;

(5) for subacute or transitional care services;

(6) by the top ten diagnosis related groups, as those groups are maintained under Code of Federal Regulations, title 42, part 412; and

(7) by designated care unit or revenue center;

G. a statement of adjustments and uncollectibles by type of payer, for charity care, and by inpatient or outpatient category:

(1) for hospital patient care services; and

(2) for other patient care services;

H. public funding for operations and donations and grants for charity care with estimates of the percentage received from private and public sources;

I. income or loss from hospital operations;

J. gross receivables by payer and net receivables;

K. a copy of charity care policies, including a description of, if applicable, income guidelines, asset guidelines, medical assistance status impact on charity care eligibility, and sliding fee schedules; charity care services provided; other benefits provided to the community; costs in excess of public program payments; and other community services costs;

L. description of the care provided in swing beds;

M. the medical care surcharge and MinnesotaCare tax paid;

N. provision for bad debts:

(1) for hospital patient care services; and

(2) for other patient care services;

O. all other operating expenses by a natural classification of expense;

P. nonoperating revenue and nonoperating expenses;

Q. nonoperating donations and grants and nonoperating public funding;

R. salaries and wages by employee classification; and

S. the number of full-time equivalent residents, resident salaries and benefits, and research expenses.

Subp. 6. Budget year reporting. A hospital shall report budgeted information or reasonable estimates of total operating expenses, the sum of hospital patient care services charges and other patient care services charges, total adjustments and uncollectibles, total salaries and wages, total patient days, total admissions, and total outpatient registrations for the hospital's full accounting period during which it submits the report. This period is called the budget year.

Subp. 7. Affiliated clinic data reporting. If affiliated clinic data is reported according to subpart 1b, the clinic data must include the following:

A. gross patient revenue, adjustments and uncollectibles, net patient revenue by type of payer, and charity care as defined in part 4651.0100, subpart 4;

B. operating revenue categorized by education revenue as defined in part 4651.0100, subpart 8, research revenue as defined in part 4651.0100, subpart 22, and donations for charity care as defined in part4651.0100, subpart 4;

C. the number of registrations by clinic location;

D. other patient care costs as defined in part 4651.0100, subpart 16, bad debt as defined in part4651.0100, subpart 2, education-degree program costs as defined in part 4651.0100, subpart 9, and research costs as defined in part 4651.0100, subpart 21;

E. the total number of full-time equivalent employees for the clinic by employee classification;

F. malpractice expenses, if separate from the hospital;

G. addresses of each clinic location;

H. names and provider identifiers of physicians by clinic location; and

I. a description of how the clinic is defined and how it is distinguished from other outpatient services of the hospital.

4650.0113 FINANCIAL, UTILIZATION, AND SERVICES REPORT; OUTPATIENT SURGICAL CENTERS.

Subpart 1. Reporting requirements. An outpatient surgical center shall submit a report, including the financial, utilization, and services information described in subpart 4, for the outpatient surgical center's last full accounting period prior to the accounting period during which it submits the report. This period is called the reporting year. Information must be reported according to subpart 3.

Subp. 2. Changes in accounting period. If an outpatient surgical center changes its audited accounting period, reports must include financial, utilization, and services information for all time periods. Required information for a period of up to 13 months may be included in one report.

Subp. 3. Estimating. Whenever reasonably possible, an outpatient surgical center must report actual numbers in all categories. If it is not reasonably possible for the facility to report actual numbers, the facility may estimate using reasonable methods. Upon request from the commissioner, the outpatient surgical center must provide a written explanation of the method used for the estimate.

Subp. 4. Financial, utilization, and services information. Financial, utilization, and services information must include:

A. the number of surgical cases;

B. the number of operating rooms;

C. the average weekly hours open;

D. the type of nonsurgical procedures or services provided, including radiology, laboratory, and medical procedures and services;

E. the average number of full-time equivalent employees by employee classification;

F. the number of physicians with staff privileges;

G. the ten surgical procedures performed most frequently during the reporting year, including the procedure name, the current procedural terminology code number, and the number of procedures. Current procedural terminology code numbers are contained in "Physician's Current Procedural Terminology" (CPT manual) (4th edition 1996 and subsequent editions), published by the American Medical Association. The CPT manual is incorporated by reference, is subject to frequent change, and is available through the Minitex interlibrary loan system;

H. gross surgical center revenue from patient care;

I. charges by type of payer;

J. adjustments and uncollectibles by type of payer, and for charity care;

K. bad debt and total operating expenses;

L. total administrative expenses;

M. an estimate of regulatory and compliance reporting expenses;

N. management information systems expenses and plant, equipment, and occupancy expenses;

O. a description of ownership, including corporations that the outpatient surgical center is owned by or owns;

P. a description of contracts or formal affiliations with hospitals, providers of radiology services, providers of laboratory services, other outpatient surgical centers, or third-party payers, including the name of the entity, the purpose of the contract, and whether the contract or affiliation includes price discounts, quality or practice patterns, performance incentives, volume of business guarantees, or exclusivity arrangements;

Q. the availability of price information, including whether:

(1) prices are posted at the surgical center;

(2) a written price list is available on request;

(3) specific service prices are available on request;

(4) prices are included in advertising and other literature; or

(5) it is the surgical center's policy not to disclose price information;

R. the number of inquiries concerning the price of services the surgical center receives in an average business week;

S. a description of charity care policies, including income guidelines, asset guidelines, medical assistance status impact, and sliding fee schedules;

T. a general description of the change in the demand for charity care to be provided in the budget year; and

U. a general estimate of the change in the amount of charity care the surgical center expects to provide in the budget year.