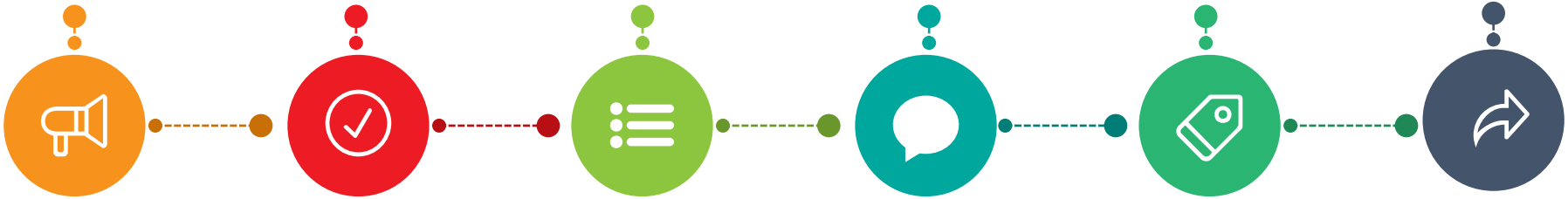
What Hospitals Should Know About Pricing Transparency Requirements

A ThinkCleverley Webinar

Learning Outcomes

- Describe the price transparency guidelines effective 1/1/2021
- List important action items that hospitals must implement
- Contrast the two different ways prices must be published

Transparency timeline



2010

ACA

Original calls for pricing transparency included in landmark legislation.

2014

FY15 Proposed Rule

Reminder in the FY15 IPPS proposed rule called for hospitals to either make pricing available to the public by posting CDM information – or – by providing a means for the public to gain access to it.

2018

FY19 Final Rule/ Responses to FAQs

Effective January 1, 2019, requirement for hospitals to make available a list of their current standard charges via the Internet in a machine readable format and to update this information at least annually.

2019

Executive Order

On June 24, President Trump signed an executive order calling for additional transparency policies and guidelines to be developed.

2019

CY20 Final Rule

The CY20 OPPS Final Rule calls for significant updates for pricing AND payment disclosures. These are to be included in an expanded machine readable file, as well as, a separate consumer shoppable posting (or patient estimation tool to satisfy the latter).

2020

FY21 Proposed Rule

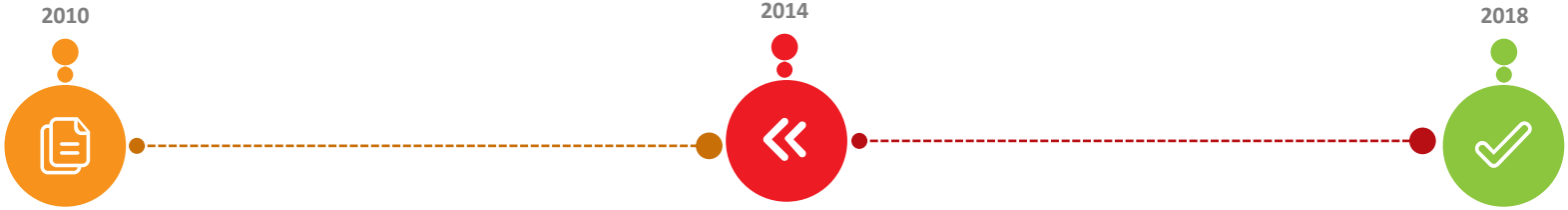
Proposal to require Medicare cost reports to include the median health plan-specific negotiated rates for inpatient services by MS-DRG.

Final Rule on Hospital Price Transparency

Key Dates:

- November 15, 2019 – Final Rule Released
  - Found here: https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and
- December 3, 2019 – Medicare Learning Network call to review the rule and answer questions
  - Additional questions can be sent here: PriceTransparencyHospitalCharges@cms.hhs.gov
- **Effective date for rule is January 1, 2021 – however, requirements from FY19 IPPS Final Rule still apply for price disclosure**

How key language changed



ACA:
The Original Request

Section 2718(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.

FY15 IPPS Final Rule:
The Reminder

In the FY 2015 IPPS/LTCH PPS proposed rule (79 FR 28169), we reminded hospitals of their obligation to comply with the provisions of section 2718(e) of the Public Health Service Act. We appreciate the widespread public support we received for including the reminder in the proposed rule. **We reiterate that our guidelines for implementing section 2718(e) of the Public Health Service Act are that hospitals either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry.** MedPAC suggested that hospitals be required to CMS-1607-F 1205 post the list on the Internet, and while we agree that this would be one approach that would satisfy the guidelines, **we believe hospitals are in the best position to determine the exact manner and method by which to make the list public in accordance with the guidelines.**

FY19 IPPS Final Rule:
The Requirement

As one step to further improve the public accessibility of charge information, **effective January 1, 2019**, we announced the update to our guidelines to **require hospitals to make available a list of their current standard charges via the Internet in a machine readable format and to update this information at least annually, or more often as appropriate. This could be in the form of the chargemaster itself or another form of the hospital's choice**, as long as the information is in machine readable format."

The Final Rule is about Definitions

Section 2718(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.

FY19 IPPS FINAL RULE – As one step to further improve the public accessibility of charge information, effective January 1, 2019, we announced the update to our guidelines to require hospitals to make available a list of their current **standard charges** via the Internet in a machine readable **format** and to update this information at least annually, or more often as appropriate. This could be in the form of the chargemaster itself or another form of the hospital's choice, as long as the information is in machine readable format."

Key Requirements of Final Rule on Price Transparency

Definition of “Hospital” and Hospitals Regarded as Having Met Requirements

Summary:

The final rule formally defines a “hospital” very broadly to include most types of hospitals from all areas of the US and US territories. The only exceptions to the reporting requirements would be “Federally-owned or operated institutions” as these facilities “are not accessible to the general public, except in emergency situations, and already make their charges publicly available are deemed to have met the requirements of Section 2718(e).” Ambulatory Surgical Centers (ASCs) or other non-hospital sites-of-care (lab, imaging centers) are also excluded.

Key Requirements of Final Rule on Price Transparency

Definition for “Items & Services”

Summary:

CMS is defining what is meant by providing pricing information for “all items and services” to be inclusive of all “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”

1) **ALL ITEMS** in the chargemaster and/or provided to patients, including drugs and supplies
2) **SERVICE PACKAGES** – meaning all other types of “aggregation of individual items and services into a single service with a single charge” the hospital could be paid under – including, MSDRGs, per diems, and other packages including those in outpatient settings
3) **PROFESSIONAL FEES** – charges for employed physicians and non-physician practitioners

Key Requirements of Final Rule on Price Transparency

Definitions for Types of "Standard Charges"

Summary:

CMS finalized the definition of 'standard charges' to include the following:

1) **Gross charge:** The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts
2) **Discounted cash price:** The charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service
3) **Payer-specific negotiated charge**:** The charge that a hospital has negotiated with a third party payer for an item or service
4) **De-identified minimum negotiated charges**:** The lowest charge that a hospital has negotiated with all third-party payers for an item or service
5) **De-identified maximum negotiated charges**:** The highest charge that a hospital has negotiated with all third-party payers for an item or service

***Medicare and Medicaid rates would not need to be disclosed as these are not negotiated*

Key Requirements of Final Rule on Price Transparency

Format Requirements – Two Primary Disclosures

1) **COMPREHENSIVE MACHINE-READABLE FILE**
    1) **WHO/WHEN:** Each hospital location operating under a single hospital license that has a different set of standard charges must separately make public the standard charges that are applicable to that location – updates at least once per year (annually)
    2) **FORMAT:** A single machine readable file – examples include (.XML, .JSON, .CSV – but not .pdf)
    3) **DATA ELEMENTS:**
        a) Description of each item or service
        b) All five standard charge types – also, any IP/OP pricing differentials that might exist
        c) Accounting/Billing codes – as example, HCPCS codes, DRG codes, or other common payer identifier
    4) **LOCATION/ACCESSIBILITY:**
        a) Prominently displayed on the web without barriers for patients to access
        b) Document must have CMS naming convention
    5) **NOTE:** While it must be one searchable file, the file could have multiple worksheets to display the different types of items, services, service packages, and types of standard charges

1) COMPREHENSIVE MACHINE-READABLE FILE – EXAMPLE PROVIDED BY CMS

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes]

Description	CPT/HCPCS Code	NDC	OP/Default Gross Charge	IP/ER Gross Charge	ERx Charge Quantity
HB IV INFUS HYDRATION 31-60 MIN	96360		$1,000.13	$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		$251.13	$383.97	
HB IV INFUSION THERAPY 1ST HR	96365		$1,061.85	$1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				$2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				$2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				$2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				$2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			$3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			$1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			$6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	$251.13	$383.97	12 Each
PHENYLEPHRINE HCL 10 % OP DROP		17478020605	$926.40	$1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	$0.00	$0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		$185.00		
GENETIC COUNSEL 15 MINS	S0265		$94.00		
DIALYSIS TRAINING/COMPLETE	90989		$988.00		
ANESTH, PROCEDURE ON MOUTH	170		$87.00		

**Call on 12/3 said the ERx Charge Quantity was optional

[1] Note that this example shows only one type of standard charge (specifically the gross charges) that a hospital would be required to make public in the comprehensive machine-readable file. Hospitals must also make public the payer-specific negotiated charges, the de-identified minimum negotiated charges, the de-identified maximum negotiated charges, and the discounted cash prices for all items and services.

Cleverley + Associates Comment For Different Worksheets Within the Single Comprehensive Machine Readable File

DEFINITION OF ITEMS & SERVICES

DEFINITION OF STANDARD CHARGES	HOSPITAL/TECHNICAL		PROFESSIONAL
	Services	**Service Packages**	**Services**
	Per Unit (Examples: CDM, HCPCS)	**Aggregation of individual items and services into a single service with a single charge (Examples: Per Diems, MSDRGs)**	**Per Unit (Examples: CDM, HCPCS**
Gross Charges	✓ **WORKSHEET ONE** We envision this being one of the worksheets in the machine readable disclosure. This would follow the current FY19 IPPS Disclosure but with the added data elements (billing codes).	✗ Gross charges are not typically established and stored for this definition element.	✓ **WORKSHEET THREE+** Since many professional CDM and payer fee schedules are at the per unit (HCPCS) level, there would be the potential to provide all five definitions of standard charges in one worksheet. Still, the hospital has the flexibility to create multiple worksheets for each element and for each payer, if desired. An argument could be made that a patient could more easily locate information if on one separate worksheet for their payer.
Discounted Cash Price	✓ **WORKSHEET TWO** There is a potential that discounted cash prices could exist at a per unit, service level and could be combined with the gross charge disclosure worksheet. However, discounted cash prices could also be defined at a service package level. As such, it may make most sense to disclose discounted cash prices as the hospital has defined them on a separate worksheet.		
Payer-Specific Negotiated Charges	✗ Specific rates at a service, per unit level, do not exist for most contracts unless the entire contract is based on a discount of charges. In addition, when certain fee schedules are used at a HCPCS level, there still could be other payment logic in the contract that could be misleading to the patient to list fee schedule rates next to CDM lines. As such, it's likely best in all circumstances to not include payment information next to CDM line information. By not displaying together, it could also help communicate to the patient that payment is ALWAYS at the claim (or encounter, visit) level.	✓ **WORKSHEET FOUR+** Because of the complexity and unique service definitions within many payer contracts, it is likely that each payer will require its own disclosure worksheet within the file.	
De-identified minimum negotiated charges		✓ **WORKSHEET FIVE & SIX** It could be possible to have these two definition elements side-by-side in one worksheet. However, two challenges emerge: 1) Because many contracts do not contain the exact same definitions for service packages it is likely that the minimum and maximum could be exactly the same 2) A side-by-side presentation could show larger payment disparities that might lead some to conclude minimums are always profitable – whereas, these rates could have been established as loss leaders within the negotiation. For both reasons, a hospital might conclude it should separate these into separate worksheets.	
De-identified maximum negotiated charges			

Key Requirements of Final Rule on Price Transparency

Format Requirements – Two Primary Disclosures

2) CONSUMER FRIENDLY SHOPPABLE SERVICES

1) **WHO/WHEN:** Each hospital location operating under a single hospital license that has a different set of standard charges must separately make public the standard charges that are applicable to that location – updates at least once per year (annually)
2) **QUANTITY:** CMS is requiring 300 items and services be provided (including 70 CMS-specified and 230 hospital-selected)
    a) If the hospital doesn't provide one of the 70 it should note that but still select replacements so that the total is at least 300. If 300 aren't provided to fit the definition then as many as possible should be provided.
3) **SELECTION:** A 'shoppable service' is a service that can be scheduled by a health care consumer in advance. The hospital should select services that are commonly provided to its patients.
4) **LOCATION/ACCESSIBILITY:**
    a) Prominently displayed on the web without barriers for patients to access

Key Requirements of Final Rule on Price Transparency

Format Requirements – Two Primary Disclosures

2) CONSUMER FRIENDLY SHOPPABLE SERVICES, continued

5) DATA ELEMENTS:

a) Plain-language description and primary code used by the hospital for accounting/billing

b) Ancillary services that the hospital customarily provides in conjunction with the primary shoppable service

c) Location and whether the standard charge applies for IP, OP, or both settings

d) Standard Charges - **ALL FIVE EXCEPT GROSS CHARGE**

6) FORMAT:

a) Hospitals have discretion to choose a format for making public the consumer-friendly information

b) CMS will deem a hospital as having met the requirements if the hospital maintains an internet-based price estimator tool that meets the following requirements:

i. There are still at least 300 services provided (including the CMS 70)

ii. Provides an **estimate** of the amount the patient will be obligated to pay for

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

2) CONSUMER FRIENDLY SHOPPABLE SERVICES – EXAMPLE PROVIDED BY CMS

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes or disclaimers]

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
Colonoscopy	Primary Diagnostic Procedure	45378	$750
	Anesthesia (Medication Only)	[Code(s)]	$122
	Physician Services	Not provided by hospital (may be billed separately)	
	Pathology/Interpretation of Results	Not provided by hospital (may be billed separately)	
	Facility Fee	[Code(s)]	$500
Office Visit	New Patient Outpatient Visit, 30 Min	99203	$54
Vaginal Delivery	Primary Procedure	59400	[$]
	Hospital Services	[Code(s)]	[$]
	Physician Services	Not provided by hospital (may be billed separately)	
	General Anesthesia	Not provided by hospital (may be billed separately)	
	Pain Control	Not provided by hospital (may be billed separately)	
	Two Day Hospital Stay	[Code(s)]	[$]
	Monitoring After Delivery	[Code(s)]	[$]

Key Requirements of Final Rule on Price Transparency

Non-compliance

Summary: One final key point is that the CMS proposes a penalty of up to $300 per day for non-compliance. This would amount to $109,500 for a hospital that was not compliant for an entire year. The rule provides information on the process for enforcement and appeal.

Comprehensive Compliance Solution

The Cleverley + Associates Solution

RATE ADVISOR™ CONSULTING	COMPREHENSIVE MACHINE READABLE FILE	CONSUMER FRIENDLY SHOPPABLE SERVICES
Cleverley + Associates is nationally recognized for hospital price strategy development and revenue impact modeling. Rate Advisor™ is our industry-leading consulting service that is utilized by hundreds of hospitals across the country each year. In addition to collecting the information needed to build the disclosure documents, this service also allows the organization to proactively assess and make necessary adjustments to enhance market position.	To comply with the FY19 Final Rule, Cleverley + Associates provided disclosure files to hundreds of hospitals. Our core offering will be expanded to meet the additional requirements in the CY20 Final Rule as outlined in our format guidance. Clearly, the most challenging portion of the new requirements is the section dealing with payment disclosures. The contract modeling conducted in the Rate Advisor™ consulting service permits the electronic compilation of all necessary components for public display. Additional fees will be required for the professional services disclosure, if applicable/desired.	Hospitals have the opportunity to either post a static view of the required information or utilize a web-based tool to estimate patient responsibility for these services. Cleverley + Associates will also provide hospitals these two options. In addition, the Rate Advisor™ consulting service can assist hospitals with the development and selection of the codes and services for public consumption.

Subject to communication with the CMS Price Transparency team, a responses to frequently asked questions is being developed to clarify reporting requirements. Cleverley + Associates has presented proposed formats and is awaiting the public release of this document in order to finalize our offering. The CMS Price Transparency team has said that the document is forthcoming.

Comprehensive Compliance Solution

The Cleverley + Associates Solution

Gather

The first stage in our process is to gather the primary data elements:

1) CDM
2) Payment information
3) Patient claim detail

Build

Next, our team of experts integrates the CDM, contract modeling, and patient claims to build the disclosure documents.

Refine

We assess market position and assist in creating the consumer shoppable list. Price adjustments can be made prior to reporting with associated impact.

Disclose

All required reporting elements are provided for public disclosure. Web hosting is available for a completely turnkey solution.

Contact

Jamie Cleverley

About Jamie

Jamie's expertise and focused, strategic thinking helps hospitals grow and expand their business, identify potential issues, and craft individual solutions. He continues the Cleverley tradition of client-focused solutions and creative, critical thinking. Jamie works with hospitals to identify financial opportunities and create solutions customized for their business.

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