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National Hospital Survey Shares Insight into CMS's Price Transparency Requirement

Reporting drug and supply prices is an area of particular challenge for hospitals and health systems.

By **Jamie Cleverley**

Beginning Jan. 1, 2019, hospitals across the country were required to make public a list of their standard charges via the internet, but there was no way for these facilities to see how other hospitals have responded to this call to action. A national survey conducted by Cleverley & Associates in January provides insight from 100 individual responses, representing hospitals across the country on the FY19 Inpatient Prospective Payment System (IPPS) Pricing Transparency Requirement. The survey results provide insight into how it might be best to structure such disclosures now and in the future.

Background Sheds Light on Survey Results

Hospitals and health systems were familiar with the requirement included in the FY19 IPPS proposed and final rules as there was language calling for increased price transparency as part of the Affordable Care Act (ACA) of 2010. That original language, subsequent guidance, and a reminder in the FY15 IPPS proposed rule called for hospitals to either make pricing available to the public by posting chargemaster information or by providing a means for the public to gain access to it.

While most hospitals complied with this by making the information available upon request, many industry leaders believe the Centers for Medicare & Medicaid Services (CMS) was not satisfied with that being the standard. Four

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Compliance Options for Making Hospital Charges Public

This compliance continuum offers hospitals and health systems various options for meeting CMS's requirement to post standard charges.

Transparency Continuum: Increasing usefulness of transparency information to the patient

	No Reporting	Minimum Chargemaster	Top Consumer Codes	Expanded Chargemaster	Encounter Charges	Encounter Payments	Patient-Specific Payments
What is it?	A hospital could elect to not report information	Electronic file containing only charge code and average price	Pricing by HCPCS for top sensitive codes (e.g., Transparency Fifty™)	Adding fields like HCPCS and item descriptions to the minimum chargemaster	Average inpatient and outpatient claim charges (e.g., MS-DRG, primary APC)	Average inpatient and outpatient claim payments	Resource for patients to reach the hospital to determine their specific payment options
Notes	While not compliant, the CMS does not specify penalties at this time	While not useful to the patient, this would satisfy the requirement	Would provide patients with the most requested charges. **Based on the FAQ update by CMS, this is not compliant as it does not represent all codes.	Would provide patients more ability to search for specific items	Ultimately, for prices, patients would be interested to know what their average charge would be for their entire encounter.	Beyond average gross charges, patients would be interested in knowing what the average reimbursed payment would be. **This isn't compliant, though, because it isn't a "charge."	This is ultimately what is of most interest to patients. **This isn't compliant, though, because it isn't a charge and can't be posted to the internet in machine-readable format.
	Compliant Option	Non-Compliant Option	Options that could be provided with peer benchmarks to promote patient comparison				

Source: Cleverley + Associates. Used with permission.

years later in the FY19 IPPS rule, CMS provided the following four communications about requiring hospital charge postings:

- > The original FY19 IPPS Proposed Rule language that reads:

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 FY19 IPPS Final Rule did not alter the language above but did include some

additional insight through the responses to comments.

- > The first responses to frequently asked questions posted by CMS in September 2018
- > The second responses to frequently asked questions posted in December 2018

Because the first two communications were part of the FY19 IPPS proposed and final rules, they were prominently disseminated throughout the industry. The latter two, however, were not released with much fanfare from the CMS. So, there are still some in the healthcare industry who are unaware of their existence and who may have missed some technical elements that would make their disclosure non-compliant. Knowing this caveat furthers understanding of the Cleverley & Associates' survey results.

Survey Results and Insights

Of the 100 respondents asked about their awareness of the FY19 IPPS call for transparency, 92 percent were aware of the new requirement and 8 percent did not answer. However, from subsequent questions and answers in the survey, it can be surmised that all respondents were aware of the rule.

Likely the question of most interest was the second in the survey: How did you choose to comply (see the exhibit on page 3)? Respondents were able to select more than one option because the rule does not specify one prescribed method. In fact, based on the rule's language and subsequent guidance from CMS responses to frequently asked questions, it seems there are four keys to providing a compliant disclosure:

- > Type of information: Hospitals must show standard charges via the chargemaster or another form chosen by the

hospital, however, all items and services must be represented.

- > Availability of information: Information must be made available on the internet; however, participation in a state online transparency initiative does not exempt a hospital from the requirement.
- > Format of information: Data must be machine readable; a pdf document is not sufficient.
- > Update to information: At least annually.

Compliance Options

Given the four keys to compliance, Cleverley & Associates created a compliance continuum to help hospitals identify approaches that would meet the requirements (see the exhibit on page 2). While early interpretations of the rule would have suggested that any one of the three compliant options (minimum chargemaster, expanded chargemaster, and encounter charges) would be sufficient on their own, there was information in CMS’s December 2018 responses to frequently asked questions that implied CMS wanted both a chargemaster-type disclosure, such as the minimum chargemaster or expanded chargemaster options, plus a disclosure of average charges by Medicare Severity Diagnosis Related Groups (MS-DRG), such as the encounter charges option.

Cleverley & Associates believes this was presented by CMS to cover the original ACA transparency language that included mention of DRGs. That language is what caused us to believe that encounter-level disclosures would satisfy CMS requirements when the rule was first proposed. While that still could be argued, it seems that CMS would now like to see both chargemaster-type disclosures and average charges by MS-DRG. However, it also appears the encounter-level charges disclosures still meet all four keys to compliance.

The compliant methods presented in the continuum served as options the respondents could choose from in the survey. Nearly three quarters of respondents chose to use a minimum chargemaster disclosure—meaning a disclosure that included

How Hospitals Complied with CMS’s Standard Charge Posting Requirement	
Almost three-quarters of hospitals responding to a survey about standard charge posting compliance said they chose a minimum chargemaster approach.	
How did you choose to comply (check all that apply)?	% Respondents
By disclosing minimum chargemaster data (item code and/or description and price)	74%
By disclosing enhanced chargemaster data (minimum plus HCPCS and potentially other fields)	19%
By disclosing average encounter charges by MS-DRG	53%
By disclosing average encounter charges by primary Ambulatory Payment Classification	4%
Our organization plans to comply, but, has not finalized our disclosure	0%
Our organization does not plan to provide a disclosure	0%
Other	9%
Source: Cleverley + Associates. Used with permission.	

Disclosing Prices for Drugs and Supplies in Response to CMS’s Standard Charge Posting Requirement	
Hospitals can choose how they disclose prices for drugs and supplies under CMS’s standard charge posting requirement.	
How did you disclose pricing information for drugs and supplies (check all that apply)?	% Respondents
The current price in the chargemaster (this could include null or zero values because that is what is represented in the chargemaster)	52%
The average charge from a representative time period (e.g., previous year, previous quarter)	30%
No pricing information was provided for these codes as a “standard charge” is not defined in the rule and cannot truly be provided in “dynamic” charging environments where prices are created based on current relationships to cost/other	6%
Drug and supply charges were part of the average encounter charges provided	10%
We did not disclose drug/supply charges	2%
Other	13%
Source: Cleverley + Associates. Used with permission.	

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Guidance on Disclosing Hospital Drug and Supply Prices

Many hospitals are seeking guidance on disclosing drug and supply prices.

Provider Pricing/Billing Method	Options for Disclosure
Codes are contained in the chargemaster and pricing is “static” at set values (not zero or null), meaning, prices do not change based on relationships to current cost (or other) throughout the year.	Disclose the set price
Codes are contained in the chargemaster and pricing is “dynamic,” meaning, prices <i>do</i> change based on relationships to current cost (or other) throughout the year. The stored “price” in the chargemaster could be zero or null and is updated on the patient claim.	<ul style="list-style-type: none"> > Disclose the current price in the chargemaster. This could include null or zero values as represented in the chargemaster. Using a clarifying statement would be helpful (e.g., “Price is variable based on type of drug/supply and variable cost.”).
“Shell” codes are contained in the chargemaster and pricing is dynamic—meaning, prices <i>do</i> change based on relationships to current cost (or other) throughout the year. The stored “price” in the chargemaster could be zero or null and is updated on the patient claim.	<ul style="list-style-type: none"> > Disclose average charges from representative time periods (e.g., previous year, quarter) > Because a standard charge is not defined in the rule and cannot truly be provided in this type of dynamic charging environment, the hospital could provide a qualifying statement in the cell (e.g., “Price is variable based on type of drug/supply and variable cost.”).
Codes are <i>not</i> contained in the hospital’s chargemaster.	Include from alternate system: A hospital could provide charge data from the ancillary system and disclose using one of the disclosure methods described above.

Source: Cleverley + Associates. Used with permission.

basic chargemaster information such as an item code, description, and price, while 19 percent chose to add the designation “HCPCS, among potentially other fields,” to the document. This point is interesting because the primary means for comparison would be achieved through HCPCS codes at the chargemaster price level. Likely, many hospitals have omitted these references as they recognize that comparing list prices at the item level can be confusing and problematic to patients for two primary reasons:

- > Per unit price comparison can be misleading because of varying degrees of bundling at different hospitals (e.g., one provider could charge individually for all items received while another could bundle some of those services and supplies into a packaged price).

- > Per unit pricing can be misleading because it is only one part of a patient’s total encounter charges.

For many patient encounters, the claims consist of various services. Those individual services have established prices that are consistent for all payers. However, the value of publicizing the prices for these individual services at the chargemaster- and/or procedure-code level is greatly diminished because the frequency of use for those services cannot be known until patient care is delivered—often uniquely for what each patient requires. For example, patients may see a per-minute OR price, but they can’t calculate a total charge because they don’t know how many minutes of OR time they will need.

MS-DRG Considerations

Given the hurdles mentioned above, CMS may have decided to include language to provide a pricing disclosure at the MS-DRG level as well. This language was presented in the responses to frequently asked questions posted in December 2018, shortly before hospitals were required to post, which is likely why only about half of respondents disclosed average encounter charges by MS-DRG.

It is encouraging that all respondents chose to comply and did so with good faith efforts to use compliant options. The 9 percent of “other” response options were, in general, citing additional supplements the providers felt could be useful.

Subsequent questions revealed additional key findings: 3 percent of respondents included peer-comparison data in their disclosures and 88 percent of respondents included *all* active items/services that included drugs and supplies. The other 12 percent excluded the following:

- > Drugs/supplies (3 percent)
- > Items that had patient volume (6 percent)
- > Some other criteria (3 percent)

Drug and Supply Inclusion Considerations

The drug and supply inclusion is important as there was significant discussion surrounding this in the months leading up to implementation. The definitive answer for this was not confirmed until the second set of CMS responses to frequently asked questions.

The survey found that most hospitals are including drugs and supplies in their disclosures. Still, CMS never provided guidance on *how* hospitals should disclose charges for these items and instead deferred to hospitals’ discretion. That ambiguity left many searching for appropriate ways to respond. The primary hurdle providers faced was how to display pricing at the line level when many items are priced “dynamically” at the time of the charge based on relationships to cost, average wholesale price (AWP), or some other basis. While encounter-level charge

disclosures would not be subject to these display challenges, line item disclosures are problematic. Several options would be available, and those different approaches served as the basis for our fifth question (see exhibit on page 3).

As seen, most respondents presented the information for drugs and supplies as it is contained in the chargemaster—which could include null or zero values. However, almost one-third of respondents created an average charge for these items based on a representative time period. Of interest is that a number of the “other” methods included a price calculation based on the cost and markup that existed at the time of disclosure.

How to Disclose Prices for Drugs and Supplies

Questions on how to appropriately disclose prices for drugs and supplies is the question most asked of Cleverley & Associates. As such, a matrix can help providers create appropriate responses (see exhibit on page 4).

Additional Survey Results

Three of the questions centered around timing and responsibility for creation and ongoing maintenance and support of disclosure documents. Respondent answers show 64 percent plan to update prices

annually, 12 percent to do so semi-annually, 12 percent chose quarterly, 3 percent monthly, and 9 percent by some other or unknown criteria. Survey results show that 90 percent of respondents created their disclosure documents internally, 8 percent used an external partner, and 2 percent provided no response.

Another survey question asked respondents which department would be responsible for ongoing disclosure document support and maintenance. While some respondents said “finance,” “decision support,” and “patient accounting,” the vast majority listed some form of a revenue cycle/revenue integrity/revenue management department.

The final survey question about challenges experienced in complying with this new requirement garnered 62 responses. Two major themes were prevalent among the answers and can be summarized, as follows:

- > Respondents expressed confusion with how to comply with the new rule because of what seemed to many respondents a lack of adequate, consistent, and timely communication from CMS about implementation specifics and how to overcome challenges, with several comments on continued confusion specifically on how to report pricing for drugs and supplies.

- > Respondents struggled with understanding the intent behind the requirement to provide greater transparency when the reality is that much of the information providers are being required to disclose will lead to additional confusion for patients.

Even with these challenges, and considering CMS did not prescribe any penalties for non-compliance, it was encouraging that all 100 Cleverley & Associates respondents complied with the new requirement.

While there is a belief among those working in the healthcare industry that this information might not be the best way to provide transparency to patients, there is sentiment from many that their organizations continue to provide useful information to patients that extend beyond the new requirement. This is likely the spirit that CMS hopes the entire industry will embrace.

As seen over the past nine years, calls for greater transparency within the healthcare industry continue, but also collectively, the industry appears to recognize that although there are significant challenges to the cause, the cause is worthwhile. //

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