Cleverley + Associates

SPRING SUMMIT: ADDRESSING PRICE TRANSPARENCY'S KEY QUESTIONS

Session Two:
How is the disclosed data being used?

Spring Summit Agenda

Addressing Price Transparency's Key Questions:

1) How are hospitals complying?
2) **How is the disclosed data being used?**
3) How can hospitals defend their position?
4) How can hospitals prepare for the future?

Session Two Overview: Now that the data has been disclosed, this session will focus on how hospitals and other organizations are using this information. The strengths and limitations of the data will be discussed, as well as, options to overcome some of the inherent challenges in making comparisons.

How is the disclosed data being used?

Who is accessing the data?

Government

FRANK PALLONE, JR., NEW JERSEY
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ONE HUNDRED SEVENTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

April 13, 2021

Dear Secretary Becerra:

We write today regarding the implementation of the Hospital Price Transparency Final Rule, which went into effect on January 1, 2021.[1] We are concerned about troubling reports of some hospitals either acting slowly to comply with the requirements of the final rule, or not taking any action to date to comply. We urge you to ensure that the Department of Health and Human Services (HHS) conducts vigorous oversight and enforces full compliance with the final rule.

Media

THE WALL STREET JOURNAL.

Home World U.S. Politics Economy **Business** Tech Markets Opinion Life & Arts Real Estate WSJ. Magazine

How Much Does a C-Section Cost? At One Hospital, Anywhere From $6,241 to $60,584.

New federally mandated disclosures by California's Sutter Health illustrate the wide disparity in healthcare rates negotiated by insurers

By Anna Wilde Mathews, Tom McGinty and Melanie Evans
Feb. 11, 2021 8:45 am ET

When a woman gets a caesarean section at the gleaming new Van Ness location of Sutter Health's California Pacific Medical Center, the price might be $6,241. Or $29,257. Or $38,264. It could even go as high as $60,584.

The rate the hospital charges depends on the insurance plan covering the birth. At the bottom end of the scale is a local health plan that serves largely Medicaid recipients. At the top are prices for women whose plans don't have the San Francisco hospital in their insurers' network.

The nation's roughly 6,000 hospitals have begun to reveal the secret rates they negotiate with insurers for a range of procedures. The data offer the first full look inside the confidential deals that set healthcare rates for insurers and employers covering more than 175 million Americans. The submissions also illuminate how widely prices vary—even for the same procedure, performed in the same facility—depending on who is paying.

Advocacy Groups

Researchers

HealthAffairs

Low Compliance From Big Hospitals On CMS's Hospital Price Transparency Rule

Morgan Henderson, Morgane C. Mouslim

MARCH 16, 2021 10.1377/hblog20210311.899634

KFF Filling the need for trusted information on national health issues

Analysis: Hospital Price Transparency Data Lacks Standardization, Limiting Its Use to Insurers, Employers, and Consumers

Published: Apr 09, 2021

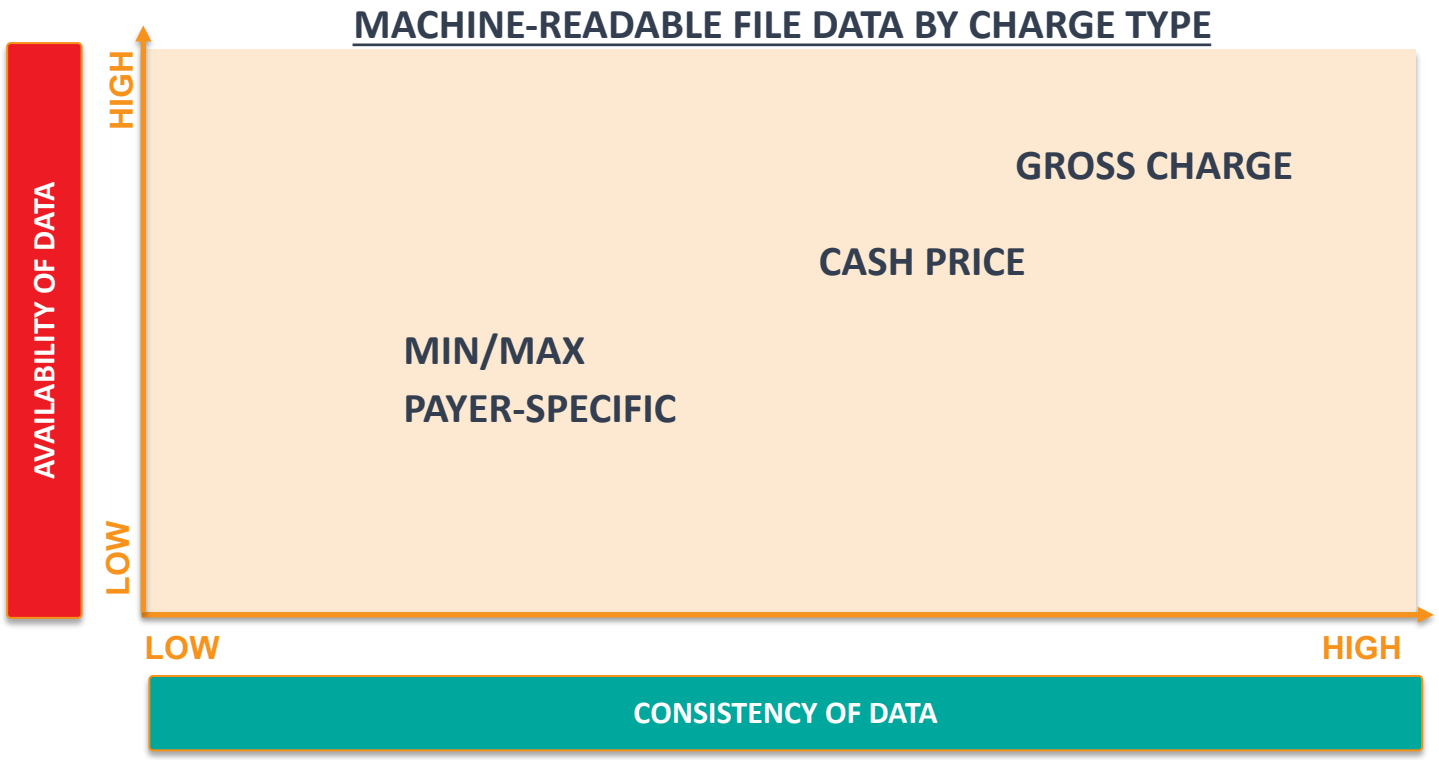
Who isn't yet accessing the data in large scale?

WHY??

How is the disclosed data being used?

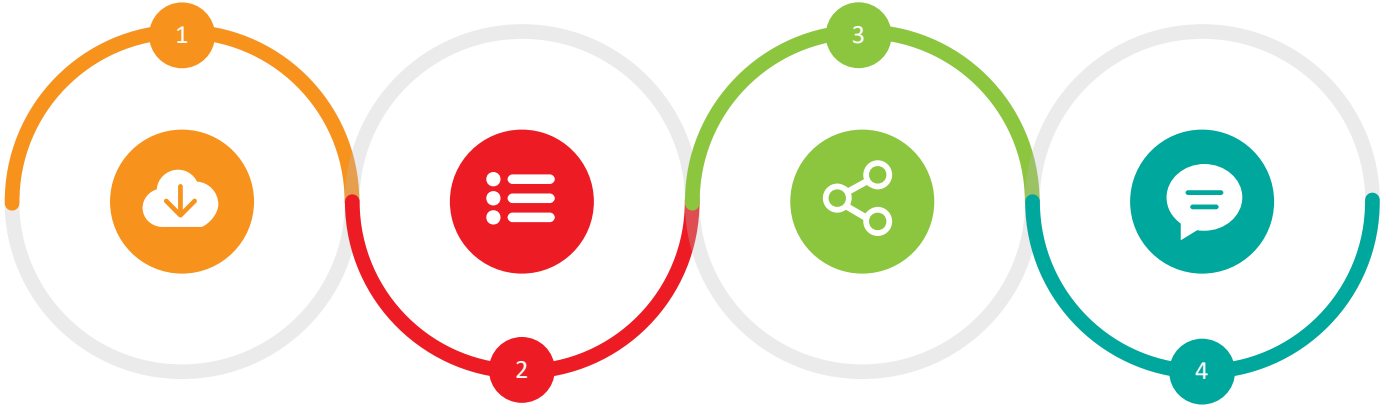
Building databases with disclosed data

Database creation from files is challenging



Database creation from files is challenging

Constructing a comparative database requires significant manual effort to account for file variation. In addition, some report elements are not present and those that are haven't been created consistently.



Presence/Updates of Information

The first challenge is locating and downloading files as many do not have CMS required naming conventions. Web links/locations change and files are not always clearly marked with effective dates.

File Type & Layout Differences

Standardizing the input files, once obtained, presents challenges as the file types (txt, xml, JSON, xlsx, etc.) and layouts (worksheets, columns, rows, etc.) vary significantly.

Relational Differences

Hospitals have decided to report negotiated charges in a variety of ways: HCPCS, MSDRG, APC, charge code. And the ways these are reported are not always consistent (MSDRG base rate versus all charges).

Payer Naming Differences

Categorizing payers into appropriate comparison buckets presents challenges as there are no standard naming conventions.

Presence/Updates of Information

Accessibility

How easy is it to locate on the website? – Rule requires within "two clicks"

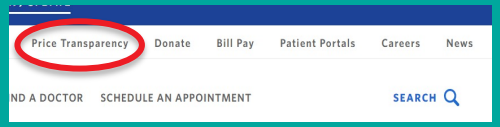
Naming Conventions

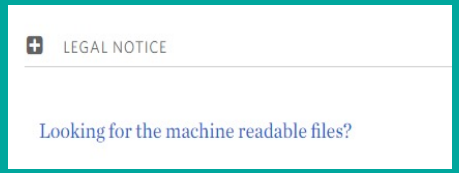
Is the file clearly labeled machine readable? – Rule requires "EIN – Facility Name – Standard Charges"

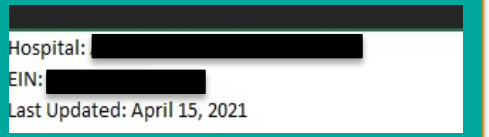
Effective Date

When was this information last updated? – Rule Requires "Prices as of…"

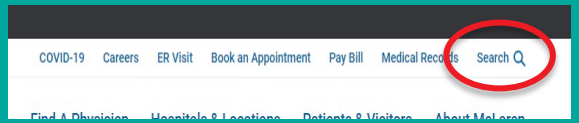
Hospital A

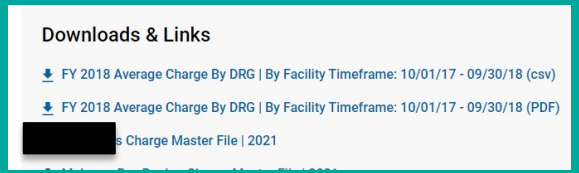






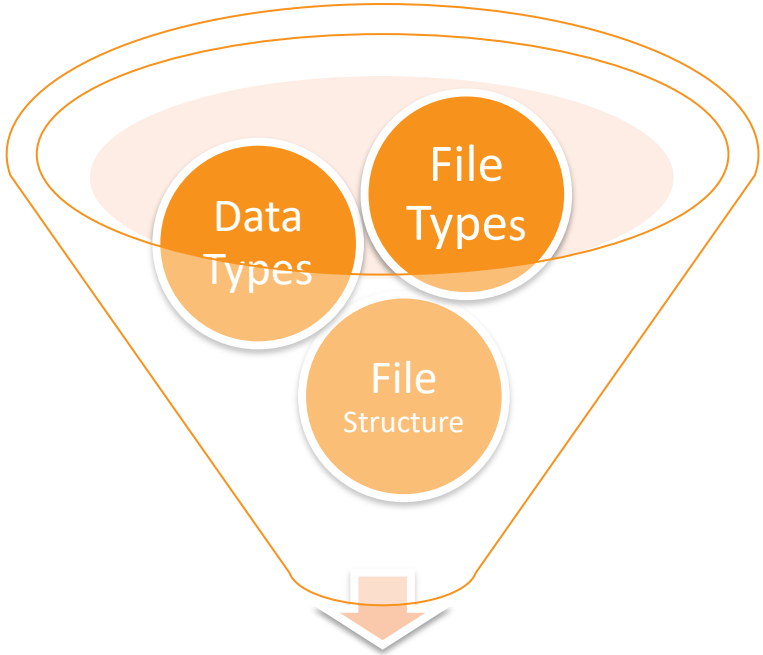
Hospital B





Not Available

File Type and Layout Differences



Data Standardization

File Types
JSON, CSV, TXT and XML are all acceptable formats. JSON would require conversion.

Data Types
Data may be in text, numeric or currency format and would require conversion to aggregate.

File Structure
Varying numbers of columns, table formats and naming conventions would require standardization.

File Type and Layout Differences (cont'd)

Hospital A

1. Contains multiple tabs for gross charge, CPT and DRG
2. All data is in numeric format

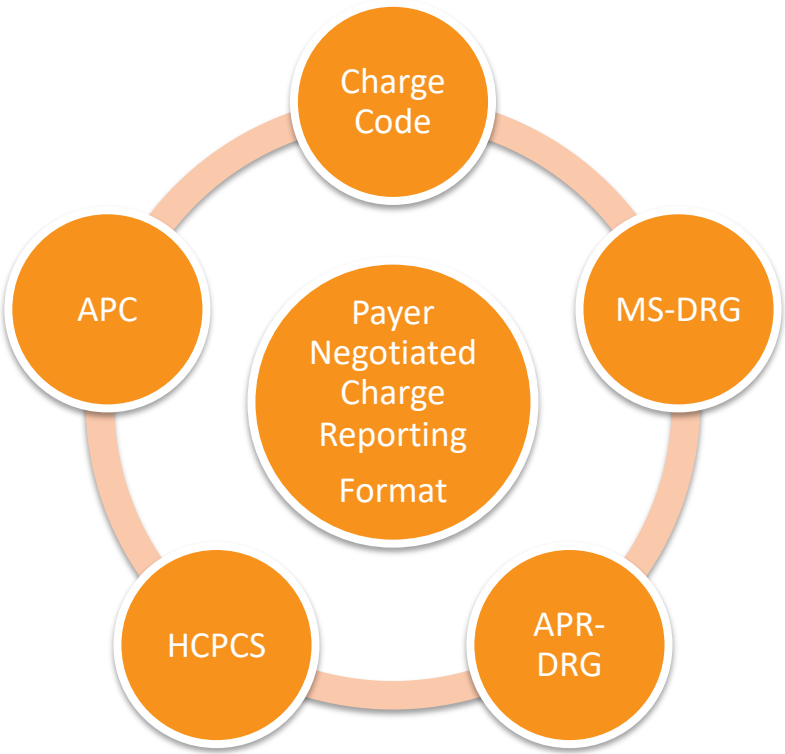
CPT	Description	Min_Negotiated_Rate	Max_Negotiated_Rate	Payer A
0042T	CEREBRAL PERFUSION ANALYS CT W/BLOOD FLOW&VOLUME	650	650	
0073T	COMPNSTR-BASED BEAM MODLJ TX DLVR INVERSE 3> FLD	340.23	340.23	340.23
0159T	COMPUTER AIDED DETECTION BREAST MRI	700	700	
0176T	AQUEOUS CANAL TRLUML DILAT W/O STENT RETENTION	8861	8861	
0177T	AQUEOUS CANAL TRLUML DILAT W STENT RETENTION	8861	8861	
0182T	HDR ELECTRONIC BRACHYTHERAPY PER FRACTION	543.55	543.55	543.55
0183T	LOW FREQUENCY WOUND ULTRASOUND	80.08	80.08	80.08
0346T	ULTRASOUND ELASTOGRAPHY	400	400	
10021	FINE NEEDLE ASPIRATION W/O IMAGING GUIDANCE			0.53

Hospital B

1. All states of charge are on one tab
2. Mix of contract term and numeric

LINE TYPE	CHARGE CODE/ PACKAGE	CHARGE DESCRIPTION	DRG	CPT	MODIFIER	REV CODE	NDC	Payer B	Payer C	...th - IP
CDM	36609560	ARIPIPRAZOLE (ABLIFY MAINTENA)400MG INJ		J0401		636	59148-0019-71	$0.13	85.5% of Charges	
CDM	36610372	ARIPIPRAZOLE ABLIFY EXT REL 300MG/1.5 ML		J0401		636	59148-0018-71	$0.18	85.5% of Charges	
CDM	36606628	HUMULIN(NPH)INSULIN3ML VL				637	00002-8315-17	$0.19	85.5% of Charges	

Relational Differences



Payer Negotiated Charge Reporting Format					
	Charge Code	MS-DRG	APR-DRG	HCPCS	APC
Hospital A	✓			✓	
Hospital B				✓	✓
Hospital C		✓	✓		✓
Hospital D	✓	✓	✓	✓	
Hospital E	✓			✓	✓

Differences in payer negotiated charge reporting formats between these five example hospitals illustrates the difficulty of aggregating this data into a comparable format.

Payer Naming Differences

Plan Name	Mapping
ANTHBC_X_FED	BCBS
5536_BLUE_CROSS_MED_SUPPLEMENT	BCBS
UHC_HMO_6798	UHC
UNITEDHEALTHCARE	UHC
39872	N/A

Many facilities have disclosed the payer negotiated charge amounts with the specific plan name. This creates difficulty when trying to compare negotiated charges across facilities and requires manual payer mapping to ensure accuracy. This is further complicated by regional differences in payers, which may make accurate mapping difficult.

How is the disclosed data being used?

Overcoming challenges

Payer transparency in coverage rule could impact

Machine-Readable Files

THREE FILES:

1) Negotiated rates for all covered items and services between the plan or issuer and in-network providers.
2) Historical payments to, and billed charges from, out-of-network providers. Historical payments must have a minimum of twenty entries in order to protect consumer privacy.
3) In-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

UPDATE FREQUENCY: Monthly
BEGIN DATE: January 1, 2022

OOP/Negotiated Rate Internet-Based Tool (Paper upon request)

INTENT:
Real-time, accurate estimates of member cost-sharing liability for health care items and services from different providers with ability to comparison shop among providers.

AVAILABLE INFORMATION:
An initial list of 500 shoppable services as determined by the Departments (HHS, Dept of Labor, Dept of the Treasury) will be required to be available via the internet based self-service tool for plan years that begin on or after January 1, 2023. The remainder of all items and services will be required for these self-service tools for plan years that begin on or after January 1, 2024.

Standardized Payer Specific Negotiated Charge

In this approach the hospital would (language from Final Rule - CMS-1717-F2 - 65559):

"consult their rate sheets or rate tables within which the payer-specific negotiated charges are often found" - and -

"display the individualized items and services and service packages for a specific payer's plan based on the rate sheet derived from the hospital's contract with the payer"

In practice, the hospital would derive the payer specific negotiated charge by consulting their contracted rate sheets and terms and applying those to actual patient claims for the specific third-party payer. The display of this data would be in a unified inpatient and outpatient format, as illustrated below:

INPATIENT SERVICE PACKAGES

		AVERAGE PAYER SPECIFIC NEGOTIATED CHARGE PER ENCOUNTER				
MSDRG	DESCRIPTION	PAYER 1	PAYER 2	PAYER 3	PAYER 4	PAYER 5
470	Major Hip And Knee Joint Replacement Or Reattach. Of Lower Extremity W/O Mcc	43,722	45,726	44,835	47,775	35,575
775	Vaginal Delivery W/O Complicating Diagnoses	10,369	13,766	10,527	11,081	11,131
795	Normal Newborn	2,845	3,138	2,815	2,905	2,911

OUTPATIENT SERVICE PACKAGES

		AVERAGE PAYER SPECIFIC NEGOTIATED CHARGE PER ENCOUNTER				
PRIMARY APC	DESCRIPTION	PAYER 1	PAYER 2	PAYER 3	PAYER 4	PAYER 5
5023	Level 3 Type A ED Visits	1,366	1,722	1,618	1,744	1,659
5301	Level 1 Upper GI Procedures	5,038	5,018	5,663	4,743	4,847
5522	Level 2 Imaging without Contrast	848	858	788	937	767

Standardized Payer Specific Negotiated Charge

Primary benefits of using this format to fulfill the "payer specific negotiated charge" display requirement:

- Better patient understanding of total encounter payment as payment is most often related to actual service utilization – even in fixed fee arrangements
- Presentation of relevant information to the patient as contract payment terms will not be as meaning
- All hospital items and services to be covered (including drugs and supplies)
- Payment comparison across payers
- Custom contract definitions, payment hierarchies, and outlier/lesser-of status to be factored into payment calculations
- In keeping with the rule's language, as well as, the intent to provide meaningful information to patients

Standardized Payer Specific Negotiated Charge

Cleverley + Associates Build Process:

1) Model, in detail, all contract terms and rates

2) Apply terms and rates to all items and services on patient claims to determine expected payment for each claim

3) Run claims through inpatient and outpatient "groupers" to assign a MSDRG and APC to each claim – regardless of differing payment methodologies

4) Derive the median expected payment for all items and services and service packages by MSDRG, APC, and payer

5) Disclose payer specific negotiated charge on machine readable file

Aggregations among “like” file structures is possible

		MEDIAN CHARGE PER DISCHARGE					MEDIAN PAYMENT PER DISCHARGE				
MSDRG	Description	All US	Northeast	Midwest	South	West	All US	Northeast	Midwest	South	West
795	Normal Newborn	4,731	4,537	4,619	4,296	5,178	2,468	2,642	2,379	2,295	2,914
807	Vaginal Delivery Without Sterilization Or D&C Without Cc/Mcc	16,997	17,525	16,362	17,407	16,954	9,009	9,154	8,294	7,672	10,393
788	Cesarean Section Without Sterilization Without Cc/Mcc	28,660	27,148	29,972	28,467	28,344	13,466	12,014	13,279	11,082	15,578
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	68,767	38,765	68,903	75,616	69,023	32,745	28,897	31,313	33,176	33,372
871	Septicemia Or Severe Sepsis Without Mv >96 Hours With Mcc	51,359	36,899	39,013	50,719	64,743	26,255	27,063	22,386	25,591	29,776
392	Esophagitis, Gastroenteritis And Miscellaneous Digestive Disorders Without Mcc	24,478	19,082	21,690	24,877	28,892	11,235	12,352	9,961	10,425	12,974

Source: Cleverley + Associates all-payer transparency database

Aggregations among “like” file structures is possible

		NATIONAL MEDIAN CHARGE PER DISCHARGE					NATIONAL MEDIAN PAYMENT PER DISCHARGE				
MSDRG	Description	Aetna	BCBS	Cigna	Humana	UHC	Aetna	BCBS	Cigna	Humana	UHC
788	Cesarean Section Without Sterilization Without Cc/Mcc	37,914	38,080	42,739	50,132	37,793	34,063	8,204	35,101	40,980	15,080
807	Vaginal Delivery Without Sterilization Or D&C Without Cc/Mcc	18,329	17,517	18,203	19,584	16,642	9,862	9,574	9,881	8,967	8,486
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	72,124	72,788	80,691	75,817	70,546	36,571	30,140	37,611	32,880	35,289

Source: Cleverley + Associates all-payer transparency database

Spring Summit Agenda

Addressing Price Transparency's Key Questions:

1) How are hospitals complying?
2) How is the disclosed data being used?
3) **How can hospitals defend their position?**
4) How can hospitals prepare for the future?

438 E Wilson Bridge Rd
Worthington, OH 43085

888-779-5663

www.thinkcleverley.com

info@cleverleyassociates.com