Cleverley + Associates

SPRING SUMMIT: ADDRESSING PRICE TRANSPARENCY'S KEY QUESTIONS

Session Four:
How can hospitals prepare for the future?

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 Four Overview: This final session will present what considerations hospitals should focus on now to prepare for the current and future transparency environment.

How can hospitals prepare for the future?

Next steps in transparency

Next steps in transparency

Evaluate your position

KEY QUESTIONS:

1) Are you comfortable with your current disclosure position?
2) How does the information you disclosed compare with your peers?

Sample checklist to research peers. This summarizes the CMS checklist found here: https://www.cms.gov/files/document/hospital-price-transparency-final-rule-quick-reference-checklists.pdf

Cleverley + Associates

CMS Price Transparency Fact Finding Report

ABC Hospital
3 Hospital Health System
Searched January 6, 2021
4 Clicks to Price Transparency

https://www.abchealthcare.org/vistors-and-patients/patient-information/billing-insurance/billing-information

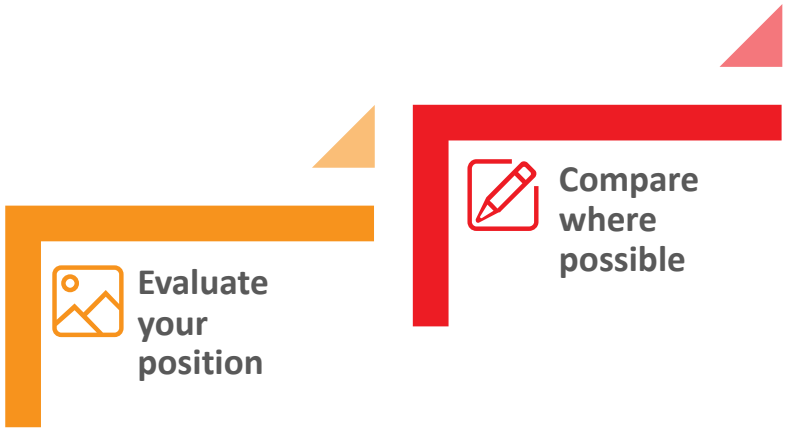
Machine Readable File

	Yes	No
Has the hospital posted a file of all standard charges for items and services?	☐	☐
If yes to the above question, what format?		
- .XML?	☐	☐
- .JSON?	☐	☐
- .CSV?	☐	☐
- .XLS	☐	☐
- Other: _____	☐	☐
Does the file include:		
- drugs and supplies?	☐	☐
- professional fees?		
- gross charge?	☐	☐
- de-identified min and max negotiated charge?	☐	☐
- discounted cash price?	☐	☐
- payer-specific negotiated charge?	☐	☐
The payer-specific negotiated charges are in what format?		
- MS-DRG/APC	☐	☐
- HCPCS	☐	☐
- Item Code	☐	☐
- Other:	☐	☐
Other Notes: - Last updated 1/1/2021		

Consumer Shoppable

	Yes	No
Has the hospital posted standard charges for a set of shoppable services?	☐	☐
Format of display:		
- Patient Estimation Tool	☐	☐
- File	☐	☐
If using File format, Does the file include:		
- all required charge formats?	☐	☐
- charges for associated ancillary services, as applicable?	☒	☐
If using Shoppable Tool,		
- Does the patient need to enter specific plan information (member ID)?	☐	☐
- Is the tool accessible without having to register?	☐	☐
Other Notes: - Last updated 1/1/2021		

Next steps in transparency



KEY QUESTIONS:

1) Do you have significant GROSS CHARGE variation compared with peers?
2) Do you have significant INTERNAL payer variation by patient encounter? (Your Aetna to your BCBS plan)
3) Do you have significant EXTERNAL payer variation by patient encounter? (Your Aetna to your peer Aetna plan)

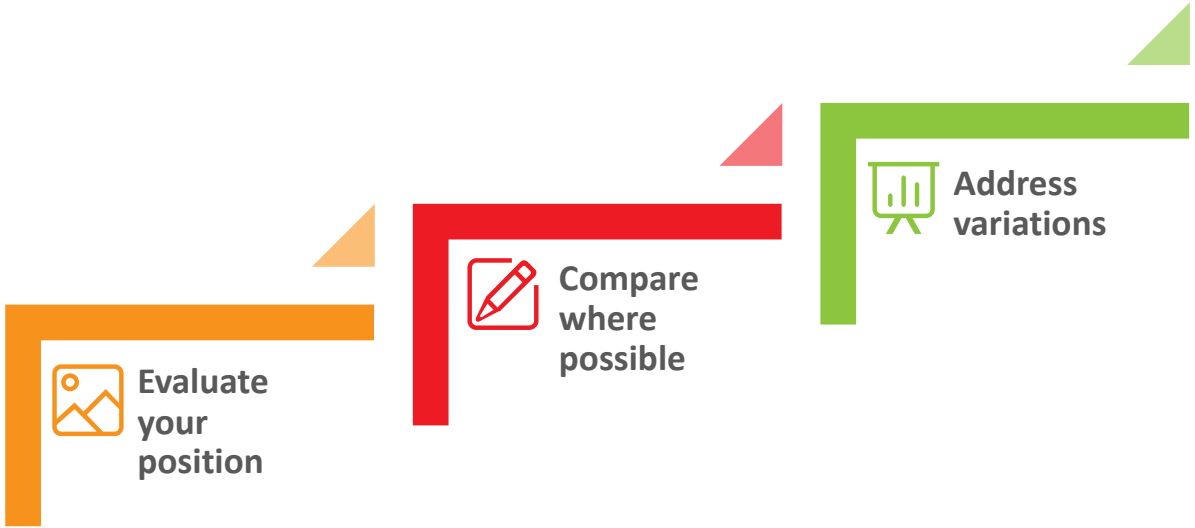
Next steps in transparency

CREATE COMPARISONS – BOTH INTERNALLY AND EXTERNALLY (WHERE POSSIBLE)

MSDRG	Description	YOUR DATA HERE	NATIONAL MEDIAN CHARGE PER DISCHARGE					NATIONAL MEDIAN PAYMENT PER DISCHARGE				
			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

Next steps in transparency



KEY ACTIONS:

1) **Plan to minimize gross charge variance through CDM adjustments**
2) Determine key drivers for payer variance: rate/term, acuity, and/or utilization differences
3) Layer cost and margin information into the encounter assessments
4) Test where payer rate/term mitigation might be necessary to due to financial impact

Next steps in transparency

ADDRESS VARIATIONS – MINIMIZE GROSS CHARGE VARIANCES THROUGH CDM ADJUSTMENTS

Whether gross charge variances are identified through encounter level (DRG/APC) or line level comparisons, the first step to minimizing variances is to link the targeted codes or encounters to the underlying CDM charge lines.

MS DRG	Description	Case Hospital Average Charge	Peer Average Charge	Percent of Peer
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	70,520	62,807	112.3%

APC	Description	Case Hospital Average Charge	Peer Average Charge	Percent of Peer
5312	Level 2 Lower GI Procedures	16,741	14,232	117.6%

HCPCS Code	HCPCS Description	Case Hospital CDM Price	Peer Average Charge	% of Peer
70450	Ct head/brain w/o dye	1,731	1,245	139%
74176	Ct abd & pelvis w/o contrast	6,101	2,685	227%

Item Code	Description	Revenue Code	HCPCS	Price
12345	HC CT HEAD WO CONTRAST	351	70450	$ 1,731
12359	HC CT ABD/PELVIS WO CON	352	74176	$ 6,101
12373	HC MISC ORTHO TOTAL KNEE	278	C1776	$ 5,620
12387	HC MISC ORTHO TOTAL HIP	278	C1776	$ 4,075
12401	HC MISC ANCHOR/SCREW	278	C1713	$ 273
12415	HC SURG LEV 3-FIRST 15 MIN	360		$ 1,177
12429	HC SURG LEVEL 3 ADDL QUARTER HR	360		$ 273
12443	HC COMMON ROOM/ PV MED/SURG	110		$ 2,850
12457	HC GI LOWER ENDOSCOPY	750		$ 9,511
12471	HC GI UPPER ENDOSCOPY	750		$ 4,379
12485	HC SURG PATH SPECIMEN LEVEL IV	312	88305	$ 788

Next steps in transparency

ADDRESS VARIATIONS – MINIMIZE GROSS CHARGE VARIANCES THROUGH CDM ADJUSTMENTS

Prior to making charge adjustments based on comparative charge data, especially using encounter data, determine if acuity or utilization is a major driver of variances.

MS DRG	Description	Case Hospital Average Charge	Peer Average Charge	Percent of Peer
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	70,520	62,807	112%

Metric	Case Hospital	Peer Average	Percent of Peer
Ancillary Charges	64,005	57,086	112%
Nursing Charges	6,515	5,721	114%
Total Charges	70,520	62,807	112%
Charge per Day	33,581	27,307	123%
Discharges	716	362	198%
Average Age	75	75	100%
Average LOS	2.1	2.3	91%
Average Routine LOS	2.1	2.1	100%
Average ICU/CCU LOS	0	0.1	0%
Average Number Secondary Diagnoses	11.8	9.5	124%
Average Number of Procedures	1.2	1.5	80%
Wage Index	0.9256	0.9169	101%

- Cleverley + Associates utilizes Medicare and all payer data to assess acuity metrics
  - Inpatient (MS-DRG) – LOS, routine vs. ICU days, secondary procedures
  - Outpatient (APC) – utilization of procedures, average relative weight per visit
- DRG 470 example shows similar LOS but some modest acuity differences that could explain a portion of the charge variance. These acuity differences can also support review of claim payment variances.

Next steps in transparency

ADDRESS VARIATIONS – MINIMIZE GROSS CHARGE VARIANCES THROUGH CDM ADJUSTMENTS

Testing gross and net impact of CDM price changes is critical to understanding if adjustments produce an acceptable financial impact.

Price Model Action	Modeling Preset	Item codes	Recovery	Original Charges	Proposed Charges	Incremental Charges	Incremental Net Impact	Percent Change
Preset	CT/CTA Adjustments	6	0.5%	16,696,244	15,026,620	(1,669,624)	(8,733)	-10.0%
Preset	DRG 470 Adjustments	25	4.8%	21,130,845	20,074,303	(1,056,542)	(50,186)	-5.0%
Preset	Endoscopy Adjustments	7	3.2%	11,554,942	9,821,701	(1,733,241)	(55,575)	-15.0%
Preset	Freeze All Other Codes	16,256	1.2%	6,004,842,028	6,004,842,028	-	-	0.0%
		16,294		6,054,224,059	6,049,764,651	(4,459,408)	(114,494)	-0.07%

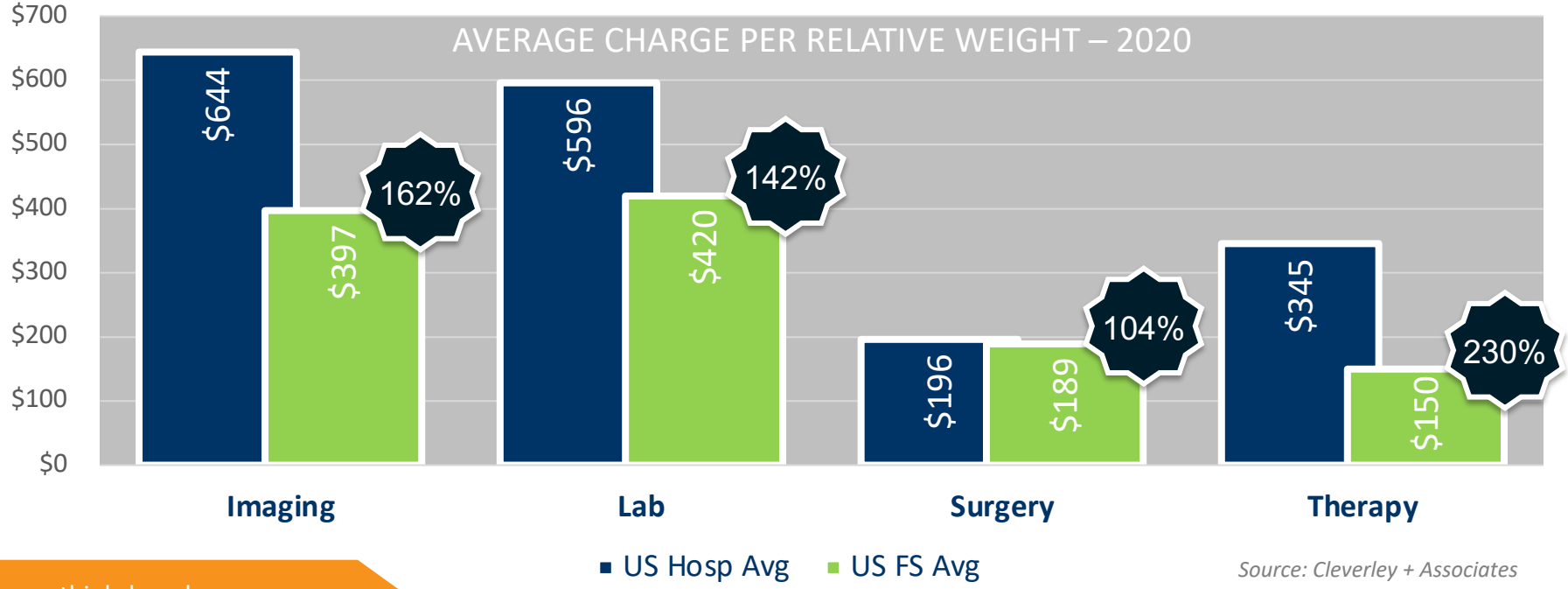
Price Model Action	Modeling Preset	Item codes	Recovery	Original Charges	Proposed Charges	Incremental Charges	Incremental Net Impact	Percent Change
Preset	CT/CTA Adjustments	6	0.5%	16,696,244	15,026,620	(1,669,624)	(8,733)	-10.0%
Preset	DRG 470 Adjustments	25	4.8%	21,130,845	20,074,303	(1,056,542)	(50,186)	-5.0%
Preset	Endoscopy Adjustments	7	3.2%	11,554,942	9,821,701	(1,733,241)	(55,575)	-15.0%
Preset	Offset Adjustments	12	2.8%	124,376,890	128,842,020	4,465,130	122,791	3.6%
Preset	Freeze All Other Codes	16,244	1.2%	5,880,465,138	5,880,465,138	-	-	0.0%
		16,294		6,054,224,059	6,054,229,781	5,722	8,297	0.00%

- Impact testing should incorporate payer specific terms for accurate net impact assessments (rate increase limits, lesser of clauses, outliers)
- Consider timing of rate adjustments and impact on rate increases disclosed to managed care payers
- Coordinating significant gross charge changes with annual CDM pricing updates may help address several variances at once
- Pricing relationships between related CDM item codes or charge families can be broken if not assessed together
  - E&M visit levels, CT / MRI with and without contrast, procedure families with time or level considerations, etc.

Next steps in transparency

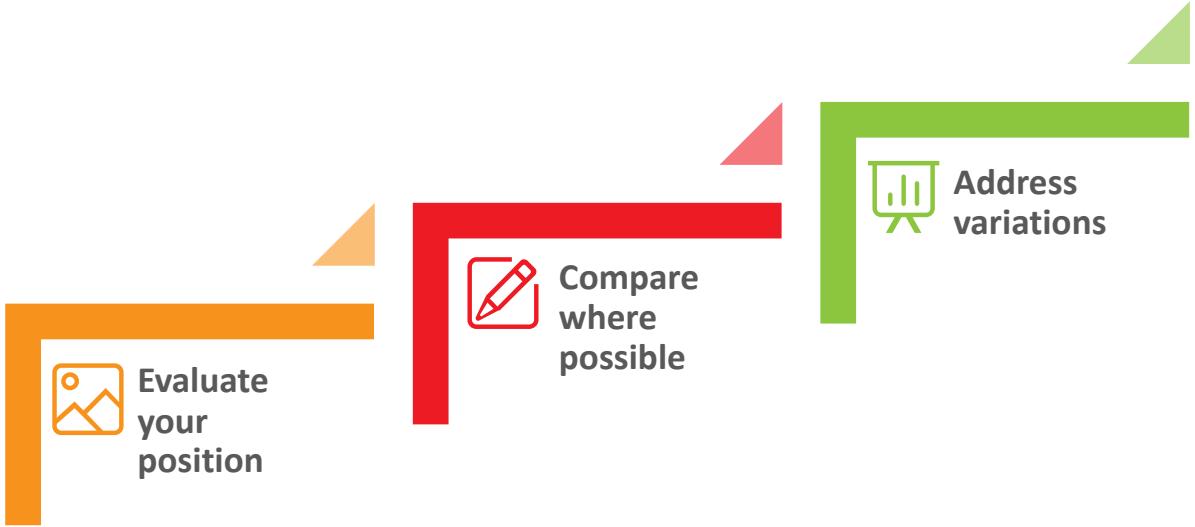
ADDRESS VARIATIONS – MINIMIZE GROSS CHARGE VARIANCES THROUGH CDM ADJUSTMENTS

While understanding current charge variances to hospitals is important in light of the transparency disclosures, comparisons to non-hospital sites of care (not subject to current transparency rules) is also important.



Source: Cleverley + Associates

Next steps in transparency



KEY ACTIONS:

1) Plan to minimize gross charge variance through CDM adjustments
2) Determine key drivers for payer variance: rate/term, acuity, and/or utilization differences
3) Layer cost and margin information into the encounter assessments
4) Test where payer rate/term mitigation might be necessary to understand financial impact

Next steps in transparency

ADDRESS VARIATIONS – EVALUATE PAYMENT VARIANCE

One of the key areas of interest in the transparency disclosures is determining the extent of payment variance among hospitals. While we've shared there are challenges to viewing this, when possible, analysis can be important.

HCPCS Code	HCPCS Description	Case Hospital BCBS Payment	Peer BCBS Payment	% of Peer
70450	Ct head/brain w/o dye	925	1,121	83%
74176	Ct abd & pelvis w/o contrast	925	2,416	38%

			PAYMENT PER DISCHARGE	
MSDRG	Description	Metric	BCBS	UHC
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	National Median	30,140	35,289
		Case Hospital	28,723	36,469

APC	Description	Case Hospital BCBS Payment	Peer BCBS Payment	Percent of Peer
5312	Level 2 Lower GI Procedures	3,500	7,828	44.7%

Questions to consider regarding payer variances identified using transparency data:

- Are external variances likely to create upward or downward pressure on payer terms during negotiations? Both opportunities and risks are important to identify.
- Are external variances charge-based from percent of charge terms or other per diem or fixed rate type terms?
- Does utilization between market peer hospitals play a key role in contracted rates?
- Are internal variances caused by acuity, utilization, or contract term differences?

Next steps in transparency

ADDRESS VARIATIONS – EVALUATE PAYMENT VARIANCE

In this case example, we review a significant volume MSDRG to evaluate internal and external payment differences.

			BCBS – CASE HOSPITAL				UHC – CASE HOSPITAL			
MSDRG	Description		Charges	Payment	Costs	Profit	Charges	Payment	Costs	Profit
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	Total	3,982,626	2,078,733	1,067,208	1,011,525	11,937,376	4,969,052	3,290,377	1,678,675
		Per Case	69,002	28,723	19,020	9,703	69,871	36,469	18,723	17,746

Key findings from payment comparison:

- In an internal comparison of payments, Case Hospital is seeing a lower payment from UHC than BCBS, however, UHC has significantly more volume.
- Payer contract term review shows BCBS pays a case rate for DRG470 while UHC pays a base rate times a standard DRG weight.
- Does the lower utilization from BCBS support a push for a higher case rate? Is there a risk that UHC will push for a lower payment level? How do other contract areas contribute to the overall payment/profitability of the contracted payer?

Next steps in transparency

ADDRESS VARIATIONS – EVALUATE PAYMENT VARIANCE

In this case example, we review a significant volume MSDRG to evaluate internal and external payment differences.

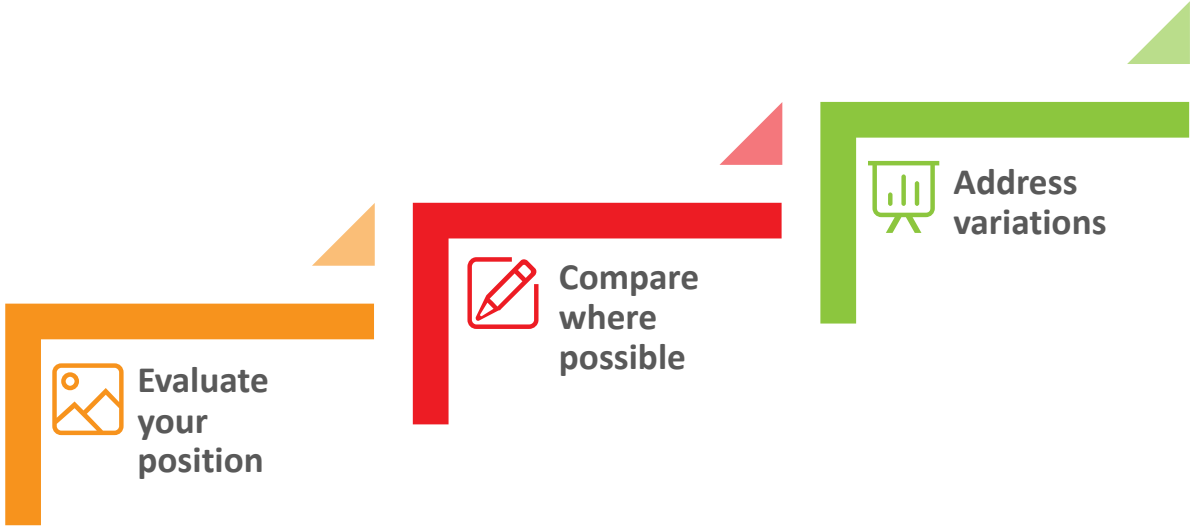
Adding in external transparency data gives support that UHC payment rate is higher than the national average while BCBS rate is lower than the national average.

			CHARGE PER DISCHARGE		PAYMENT PER DISCHARGE		COST PER DISCHARGE		MARGIN	
MSDRG	Description		BCBS	UHC	BCBS	UHC	BCBS	UHC	BCBS	UHC
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	National Median	72,788	70,546	30,140	35,289				
		Case Hospital	69,002	69,871	28,723	36,469	19,020	18,723	33.8%	48.7%

Adding in cost data allows for the determination of margin at the encounter level

- Illustrates margin differences between payers, how current contract rates compare to cost.
- Understanding costs will help strengthen negotiations with payers

Next steps in transparency



KEY ACTIONS:

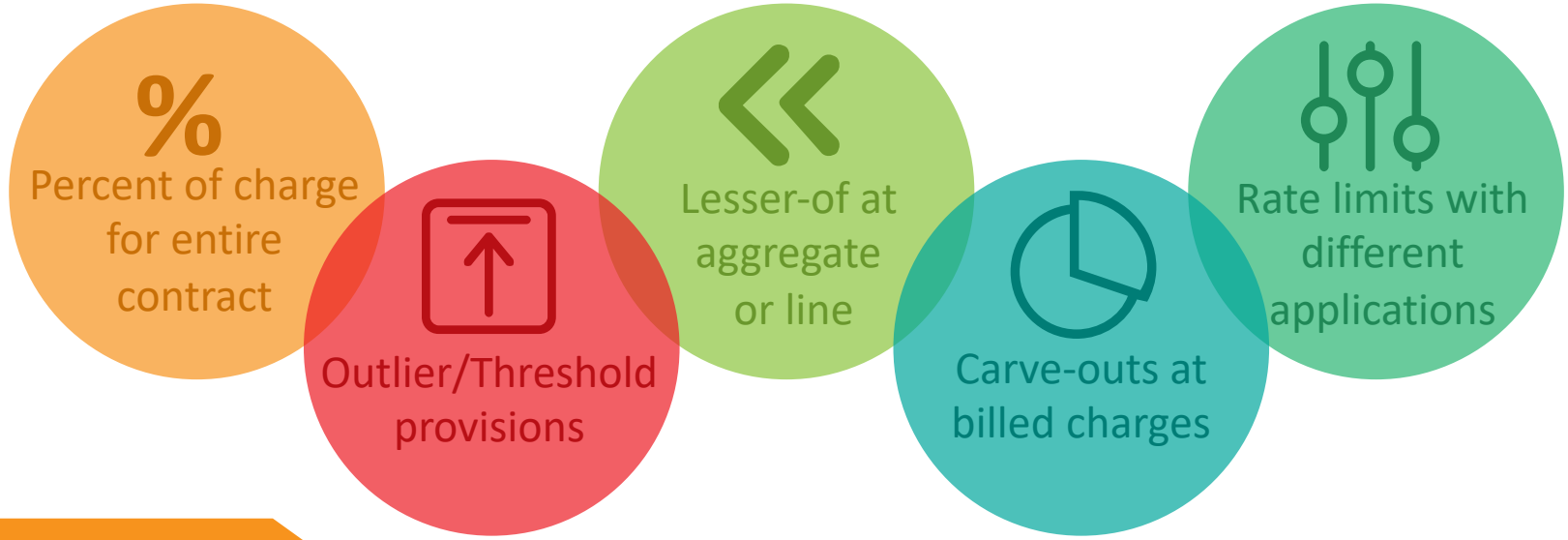
1) Plan to minimize gross charge variance through CDM adjustments
2) Determine key drivers for payer variance: rate/term, acuity, and/or utilization differences
3) Layer cost and margin information into the encounter assessments
4) **Test where payer rate/term mitigation might be necessary to understand financial impact**

Next steps in transparency

ADDRESS VARIATIONS – TEST IMPACT OF CONTRACT TERM CHANGES

While fixed terms can dominate a contract's overall net revenue generation, impact testing should address charge sensitive areas, as well, especially when considering both gross and net revenue changes at the hospital.

AREAS OF CHARGE SENSITIVITY



Next steps in transparency

ADDRESS VARIATIONS – TEST IMPACT OF CONTRACT TERM CHANGES

In this case example, we evaluate a hospital interested in understanding payment changes to a high volume MSDRG.

Contract	Patient Type	Carveout	Outlier	Lesser Of	Original Charges	Proposed Charges	Change in Charges	% Change in Charges	Original Payment	Proposed Payment	Change in Payment
Anthem - HMO/PPO	I	All Other			129,263,214	129,263,214	-	-	52,216,493	52,216,493	-
Anthem - HMO/PPO	I	All Other	YES		21,441,735	21,441,735	-	-	10,644,887	10,644,887	-
Anthem - HMO/PPO	I	Anthem MSDRG 462			1,196,721	1,196,721	-	-	708,216	708,216	-
Anthem - HMO/PPO	I	Anthem MSDRG 470			13,228,734	11,905,860	(1,322,873)	(0)	4,854,187	4,985,500	131,313
Anthem - HMO/PPO	I	Severe Level Neonate - Per Diem			1,204,156	1,204,156	-	-	719,465	719,465	-
Anthem - HMO/PPO	I	Severe Level Neonate - Per Diem	YES		2,940,423	2,940,423	-	-	1,452,433	1,452,433	-

Key considerations for contract term change impact testing:

- Incorporate all pertinent terms including accurate fee schedules, lesser of clauses, and outlier provisions
- If CDM rate changes are included with testing, timing of rate adjustments and impact on rate increases disclosed to managed care payers must be included
- What areas of the contract are “on the table” for mitigation. Ensure a micro and macro evaluation of the net revenue implications.

Next steps in transparency

KEYS TO SUCCESSFULLY ADDRESSING VARIATIONS WITH TRANSPARENCY DATA

Addressing variation seen in transparency data may involve both CDM adjustments and managed care contract changes – being able to model both simultaneously is critical.

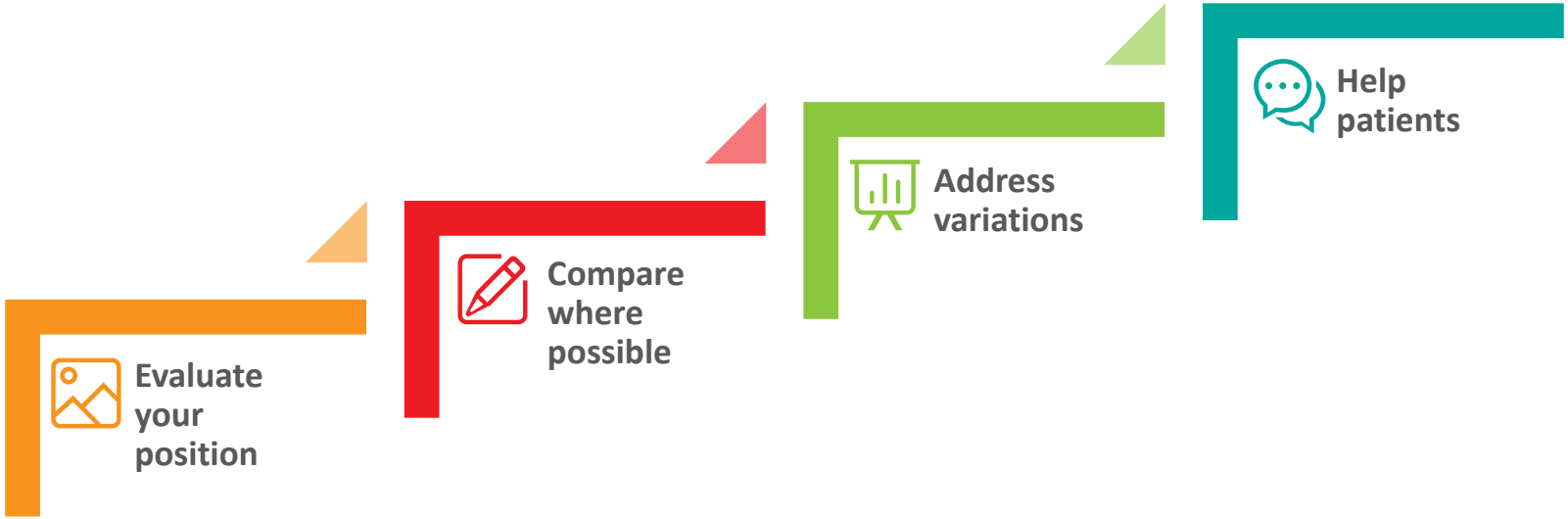
Following a few key actions will help keep efforts focused on meaningful variances and increase the likelihood of a successful outcome. Some variances did not develop overnight and will not be unwound that quickly either.

Developing a team including managed care, CDM pricing, and finance to identify and address variation seen in today's transparency data will be best practice. Leadership support is a must for organizational change.

How can hospitals prepare for the future?

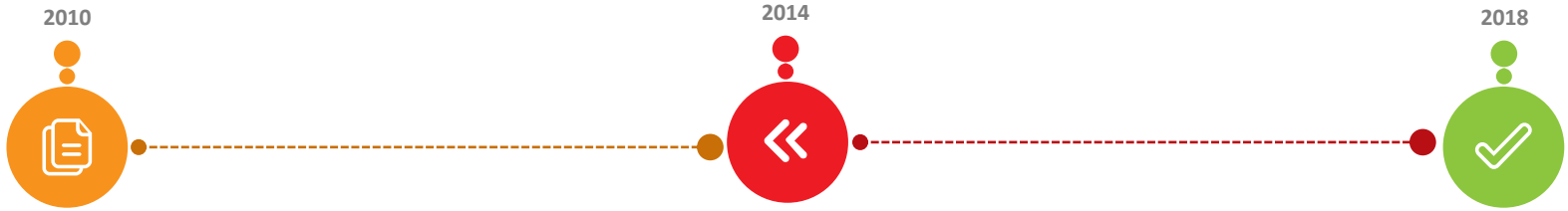
The final step – or – the first step

Next steps in transparency



Because it's commonly considered that the new transparency requirements will not help patients, it's easy to forget that they were a primary reason for the rule's creation. Including the patient experience in transparency conversations is an essential starting point for every organization.

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."

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