The No Surprises Act & The Future of Price Transparency

Presented to: Louisiana HFMA Chapter

May 2nd, 2023

By: Joe D'Onofrio





Agenda Items

01 **Speaker Introductions**

02 **Price Transparency: Recent Actions by CMS**

03 **No Surprises Act: Rule Compliance & Co-Provider Fee Schedules**

04 **Payer Peer Negotiated Rates: Provider or Payor Files – Which to Use?**

05 **Working Around Payor MRFs**

06 **Closing Remarks**

Presenter Introductions

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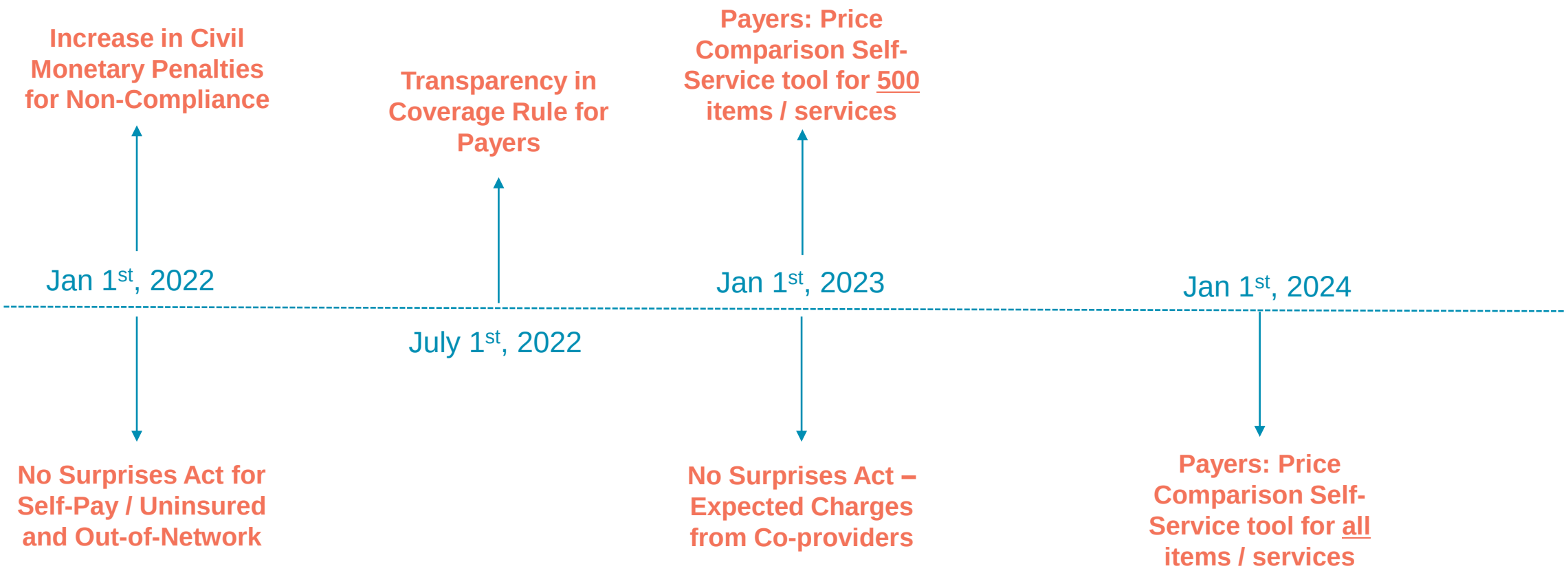
Price Transparency: Recent Actions by CMS

Setting the Stage for 2024

Key Dates Impacting Price Transparency



New Colorado's Price Transparency Law

THE DENVER POST

Health | Hospitals can't send patients' medical debt to...

NEWS > HEALTH • News

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Hospitals can't send patients' medical debt to collections or sue them unless they have prices posted under new law

Colorado's new hospital price transparency law may change how patients shop for health care

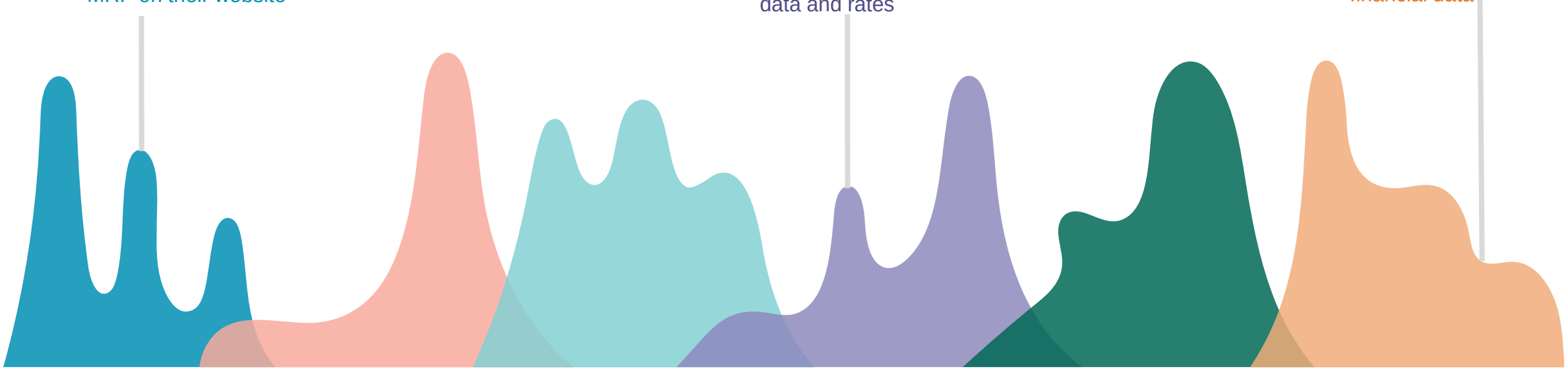
Colorado's price transparency law went into effect August 10th, 2022.

Nationwide Compliance – A Panacea Study from 2021

75%
of hospitals have an MRF on their website

55%
of hospitals have an MRF with some payer data and rates

24%
of hospitals have an MRF that contains key financial data



*Based on a study conducted by Panacea consisting of over 1,100 hospitals across the United States and as of the May / June 2021 period

CMS Begins Issuing Penalties in June 2022

CMS levies penalties for non-compliance with Hospital Price Transparency Rule

By Nicole Aiken-Shaban & Ellen Pighini on 21 June 2022

The Centers for Medicare & Medicaid Services ("CMS") issued the first round of civil monetary penalties to two hospitals in Georgia for failure to comply with the requirements of the Hospital Price Transparency Final Rule (the "Rule") on June 7, 2022.

According to the Notices of Imposition of a Civil Monetary Penalty published on the CMS Price Transparency Website, Northside Hospital Atlanta ("Northside Atlanta") and Northside Hospital Cherokee ("Northside Cherokee") failed to publish their standard charges and provide access to a machine-readable searchable tool, which would include standard prices for the hospitals' items and services. CMS took this action after both hospitals failed to respond to the Warning Notices and Requests for Corrective Action Plans issued by CMS.

CAUTION – Do NOT use Claims and Payment Data for MRF

Tips and Common Mistakes to Avoid

- List payer-specific negotiated charges by <u>both payer and plan</u>. To identify payer-specific negotiated charges, consult your third party payer contracts and associated rate sheets. Do not create average or aggregate charges. Do not create standard charges from prior claims or reimbursement information.

	A	B	C	D	E	F	G	H	I	J	K	L
1						Payer 1	Payer 1	Payer 2	Payer 2	Payer 3		
2		Description	CPT/HCPC	Gross Cha	Disc Cash	Plan 1	Plan 2	Plan 1	Plan 2	Plan 1	Min Neg Chg	Max Neg Chg
3	OS59575	0.035 260 ANGLED GLIDE CATH (59575)	C1769	$187.08	$130.96	$133.20	APR-DRG	$113.45	$113.45	per diem	$113.45	$133.20
4	OS65028	0.25 STRAIGHT STIFF ZIPWIRE (65028)	C1769	$241.57	$169.10	$172.00	APR-DRG	$146.49	$146.49	per diem	$146.49	$172.00
5	APR-DRG	APR-DRG 1-1					$74,317.46				$74,317.46	$74,317.46
6	APR-DRG	APR-DRG 1-2					$80,157.42				$80,157.42	$80,157.42
7	APR-DRG	APR-DRG 1-3					$83,682.11				$83,682.11	$83,682.11
8	APR-DRG	APR-DRG 1-4					$153,427.83				$153,427.83	$153,427.83
9	Case Rate	Obs Case Rate				$1,300.00					$1,300.00	$1,300.00
10	Case Rate	ER Levels 1-3 Case Rate							$1,398.00		$1,398.00	$1,398.00
11	Case Rate	ER Levels 4-5, Critical Care Case Rate							$3,979.00		$3,979.00	$3,979.00
12	Case Rate	Obs Hourly Rate ($9,423 Case Max)							$392.00		$392.00	$392.00
13	Per Day	IP Rehab Per Day					$1,120.22			$1,404.00	$1,120.22	$1,404.00

	A	B	C	D	E	F	G
1	CPT	HCP	DESCRIPTION	AVERAGE_COMMERCIAL_CHARGE	ESTIMATED_SELF_PAY_RATE		
2	10004		FNA BIOPSY W/O IMG GDN EA ADDL	$ 397.00	$ 119.10		
3	10005		FNA BIOPSY W/US GDN 1ST LES	$ 2,364.00	$ 709.20		
4	10006		FNA BIOPSY W/US GDN EA ADDL	$ 2,003.00	$ 600.90		
5	10007		FNA BIOPSY W/FLUOR GDN 1ST LES	$ 2,453.00	$ 735.90		
6	10008		FNA BIOPSY W/FLUOR GDN EA ADDL	$ 1,378.00	$ 413.40		
7	10009		FNA BIOPSY W/CT GDN 1ST LES	$ 1.841.00	$ 552.30		

Common Errors on the Machine-Readable File

Showing ”%” versus “$”

- Recent guidance from CMS advises hospitals to **calculate the dollar value** for ‘percent of charge payers’ at CDM and NDC level

Wrong Naming Convention

- CMS requires a **specific naming convention and file format** (<ein>_<hospital-name>_standardcharges.[json|xml|csv]).

Missing Line Items

- Hospitals must include **all items and services** with a standard charge, including items with zero volume, drugs at the NDC level, etc.

Missing Updated Date

- Hospitals must indicate the date that the MRF was most recently updated **in the file itself or associated with the file.**

Not Easily Accessible

- Machine-Readable Files should be accessible to consumers, digitally searchable and **displayed prominently without barriers.**

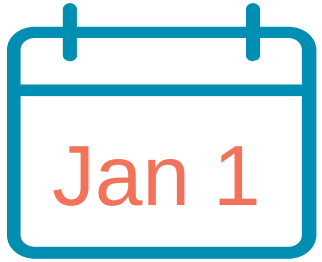
Rates Only at the Plan Level

- Payer-specific negotiated rates should be at the **payer and plan code level** and should not be averages or ranges.

No Surprises Act
Rule Compliance & Co-Provider Fee Schedules

GFE's for Self-pay / Uninsured – Highlights

Effective Date to Start Providing GFE's

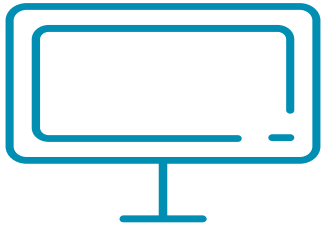


All Facilities and Providers Required to Comply

All Scheduled Items and Services or Upon Request

Disputes Process if Actual Bill >$400

Required Disclosures to Public



Up to $10K for each Violation (balance billing)

Time is of the Essence

- Date of Scheduling
- Date the Convening Provider/Facility Requests Info from Co-Provider/Facilities
- Date Co-Provider/Facilities Submit their Expected Charges back to Convening Facility/Provider
- Date a single GFE with expected charges from all facilities / providers is provided to patient
- Date of Service

JANUARY 2022

SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Non-Compliant Good Faith Estimate – Shoulder Surgery

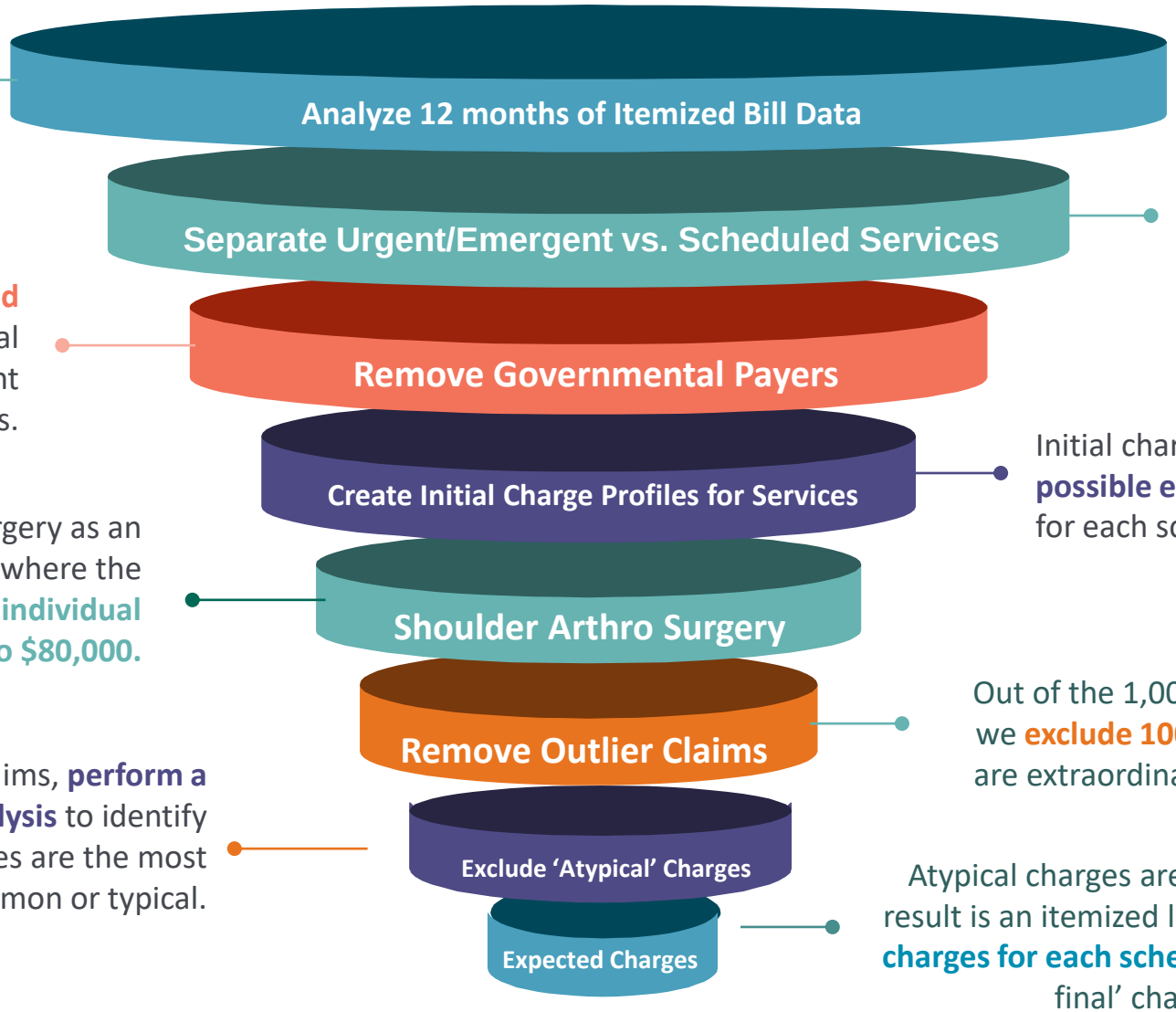
Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Shoulder Arthro	12 Health St, Med City, FL 65432	Z53.33	29824	1	$ 2,379.90
Anesthesia Time	12 Health St, Med City, FL 65432	Z53.33	370	4	$ 2,062.30
Recovery Room Time	12 Health St, Med City, FL 65432	Z53.33	710	3	$ 1,168.38
Drug Charges	12 Health St, Med City, FL 65432	Z53.33	Jxxxx	10	$ 3,000 - $5,0000
Supply Charges	12 Health St, Med City, FL 65432	Z53.33	Cxxxx	10	$ 3,120.00
Other stuff	12 Health St, Med City, FL 65432	Z53.33	n/a	3	$ 450.00

Expected Charges for Packaged Services

- Good Faith Estimates for self-pay individuals **must include any care that is reasonably expected to be provided in conjunction with the primary scheduled service(s),** including those services that may be rendered by co-providers (imaging, lab, professional services, etc.) and provided with the primary item or service that falls within the 'admission-to-discharge' period of care.

- For example, a Good Faith Estimate provided to a self-pay patient for a scheduled diagnostic colonoscopy may include, but not limited to, the following line-item expected charges;
  - **administered drugs/pharmaceuticals**
  - **clinical lab or pathology services**
  - **conscious sedation or facility anesthesia charges**
  - **professional or physician services**

Leverage a hospital or health system's **unique charging patterns and billing practices.**



Good Faith Estimates for Self-pay / Uninsured are required for all scheduled items and services.

Recommend **removing Medicare and Medicaid billing data** due to atypical resource utilization unless insufficient billing data exists.

Initial charge profiles containing **all possible expected charges** are developed for each scheduled service

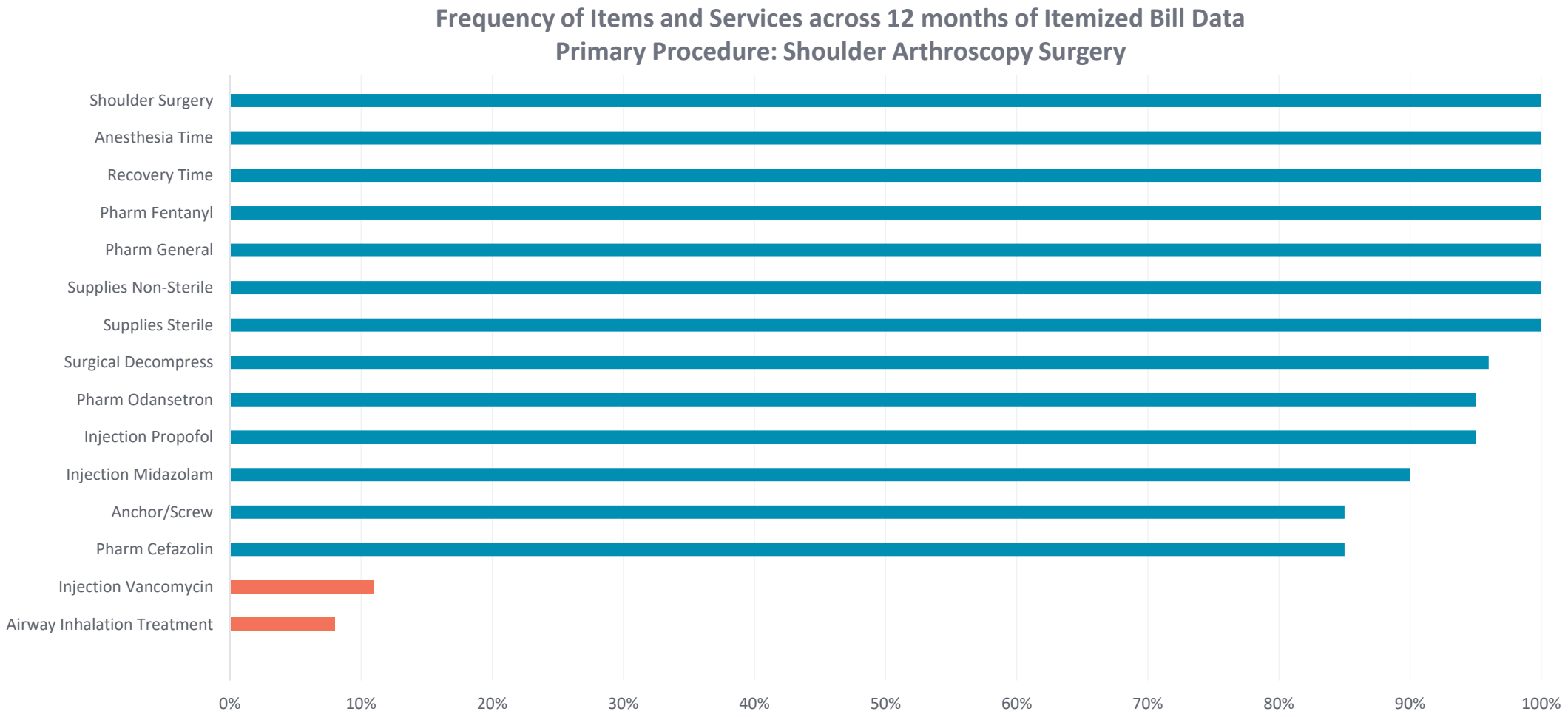
Using Arthroscopic Shoulder Surgery as an example, we identify 1,000 claims where the **average claim charges are $40,000 and individual claim charges range from $20,000 to $80,000.**

Out of the 1,000 Shoulder Surgery claims, we **exclude 100 claims as outliers** as they are extraordinarily high or low in charges.

For the remaining 900 claims, **perform a frequency distribution analysis** to identify which line-item charges are the most common or typical.

Atypical charges are excluded, and the net result is an itemized list of typical or **expected charges for each scheduled service** (i.e., 'near final' charge profiles)

Example of “Typical” Charges



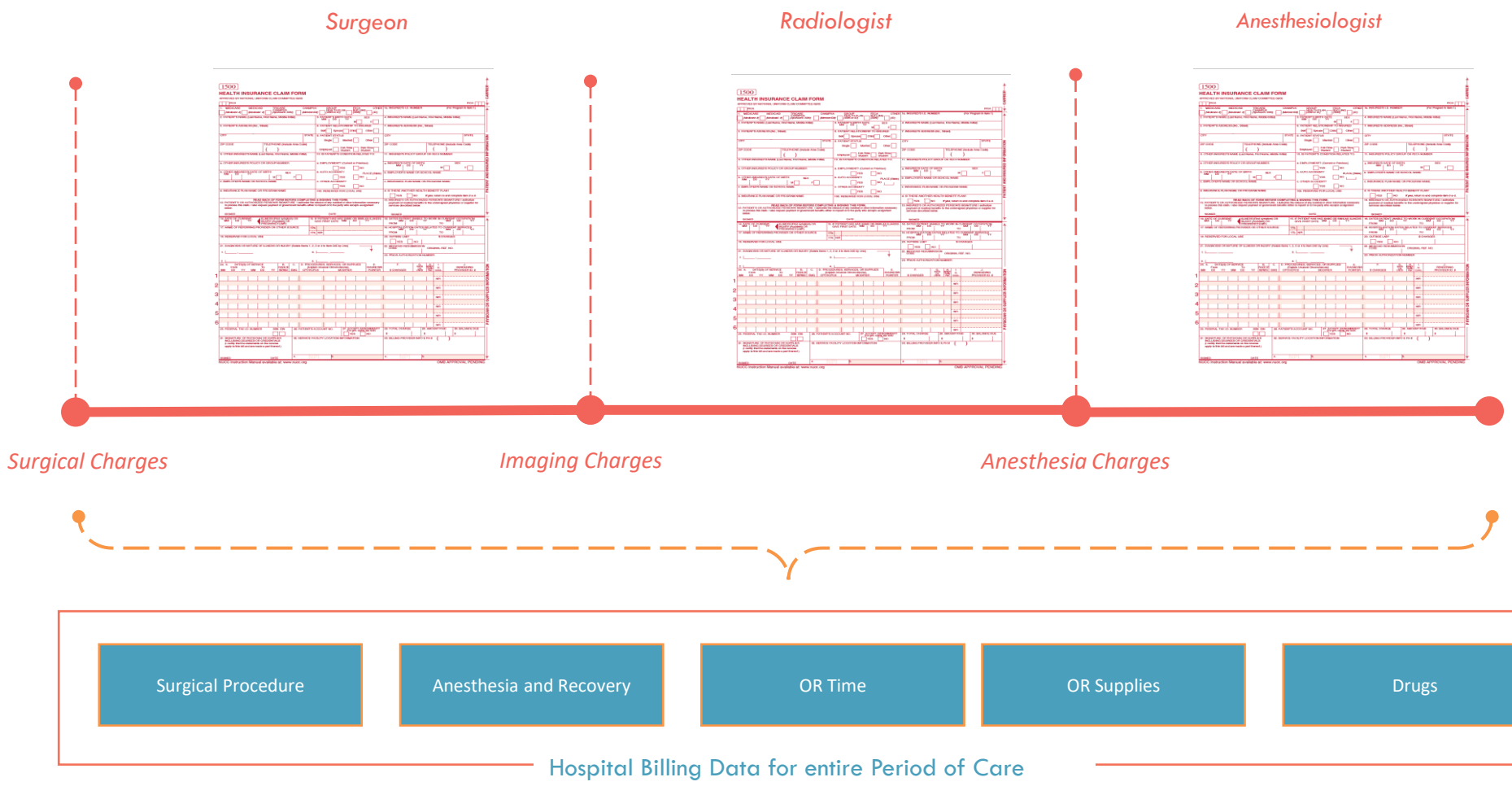
Compliant Good Faith Estimate – Shoulder Surgery

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Shoulder Arthroscopic Surgery	12 Health St, Med City, FL 65432	Z53.33	29824	1	$ 2,379.90
Surgical Decompression	12 Health St, Med City, FL 65432	Z53.33	29826	1	$ 2,271.00
Anesthesia Time	12 Health St, Med City, FL 65432	Z53.33	370	4	$ 2,062.30
Recovery Room Time	12 Health St, Med City, FL 65432	Z53.33	710	3	$ 1,168.38
Fentanyl Citrate Injection	12 Health St, Med City, FL 65432	Z53.33	J3010	2	$ 26.70
Pharmacy General	12 Health St, Med City, FL 65432	Z53.33	250	10	$ 120.00
Supplies Non-Sterile	12 Health St, Med City, FL 65432	Z53.33	271	3	$ 450.00
Supplies Sterile	12 Health St, Med City, FL 65432	Z53.33	272	10	$ 1,800.00
Ondansetron HCL Injection	12 Health St, Med City, FL 65432	Z53.33	J2405	3	$ 23.09
Ringers Lactate Infusion	12 Health St, Med City, FL 65432	Z53.33	J7120	1	$ 39.00
Injection Propofol 10 mg	12 Health St, Med City, FL 65432	Z53.33	J2704	1	$ 36.00
Injection Midazolam	12 Health St, Med City, FL 65432	Z53.33	J2250	3	$ 21.90
Anchor/Screw	12 Health St, Med City, FL 65432	Z53.33	C1713	2	$ 1,050.00
Cefazolin injection	12 Health St, Med City, FL 65432	Z53.33	J0690	2	$ 30.00

Defend Your Good Faith Estimates

GFE HCPCS	GFE HCPCS DESCRIPTION	PANACEA GFE PROFILE	SERVICE CODE	SERVICE DESCRIPTION	HCPCS	HCPCS DESCRIPTION	REVCODE	CLAIM COUNT TOTAL	CODE FREQUENCY	GFE HCPCS BILLED	CODE TOTAL CHARGES	AVERAGE CHARGE
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	Softcodes	Softcodes	42826	Removal of tonsils	360	25	100.0%	0	$ 226,206.67	$ 9,048.27
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4117420	MIDAZOLAM INJ 1MG (2MG/2) T	J2250	Inj midazolam hydrochloride	636	25	100.0%	0	$ 1,560.00	$ 62.40
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4106621	ONDANSETRON INJ 1MG (4) T	J2405	Ondansetron hcl injection	636	25	100.0%	0	$ 1,860.00	$ 74.40
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4125159	PROPOFOL INJ (200MG) 10MG T	J2704	Inj, propofol, 10 mg	636	25	100.0%	0	$ 3,240.00	$ 129.60
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4090916	FENTANYL INJ 100MCG	J3010	Fentanyl citrate injection	636	25	100.0%	0	$ 1,620.00	$ 64.80
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4103206	ROCURONIUM BR INJ 50MG			250	25	100.0%	0	$ 3,125.00	$ 125.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4096749	LIDOCAINE INJ 1% 5ML PF ANES			250	25	100.0%	0	$ 2,091.00	$ 83.64
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	3640307	TUBE ENDOTRACH STD			272	25	100.0%	0	$ 1,450.00	$ 58.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	9338906	PACU CASE MAJOR 0-60 MIN			710	25	100.0%	0	$ 107,500.00	$ 4,300.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	rollup	rollups	J1100	Dexamethasone sodium phos	636	25	96.0%	0	$ 3,538.00	$ 147.42
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	850628	LACTATED RINGERS 1000 ML	J7120	Ringers lactate infusion	636	25	96.0%	0	$ 3,304.00	$ 137.67
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	3641776	ANES GEN ASA LEVEL 1-2 0-30MIN			370	25	88.0%	0	$ 94,600.00	$ 4,300.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	rollup	rollups	J0330	Succinycholine chloride inj	636	25	84.0%	0	$ 7,029.00	$ 334.71
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	3641750	ANES GEN ASA LEVEL 1-2 ADD 15M			370	25	84.0%	0	$ 16,800.00	$ 800.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4469417	BLD/SHAVER/SAW			272	25	80.0%	0	$ 14,532.00	$ 726.60
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	rollup	rollups	J3490	Drugs unclassified injection	636	25	68.0%	0	$ 2,230.00	$ 131.18
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	1187657	HCG QUALITATIVE	84703	Chorionic gonadotropin assay	301	25	64.0%	0	$ 4,800.00	$ 300.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4029872	FAMOTIDINE TAB 20MG			259	25	56.0%	0	$ 168.00	$ 12.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	2177202	LEV III SURG PATH GROSS & MICR	88304	Tissue exam by pathologist	312	25	52.0%	0	$ 18,200.00	$ 1,400.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	rollup	rollups	J2710	Neostigmine methylslfte inj	636	25	48.0%	0	$ 1,964.00	$ 163.67
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	5120522	LEG COMPRESS SLEEVES FOR SCD			272	25	44.0%	0	$ 2,761.00	$ 251.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4065439	BUPI/EPI INJ 0.5% MDV 50ML			250	25	40.0%	0	$ 1,200.00	$ 120.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4325213	BLD/SHAVER/SAW			272	25	36.0%	0	$ 2,610.00	$ 290.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Yes	4129169	CEFAZOLIN INJ (1-AD-MS) 0.5G T	J0690	Cefazolin sodium injection	636	25	32.0%	0	$ 860.00	$ 107.50
42826	Tonsillectomy, primary or secondary; age 12 or ove	Client Review	3641545	BLANKET WARM TOUCH			271	25	28.0%	0	$ 1,169.00	$ 167.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Client Review	rollup	rollups	J1170	Hydromorphone injection	636	25	24.0%	0	$ 801.00	$ 133.50
42826	Tonsillectomy, primary or secondary; age 12 or ove	Client Review	9337874	PACU CASE MAJOR EA ADD 15M			710	25	24.0%	0	$ 3,630.00	$ 605.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Client Review	4478459	BLD/SHAVER/SAW			272	25	20.0%	0	$ 5,035.00	$ 1,007.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Client Review	43050087	EKG12LEAD TRACING ONLY-ROUTINE	93005	Electrocardiogram tracing	730	25	16.0%	0	$ 2,400.00	$ 600.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Client Review	4128161	ACET/HYDROC POL 7.5-325MG/15ML			259	25	16.0%	0	$ 240.00	$ 60.00
42826	Tonsillectomy, primary or secondary; age 12 or ove	Client Review	4014312	SCOPOLAMINE PAT 1.5MG/72HR			259	25	16.0%	0	$ 276.00	$ 69.00

Integrating Data from Employed Physicians



What about Co-providers / Co-facilities?

1. ***CREATE LETTER TO SEND TO CO-PROVIDERS***
2. ***REQUEST COPY OF THEIR FEE SCHEDULE & SELF PAY DISCOUNT POLICY***
3. ***SEND LETTER CERTIFIED RETURN RECEIPT***
4. ***INCORPORATE DATA RECEIVED BY CO-PROVIDERS INTO CHARGE PROFILES***

Effective Jan 1st, 2022, providers and facilities are required to inquire about a patients' health insurance status and provide a Good Faith Estimate of all expected charges for non-emergent scheduled services to an uninsured, or self-pay, individual (or authorized representative). Unlike a single estimate for all charges that is required with a patient estimation system, the Good Faith Estimate for self-pay individuals requires individual line-item expected charges that must include any care that is reasonably expected to be provided in conjunction with the primary scheduled service(s), including those services that may be rendered by co-providers (imaging, lab, professional services, etc.) and provided with the primary item or service that falls within the 'admission-to-discharge' period of care.

For example, a Good Faith Estimate provided to a self-pay patient for a scheduled diagnostic colonoscopy may include, but not limited to, the following line-item expected charges; administered drugs/pharmaceuticals, lab, or [illegible] such as a complete blood count (CBC), anesthesia for endoscopic [illegible] or physician services. Expected charge also refers to the [illegible] provider or facility for an uninsured or self-pay indivi[illegible]individuals. The Good Faith Estimate does not a[illegible]

Ultimately, it is the responsibil[illegible] Hospital) to collect all line-item expected [illegible]stimate. The convening provider is the prov[illegible]a Good Faith Estimate or is responsible fo[illegible]e self-pay or uninsured individual should not [illegible]uch provider or facility that delivered care.

The Good Faith Estimate must be provi[illegible]per or electronically) to uninsured individuals within the following time[illegible]

1. No later than 1 (one) business day after the date of scheduling when a primary item or service is scheduled at least 3 business days before the date of furnishing;
2. No later than 3 (three) business days after the date of scheduling when a primary item or service is scheduled at least 10 business days before such item or service is the date of furnishing; or
3. No later than 3 business days after the date of the request when a good faith estimate is requested.

CERTIFIED MAIL

Co-Providers: Hospital-to-Physician Charge Mapping

Panacea Proprietary Crosswalk (example)

Hospital Primary Procedure	Primary Procedure Desc.	Associated Physician Specialty	Physician CPT Code	Physician CPT Desc	Physician Fee Schedules
29824	Shoulder Arthroscopic Surgery	Orthopedic	29824	Shoulder Arthroscopic Surgery	$1,063.00
29824	Shoulder Arthroscopic Surgery	Orthopedic	29826	Decompression w/ partial acromioplasty	$267.00
29824	Shoulder Arthroscopic Surgery	Anesthesia	01630	Anesthesia for surgical arthroscopic procedures	$832.00
45378	Diagnostic Colonoscopy	Gastroenterologist	45378	Diagnostic Colonoscopy	$1075.00
45378	Diagnostic Colonoscopy	Anesthesia	00812	Anesthesia; screening colonoscopy	$780.00
45378	Diagnostic Colonoscopy	Pathologist	88305	Tissue exam	$510.00

Payor Peer Negotiated Rates:
Provider or Payor Files – Which to Use?

Transparency in Coverage vs. CMS Price Transparency

TiC

- Effective July 1st, 2022
- Machine- Readable Files Updated Monthly

- Applies to Health Insurers and Group Health Plans
- Three MRFs required (In-network, OON, and Rx*)

- Enforcement: States with primary and HHS back-up
- Future Requirements: Price Comparison Tools

- Format: JSON, XML, YAML
- Size: ~1TB

CMS PT

- Effective Jan 1st, 2021
- Machine-Readable Files Updated Annually

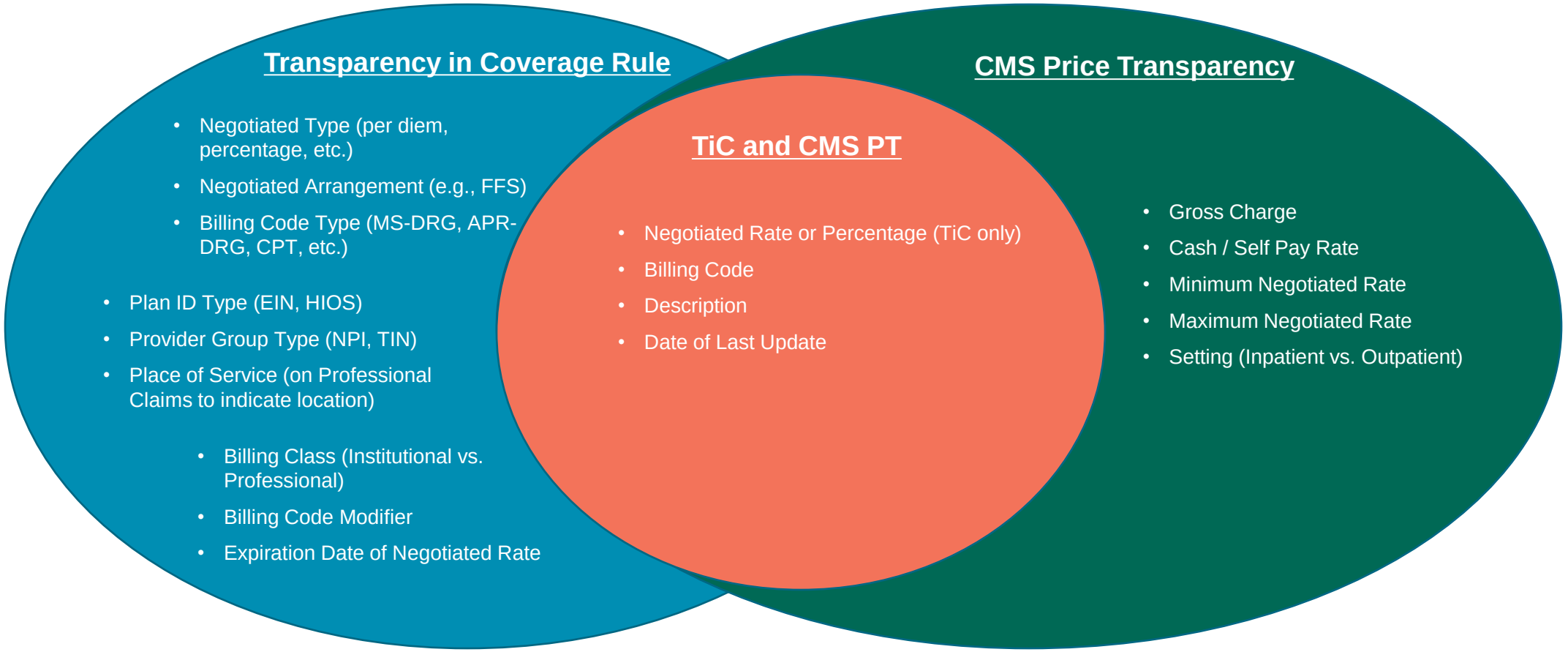
- Applies to Licensed Hospitals w// Exceptions
- One MRF required for all services and payer plans

- Enforcement: CMS Warning Letter, Corrective Action Plan, Civil Monetary Penalties to Bed Size

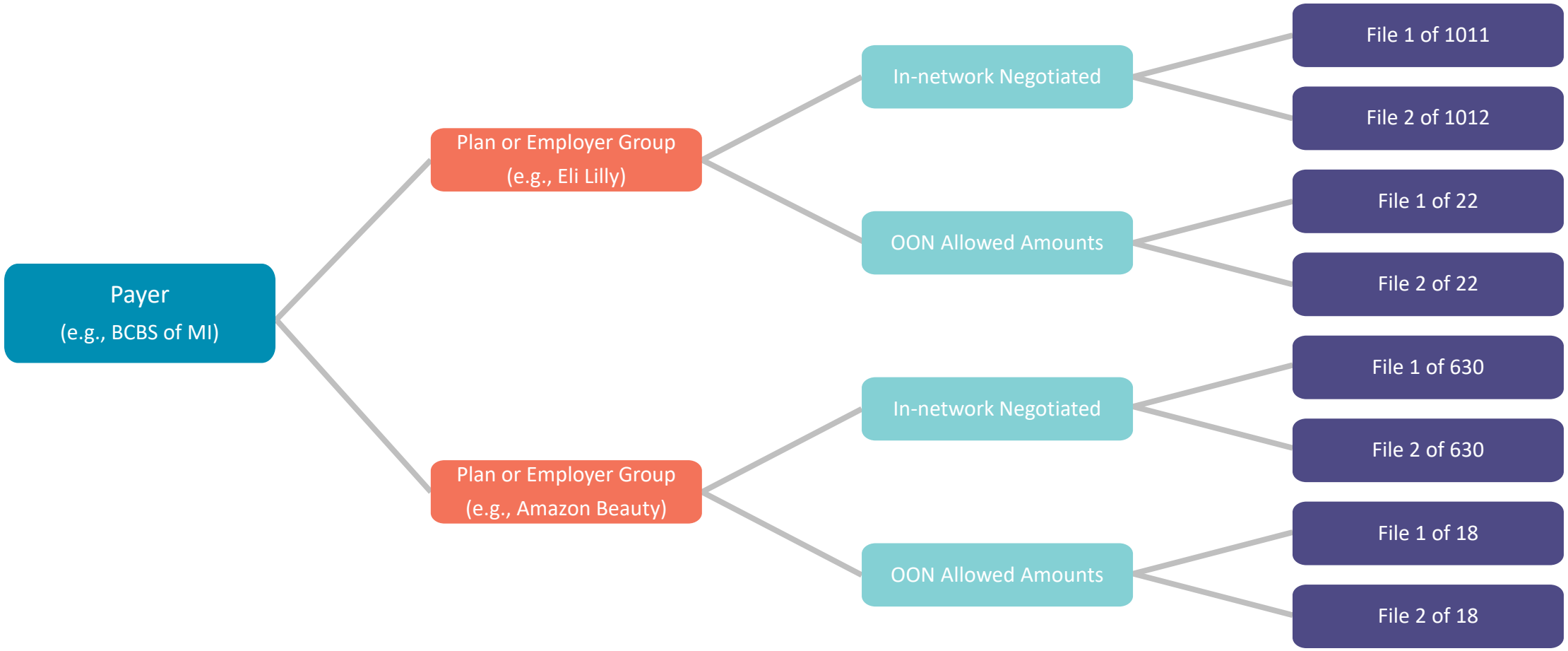
- Format: JSON, XML, CSV
- Size: ~1GB

*Requirements for payers to publish negotiated rates for covered prescription drugs has been delayed.

Attribute Comparison of Machine-Readable Files



Payer MRF – Anatomy – Know what you are looking for



It is not uncommon for a payer to have over 100K different plan / employer groups and with each plan or employer group having thousands of different negotiated rate files depending on the size of the plan and the number of contracted providers.

Negotiated Arrangement and Negotiated Type

Negotiated Arrangement	Negotiated Type			
Fee for Service	Negotiated	Percentage	Fee Schedule	Per Diem
	The negotiated rate, reflected as a dollar amount, for each covered item / service that the plan has contractually agreed to pay an in-network provider	The negotiated percentage value for a covered item or service from a particular in-network provider for a 'percentage of billed charges' arrangement.	The rate for a covered item that determines a participant's cost-sharing liability for the item / service, when that rate is different from the negotiated rate or derived amount.	The per diem daily rate, reflected as a dollar amount, for each covered item / service that the plan has contractually agreed to pay an in-network provider
Capitation	Derived	The price that a plan or issuer assigns to an item or service for the purpose of internal accounting, reconciliation with providers or submitting data in accordance with the requirements of 45 CFR 153.710(c)		
Bundled	Negotiated	Percentage	Fee Schedule	Derived

Simple Example

Payer MRF

Reporting Entity	Plan Name	Billing Code Type	Billing Code	Description	Negotiated Arrangement	Negotiated Type	TIN TYPE	TIN VALUE	Negotiated Rate	Expiration Date	Billing Class
BCBS of MI	Eli Lilly	CPT	45378	Colonoscopy	FFS	Negotiated	NPI	1871504357	*6***06.2**	12/31/22	Professional
Florida Blue	Target	CPT	45378	Colonoscopy	FFS	Percentage	EIN	12-1234567	*30.2*	12/31/22	Institutional
UHC	Amazon	CPT	45378	Colonoscopy	Capitation	Derived	EIN	45-4847383	800.5	12/21/22	Institutional

Hospital MRF

Entity Name	Payer	Plan	Billing Code	Description	Gross Charge	Self Pay / Cash Rate	Negotiated Rate	Minimum Negotiated Rate	Maximum Negotiated Rate
Medical Center ABC	BCBS of MI	PPO	45378	Colonoscopy	$3000.00	$1,500.00	$2,000.00	$1,2000.00	$2,500.00

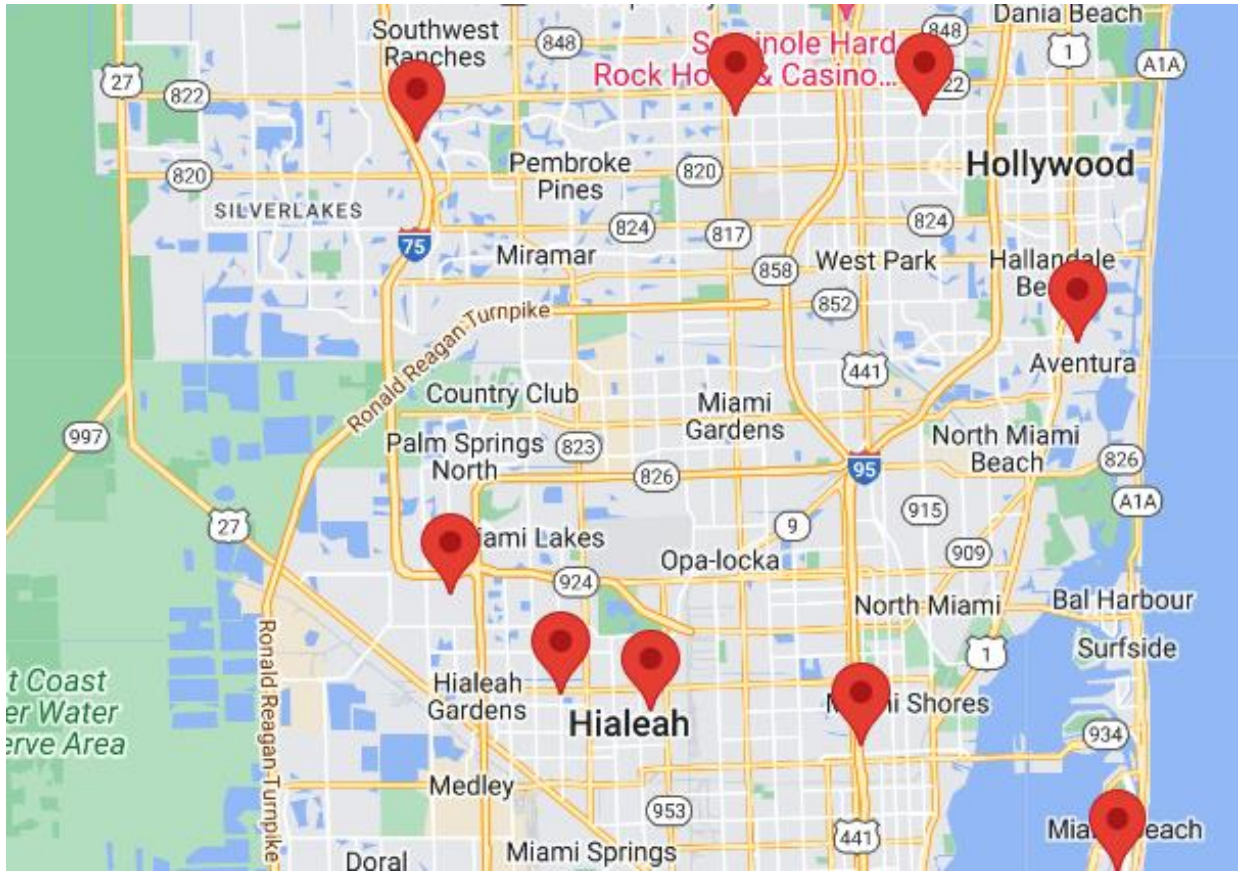
*The above examples are for illustration to show differences in requirements between payers and hospitals and are not intended to show the full detail of a compliant machine-readable file.

Working Around Payer MRFs

Utilizing Aggregated Hospital MRFs to Normalize Peer Negotiated Rates

Building your Peer Group

1. ***DETERMINE IF PEER GROUP IS LOCAL, REGIONAL and/or NATIONAL***
2. ***IDENTIFY WHICH PEERS ALLOW FOR "LIKE" COMPARISONS***
3. ***CONSIDER FACTORS LIKE GEOGRAPHY, BED SIZE, TEACHING STATUS, NFP, etc.***
4. ***PERFORM INITIAL SCREENING TO CONFIRM COMPLIANCE AND USABILITY OF MRFs***

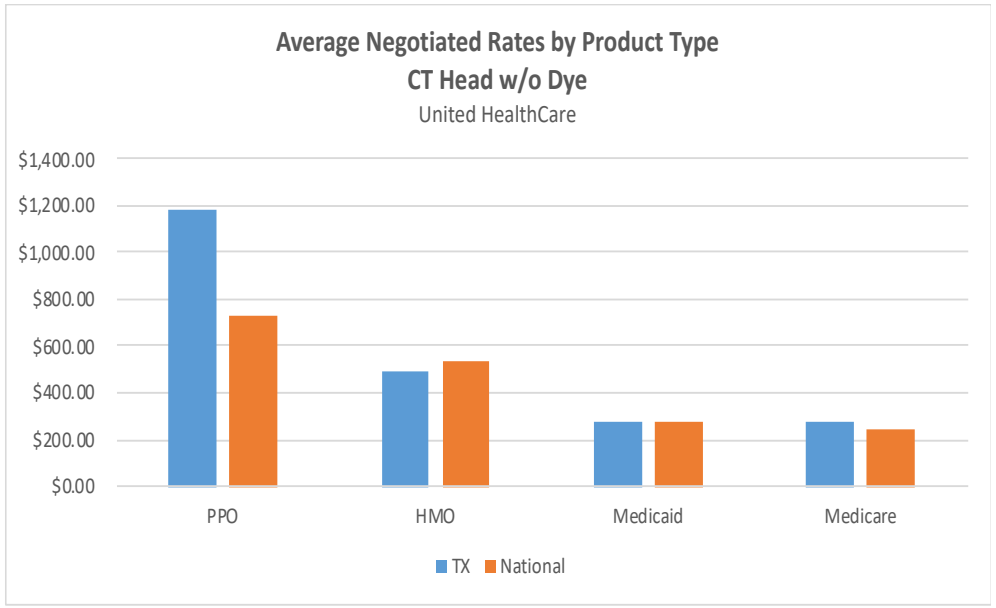


Classification of Disparate Payer / Plans to a Standard Payer and Plan

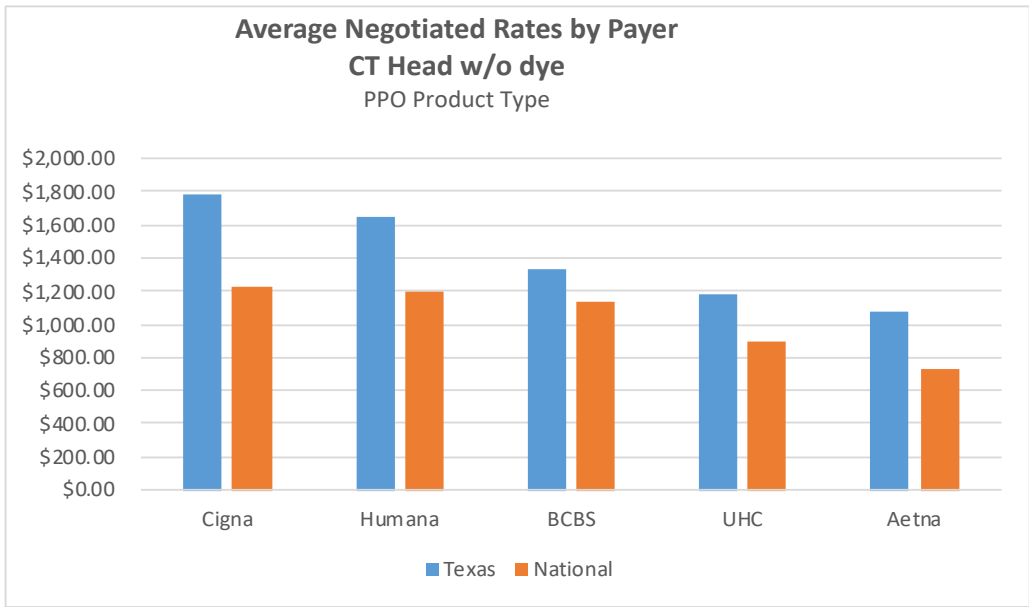
Unique Payer / Plan on MRF	Standard Payer	Standard Plan	Payer Roll Up
BCBS Select PPO	BCBS	PPO	Commercial
Aetna Care PPO	Aetna		
Cigna Med PPO	Cigna		
BCBS Choice HMO	BCBS	HMO	
Aetna Preferred HMO	Aetna		
Cigna HMO Network	Cigna		
BCBS Indemnity One	BCBS	Indemnity	
Aetna Indemnity One	Aetna		
Cigna Health Indem	Cigna		
BCBS Freedom	BCBS	Other	
Aetna Health Med	Aetna		
Cigna Best	Cigna		
BCBS Medicare	BCBS	Medicare Advantage	Medicare Advantage
Aetna Medicare Plus	Aetna		
Cigna Adv Medicare	Cigna		
BCBS Health Medicaid	BCBS	Medicaid Advantage	Medicaid Advantage
Aetna Medicaid True	Aetna		
Cigna Caid True	Cigna		

Extreme Variation in Negotiated Rates between Product Types

Same Payer but Different Product Types



Different Payers but Same Product Types



Rate Methodology not required in Hospital MRF

CMS Example - Rate Methodology is embedded in the Service Description

	B	C	D	E	F	G	H	I	J	K	L
					Payer 1	Payer 1	Payer 2	Payer 2	Payer 3		
	Description	PT/HCPC	Gross Cha	Disc Cash	Plan 1	Plan 2	Plan 1	Plan 2	Plan 1	Min Neg Chg	Max Neg Chg
	0.035 260 ANGLED GLIDE CATH (59575)	769	$187.08	$130.96	$133.20	APR-DRG	$113.45	$113.45	per diem	$113.45	$133.20
	0.25 STRAIGHT STIFF ZIPWIRE (65028)	769	$241.57	$169.10	$172.00	APR-DRG	$146.49	$146.49	per diem	$146.49	$172.00
	APR-DRG 1-1					$74,317.46				$74,317.46	$74,317.46
	APR-DRG 1-2					$80,157.42				$80,157.42	$80,157.42
	APR-DRG 1-3					$83,682.11				$83,682.11	$83,682.11
	APR-DRG 1-4					$153,427.83				$153,427.83	$153,427.83
	Obs Case Rate				$1,300.00					$1,300.00	$1,300.00
	ER Levels 1-3 Case Rate							$1,398.00		$1,398.00	$1,398.00
	ER Levels 4-5, Critical Care Case Rate							$3,979.00		$3,979.00	$3,979.00
	Obs Hourly Rate ($9,423 Case Max)							$392.00		$392.00	$392.00
	IP Rehab Per Day					$1,120.22			$1,404.00	$1,120.22	$1,404.00

"Preferred" Example - Rate Methodology is in a separate column outside of the Service Description

Contract Nan	Product Name	Billing Cod	Billing Code Description	Service Area	Rate Methodology	ase Rate or Negotiated Rate Per Contract	De-identifed Lowest Negotiated Rate	De-identifed Highest Negotiated Rate	Discounted Cash Price
MULTIPLAN / PHC	694-XR OKC MULTIPLAN PHCS NEW	38525	Biopsy/removal lymph nodes	SDS	Case Rate	$1,254.00	$1,254.00	$1,254.00	$7,503.78
BCBS	525- OK SASH BLUE TRADITIONAL	38525	Biopsy/removal lymph nodes	Outpatient	EAPG	$6,767.38	$4,073.34	$6,767.38	$2,177.19
BCBS	524- OK SASH BLUE CHOICE	38525	Biopsy/removal lymph nodes	Outpatient	EAPG	$5,886.28	$4,073.34	$6,767.38	$2,177.19
BCBS	895-OK SASH BLUE PREFERED	38525	Biopsy/removal lymph nodes	Outpatient	EAPG	$5,005.18	$4,073.34	$6,767.38	$2,177.19
BCBS	615- OK SASH BLUE ADVANTAGE	38525	BIOPSY/REMOVAL LYMPH NODES	Outpatient	EAPG	$4,073.34	$4,073.34	$6,767.38	$2,177.19
BCBS	526-OK SASH BLUELINCS	38525	Biopsy/removal lymph nodes	Outpatient	EAPG	$4,073.34	$4,073.34	$6,767.38	$2,177.19
HUMANA	532-OK SASH HUMANA CHOICE CA	38525	Biopsy/removal lymph nodes	Outpatient	OP Default Percent	$3,773.34	$2,073.34	$7,767.38	$2,177.19
WELLFIRST	815-OKC WELLFIRST	38525	Biopsy/removal lymph nodes	Outpatient	OP Default Percent	$3,358.16	$2,073.34	$7,767.38	$2,177.19
AETNA	521-OK SASH AETNA 10/01/2015	38525	Biopsy/removal lymph nodes	Outpatient	OP Default Percent	$2,585.23	$2,073.34	$7,767.38	$2,177.19
UHC	543-OK SASH UNITED COM	38525	Biopsy/removal lymph nodes	Outpatient	OP Default Percent	$2,513.97	$2,073.34	$7,767.38	$2,177.19
SELF PAY	Self Pay	38525	Biopsy/removal lymph nodes	Outpatient	OP Default Percent	$2,513.97	$2,073.34	$7,767.38	$2,177.19
CIGNA	527-OK SASH CIGNA HMO & PPO	38525	Biopsy/removal lymph nodes	Outpatient	OP Default Percent	$2,513.97	$2,073.34	$7,767.38	$2,177.19
HEALTHCARE HIGH	529-OK SASH HEALTH CARE HIGH	38525	Biopsy/removal lymph nodes	Outpatient	OP Default Percent	$2,213.97	$2,073.34	$7,767.38	$2,177.19
GLOBALHEALTH	559-OK SASH GLOBAL HEALTH CO	38525	Biopsy/removal lymph nodes	Outpatient	Per Unit Via Fee Schedule Final OPPS	$3,658.16	$2,813.97	$7,372.60	$2,177.19
COMMUNITY CARE	55-OKC CCHMO SELECT MEDICARE	38525	Biopsy/removal lymph nodes	Outpatient	Per Unit Via Fee Schedule OPPS	$7,372.60	$2,813.97	$7,372.60	$2,177.19
COMMUNITY CARE	65-OKC CCHMO	38525	Biopsy/removal lymph nodes	Outpatient	Per Unit Via Fee Schedule OPPS	$7,372.60	$2,813.97	$7,372.60	$2,177.19

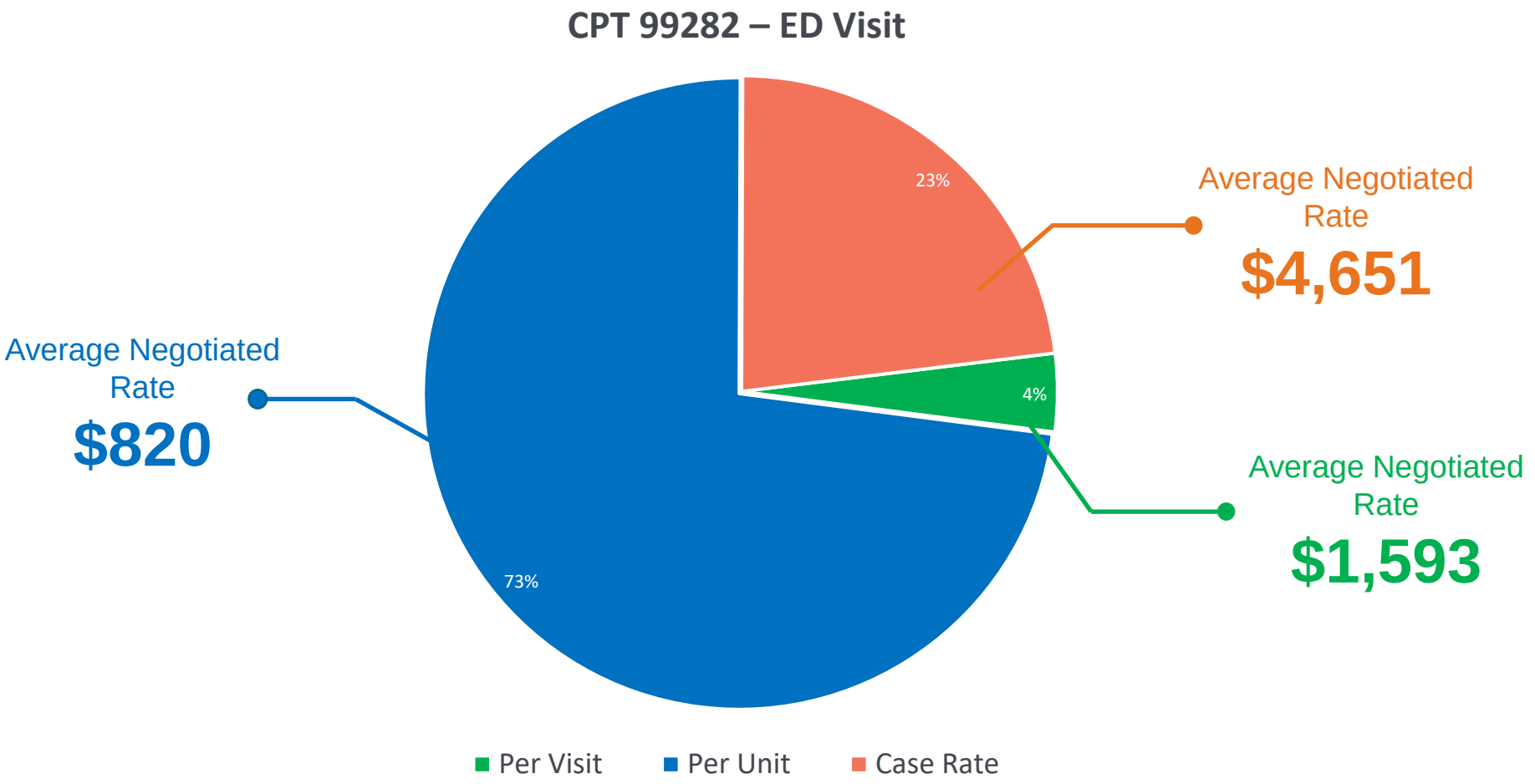
What happens if you don't control for Rate Methodology?

	Negotiated Rate by Hospital for Same Payer / Plan		
PROCEDURE	**Hospital A**	**Hospital B**	**Hospital C**
Colonoscopy	$4,000	$1,500	$3,800
MRI of Chest	$2,200	$2,500	$2,300
Shoulder Surgery	$10,000	$9,000	$3,800

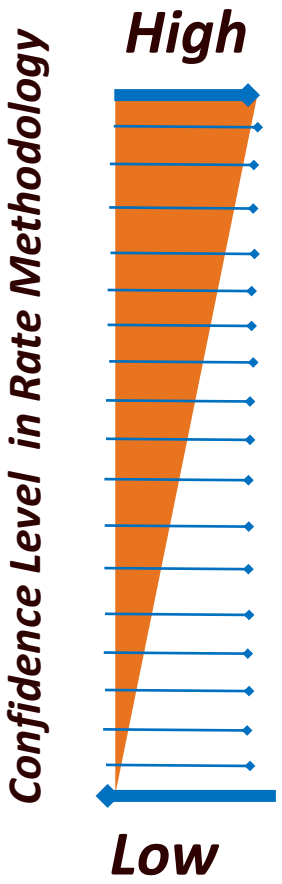
Incorporating the Rate Methodology

	Negotiated Rate by Hospital for Same Payer / Plan		
PROCEDURE	**Hospital A**	**Hospital B**	**Hospital C**
Colonoscopy	$4,000 (case rate)	$1,500 (per unit)	$3,800 (case rate)
MRI of Chest	$2,200 (per unit)	$2,500 (per unit)	$2,300 (per unit)
Shoulder Surgery	$10,000 (case rate)	$9,000 (case rate)	$3,800 (per unit)

Disparity by Rate Methodology for Same Service



Confidence Levels by Frequency of Rate Methodology



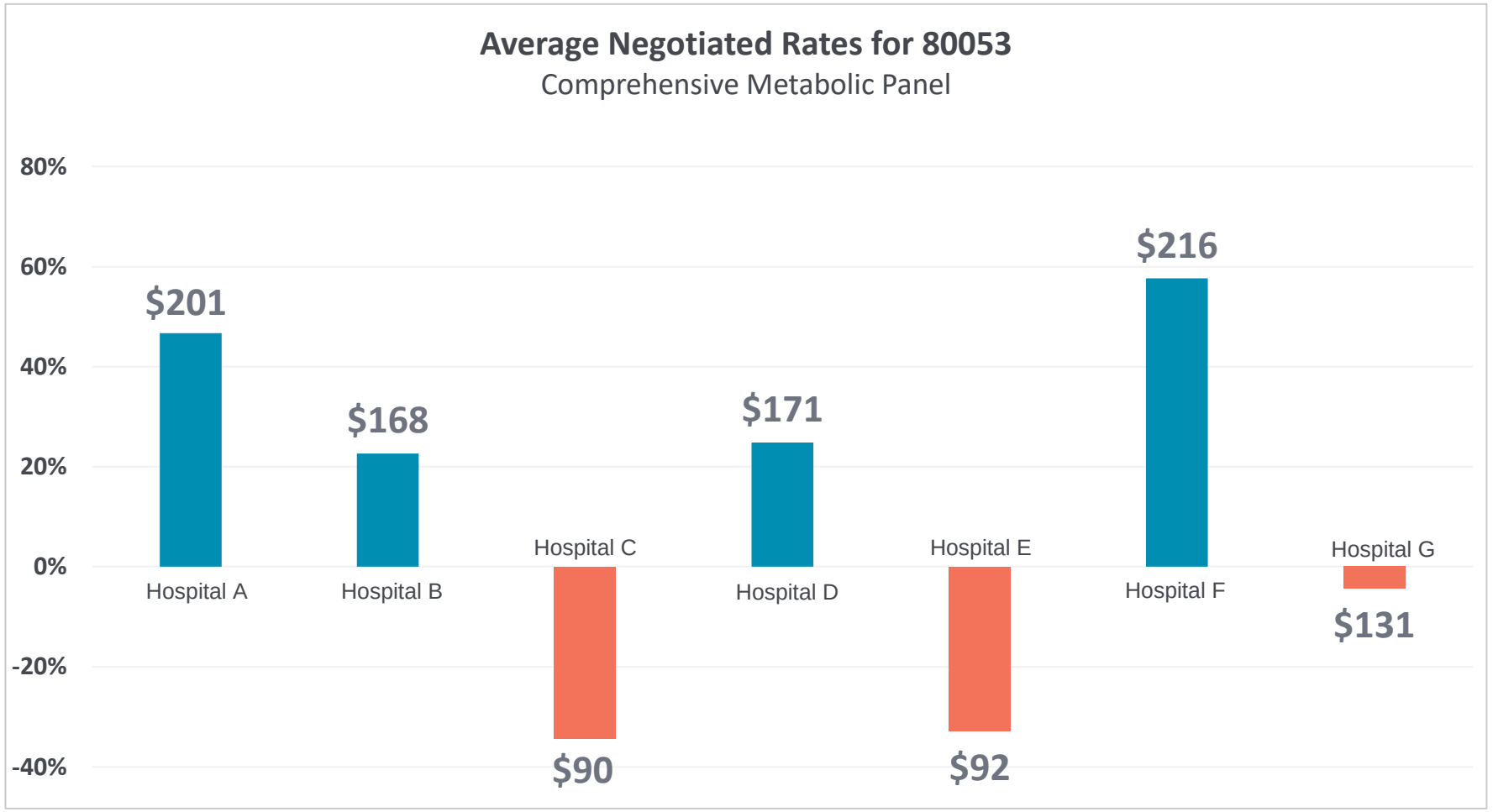
Billling Code	Description	Confidence Level	Predominant Rate Methodology (Claim vs. Line Item)	Frequency of Predominant Rate Methodology
80050	General health panel	Primary	Line Item	95%
73030	X-ray exam of shoulder	Primary	Line Item	87%
71550	Mri chest w/o dye	Primary	Line Item	85%
99282	Emergency dept visit	Secondary	Line Item	77%
76932	Echo guide for heart biopsy	Secondary	Line Item	72%
64642	Chemodenervation	Tertiary	Claim Level	68%
31625	Bronchoscopy w/biopsy	Tertiary	Claim Level	65%
27447	Total knee arthroplasty	Tertiary	Claim Level	61%

Importance of Removing Outlier Rates - CBC Lab Test

Before Removing Outliers								
Payer	Average	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G
BCBS HMO	**$ 120**	$ 100			$ 140			
BCBS HMO	**$ 163**		$ 150	$ 160		$ 180		
BCBS HMO	**$ 1,560**		$ 120				$ 3,000	
BCBS HMO	**$ 165**	$ 130						$ 200
BCBS HMO	**$ 120**	$ 100			$ 140			
BCBS HMO	**$ 140**						$ 140	
Average	**$ 416**	**$ 110**	**$ 135**	**$ 160**	**$ 140**	**$ 180**	**$ 1,570**	**$ 200**

After Removing Outliers								
Payer	Average	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G
BCBS HMO	**$ 120**	$ 100			$ 140			
BCBS HMO	**$ 163**		$ 150	$ 160		$ 180		
BCBS HMO	**$ 120**		$ 120					
BCBS HMO	**$ 165**	$ 130						$ 200
BCBS HMO	**$ 120**	$ 100			$ 140			
BCBS HMO	**$ 140**						$ 140	
Average	**$ 178**	**$ 110**	**$ 135**	**$ 160**	**$ 140**	**$ 180**	**$ 140**	**$ 200**

Meaningful Variation in Rates within same Peer Group and PPO Product Type



Payer Analysis

Target Hospital: ABC Medical Center
Patient Class: Outpatient (SDS, POP, etc.)
Payers: Big 5, excl. Managed Medicare / Medicaid
Plan Type: PPO only
Outlier Logic Included: Yes

Confidence Level for Rate Methodology:

- ✓ Primary
- ✓ Secondary
- ✓ Tertiary

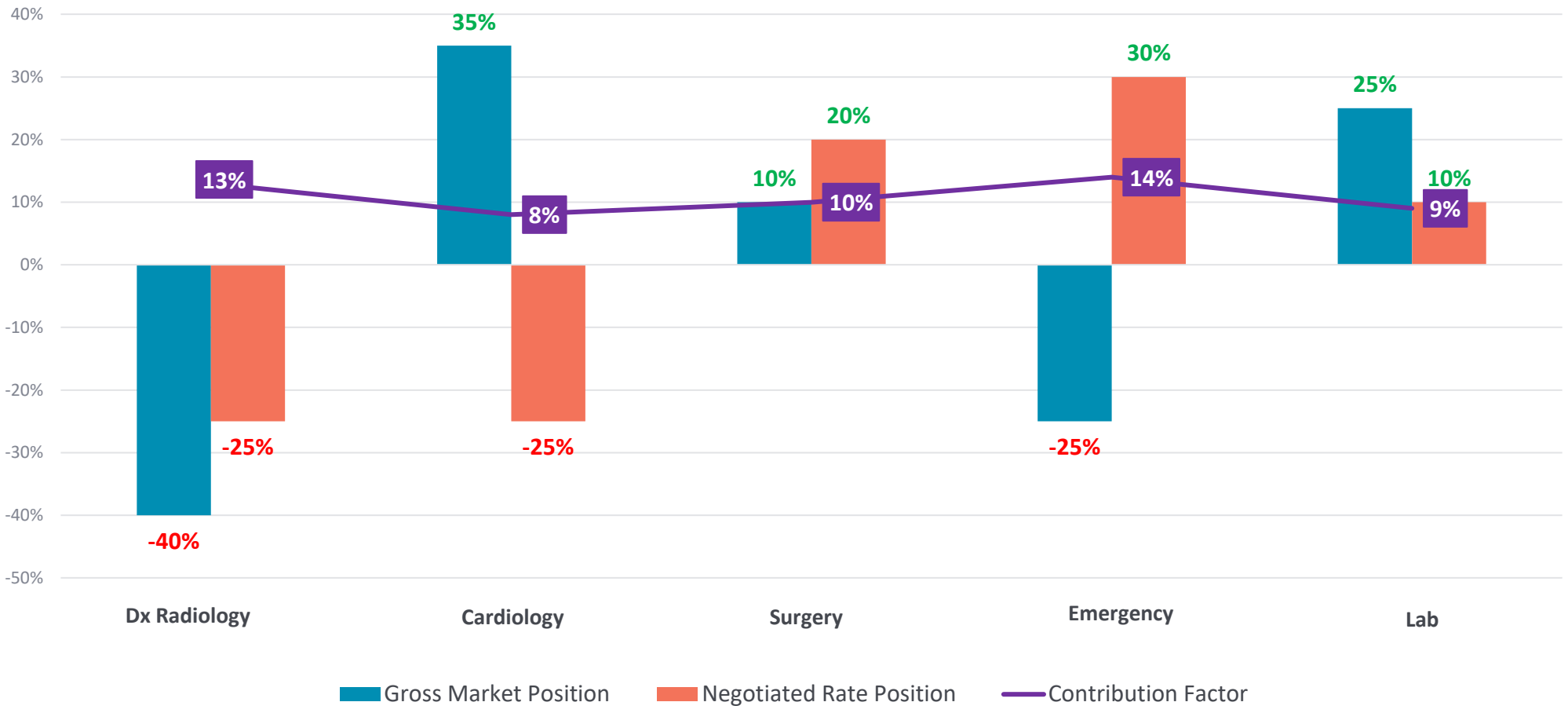
Peer Group

1. Peer Hospital A
2. Peer Hospital B
3. Peer Hospital C
4. Peer Hospital D
5. Peer Hospital E

Payer and Plan Type	Negotiated Rate Position	Peer Group Rank (1=Highest)	Gross Charge Position
BCBS PPO	5%	2/5	120%
Aetna PPO	30%	1/5	
Cigna PPO	10%	2/5	
UHC PPO	-10%	4/5	
Humana PPO	-15%	5/5	
Overall	8%	2/5	
Overall (w/ Primary Confidence Level)	10%	2/5	

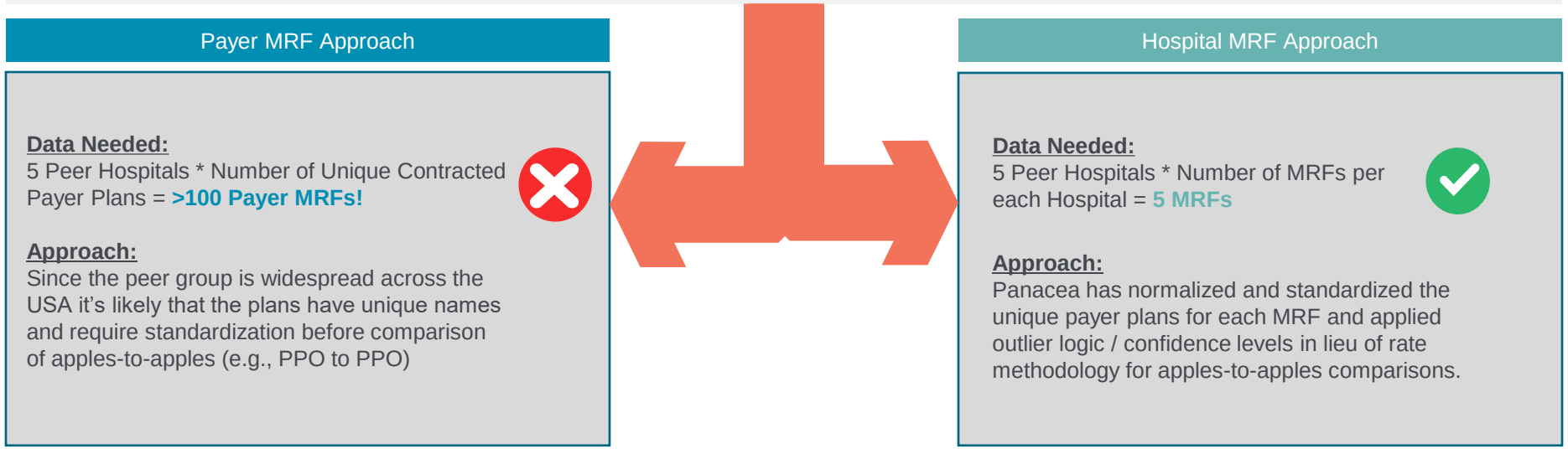
*Negotiated Rate Position is based on a weighted average. 0% is the average.
**Peer Group Rank is based on Negotiated Rates and not Gross Charges (i.e., price)

Service Line Analysis: Raise Prices or Negotiate Better Rates



Case Study

Objective: Produce a negotiated rate comparison report for all items and services which compares the negotiated rates for ABC Medical Center (i.e., target facility) against five (5) peer hospitals across the USA and include all payer plan levels.



Result: While each approach may have its pros / cons in terms of available data, normalization, data integrity, etc. the hospital MRF approach is the most efficient for this case study.

Other strategic points to consider…

- ✓ Be proactive! Analyze your own MRF. Identify within your own MRF those payer rates extraordinarily high and low. **Be prepared for downside pressure.** Leverage low comparative payer rates in subsequent negotiations.
- ✓ If using Payer MRFs, you will need tools to open and convert files plus a crosswalk of NPI and/or TIN to a hospital or provider name. You may also need a crosswalk of the employer group to plan name.
- ✓ **CAUTION:** If you are using Payer MRFs make sure to review the values for the **Negotiated Arrangement and Negotiated Type** before using the Negotiated Rates.
- ✓ If rates generally higher consider supplementing the consumer display or estimation system with **favorable quality rankings** where feasible and/or for inner city or teaching hospitals comparative rate data for comparable hospitals.
- ✓ **Restructure your chargemaster pricing each year** with careful gross and net revenue modeling using annually updated cost, market data, payer contract data, fee schedules and financial objectives.

Predictions for 2023 & 2024

- ✓ CMS will continue to enforce Price Transparency penalties, likely increasing efforts on non-compliant hospitals
- ✓ No Surprises Act Penalties Outlined / Enforced
- ✓ No Surprises Act: Considerations to expand to all schedulable services for insured in-network patients
- ✓ Payor Files and Provider Files: Combination of both file types and analytics engines begin to unlock true price transparency for Negotiated Rate Comparisons

“A lack of transparency results in distrust and a deep sense of insecurity.”

- Dalai Lama -

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