Taking the Next Steps In Transparency

Cleverley + Associates

Providence

Presentation to Washington Alaska HFMA Chapter

October 12, 2023

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Understanding the requirements

Two forms of disclosure

Comprehensive Machine-Readable File

1) **WHEN:** updates at least once per year
2) **FORMAT:** A single machine-readable file
3) **DATA ELEMENTS:**
    a) Description of each item or service
    b) All five standard charge types
    c) Accounting/Billing codes
4) **LOCATION/ACCESSIBILITY:**
    a) Prominently displayed on the web without barriers for patients to access
    b) Document must have CMS naming convention

Consumer Friendly Shoppable Services (File or Web Tool)

1) **WHO/WHEN:** updates at least once per year
2) **QUANTITY/SELECTION:** CMS is requiring 300 items and services be provided (including 70 CMS-specified and 230 hospital-selected). 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.
3) **FILE DATA ELEMENTS:** A hospital can disclose in a static file with primary code, plain-language descriptions, ancillary services, location setting, and all five standard charges (except gross charge)
4) **WEB ALTERNATIVE REQUIREMENTS:** 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

Cleverley + Associates Comment for Single Comprehensive Machine-Readable File

		DEFINITION OF ITEMS & SERVICES		
		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
DEFINITION OF STANDARD CHARGES	Gross Charges	✓CDM VIEW OF DATA	✗NOT TYPICALLY CREATED/STORED	✓ MUST PROVIDE IF EMPLOYED, BUT THE RULE INTENTIONALLY DOESN'T DEFINE EMPLOYMENT
	Discounted Cash Price	✓ MUST PROVIDE IF DEVELOPED, POLICIES CAN INCLUDE PRICING FOR PER SERVICE AND/OR PACKAGED SERVICES		
	Payer-Specific Negotiated Charges	✗ FUNDAMENTALLY, PAYMENT IS ALWAYS AT A CLAIM LEVEL	✓ TOTAL EXPECTED ENCOUNTER PAYMENT BASED ON CONSULTING CONTRACTED RATES/TERMS – NOT HISTORIC REIMBURSEMENT – ILLUSTRATES ALL ITEMS, SERVICES, AND SERVICE PACKAGES	
	De-identified minimum negotiated charges			
	De-identified maximum negotiated charges			

Potential Changes in CY24 OPPS Proposed Rule

1) MODIFYING CURRENT TRANSPARENCY REQUIREMENTS

A. REQUIRING HOSPITALS TO AFFIRM THE ACCURACY/COMPLETENESS OF THE MRF CONTENT

B. STANDARDIZING THE MRF'S FORMAT AND DATA ELEMENTS

1) Three file formats
   - A. JSON schema
   - B. CSV "tall" – with static headers and all payer data contained in additional rows
   - C. CSV "wide" – with variable column headers unique for each negotiated payer

2) Notable additional data elements
   - A. Drug Unit & Type of Measurement
   - B. Contracting Method & Consumer Friendly Expected Allowed Amount

C. TIMING & ENFORCMENT

1) January 1, 2024 with a 60-day grace period for enforcement

D. ACCESSIBILITY

1) Including a .txt file in the root folder that includes a standardized set of fields
2) Including a link in the footer on its website to price transparency

2) ENFORCMENT ACTIVITIES

A. ASSESSMENT ACTIVITIES

B. SYSTEM NON-COMPLIANCE

C. PUBLICIZING COMPLIANCE ACTIONS & OUTCOMES

Will the proposed changes impact who accesses the data and how it’s used?

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.

NBC Nightly News: February 2023

Researchers

KFF Filling the need for trusted information on national health issues

Analysis: Inconsistencies Within Hospital Price Transparency Data Make Cost Comparisons Difficult

Federal Rules Aren't Specific Enough to Ensure Hospitals Provide Comparable Data

Published: Feb 10, 2023

Advocacy Groups

Fourth Semi-Annual Hospital Price Transparency Report
February 2023

PATIENT RIGHTS ADVOCATE.ORG

Advocacy Groups

TWO DIFFERENT PICTURES IN FEBRUARY 2023

Patient Rights Advocate

CMS/HealthAffairs

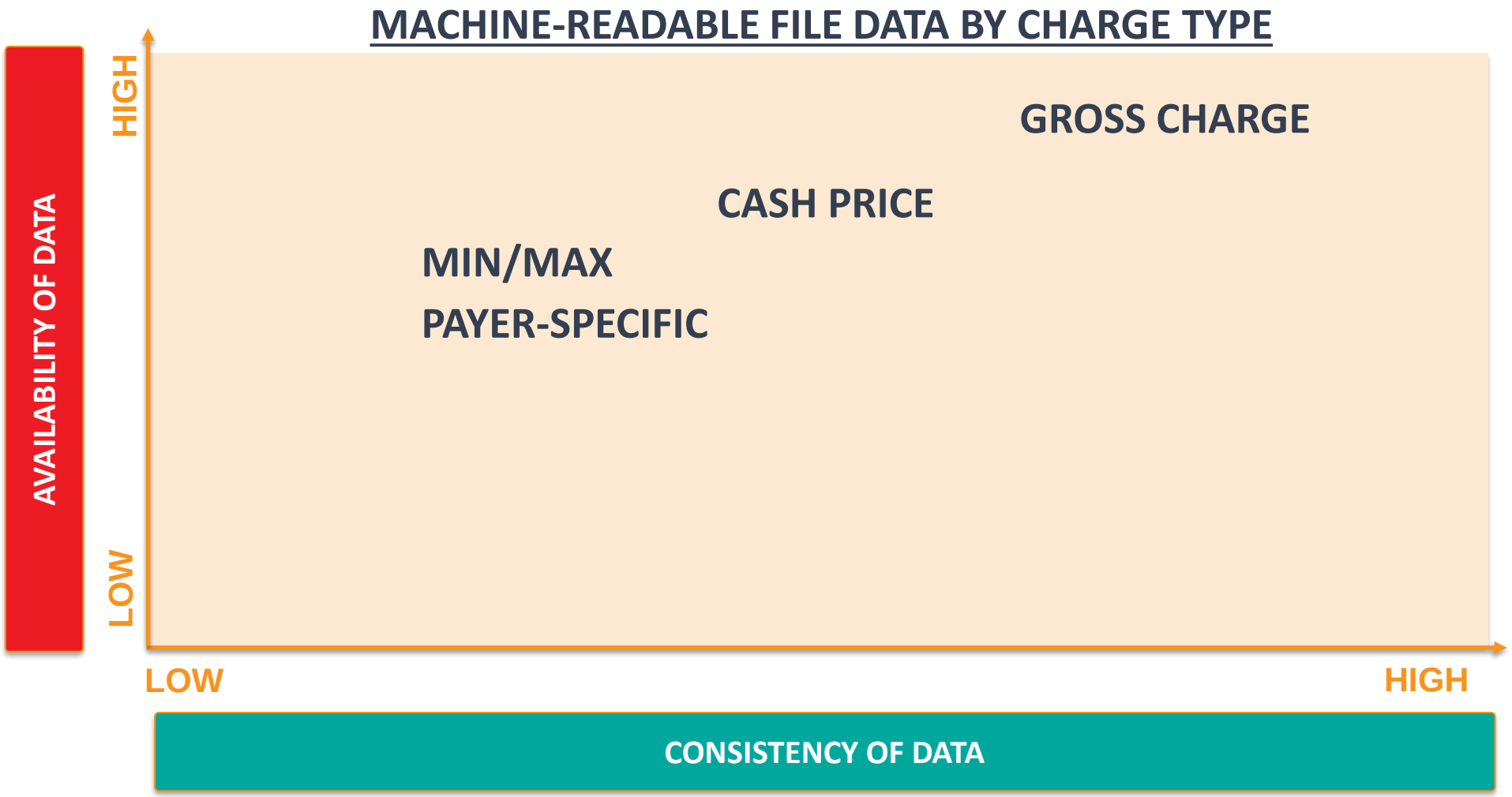
Advocacy Groups

Why the significant differences in compliance rates?	
Patient Rights Advocate	**CMS/HealthAffairs**
PRA Finding: 48.8% of the hospitals (975/2,000) did not publish all payer-specific negotiated charges "clearly associated with the names of each third-party payer and plan" as required.	The rule requires NEGOTIATED rates to be disclosed. So, if there is only one Aetna plan that has been negotiated than the hospital would only need to list Aetna once. PRA seems to be assuming non-compliance based on not finding multiple plan entries for each payer which would lead to an overstated value of non-compliance.
PRA Finding: 46.2% of the hospitals (923/2,000) did not publish a sufficient amount of negotiated rates.	This is the most subjective criteria for PRA as the definition of "sufficient" isn't disclosed in the report nor is it in the CMS rules. The absence of a "completeness" standard in the CMS rule is appropriate as there are countless examples where values will not exist for the different definitions of standard charge in application to all items, services, and service packages within the hospital's billing environment.
PRA Finding: 16.4% of the hospitals (327/2,000) did not publish any discounted cash prices.	While CMS requires this to be posted if the hospital has developed cash pricing, PRA should not assume the exclusion of this information means the hospital has determined not to post it.

Bottom Line: Patient Rights Advocate has come to a substantially higher value of hospital non-compliance in its latest report because of the use and application of criteria that is not in the CMS Price Transparency final rules

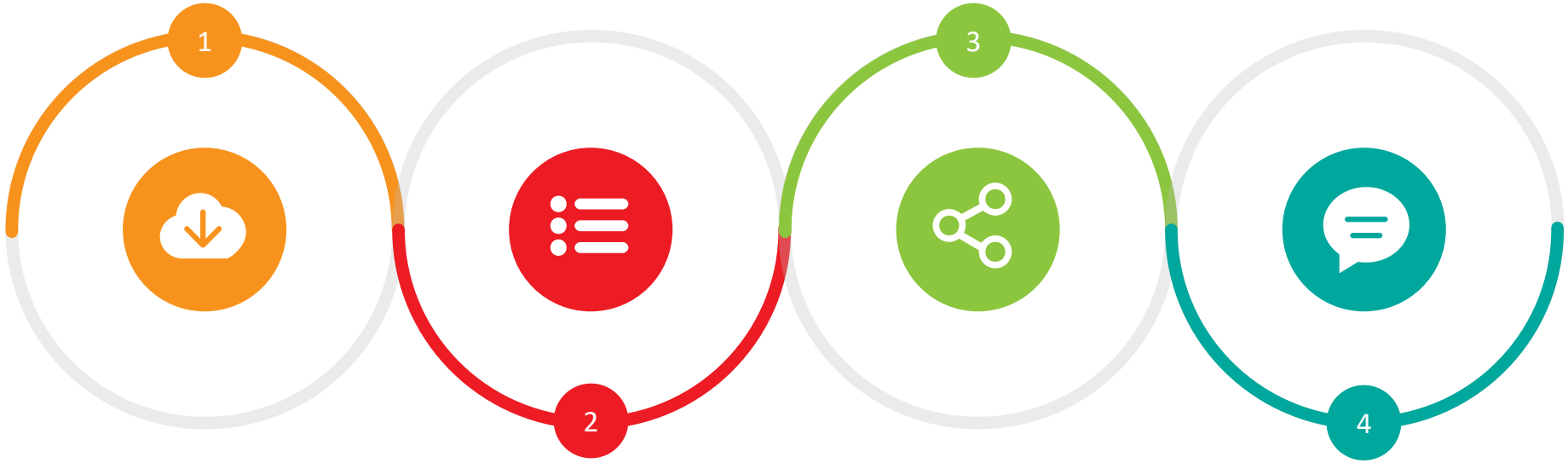
MORE INFO: https://www.cleverleyassociates.com/blog/patient-rights-advocate-dramatically-overstates-hospital-non-compliance/

Creating meaningful transparency data



Creating meaningful transparency data

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.

Creating meaningful transparency data

A standardized payer specific negotiated charge can be determined based on current hospital resources and supported by current language from CY 2020 OPPS Final Rule on Transparency (CMS-1717-F2). The CMS has established payment systems for inpatient and outpatient claims that are utilized by all hospitals subject to the transparency reporting requirements. The solution to standardizing disparate payment systems is for hospitals to determine how the claim would be paid using the specific payer negotiated contractual language and then reported under Medicare-based grouping logic by MS-DRG (inpatient) or primary APC (outpatient).

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

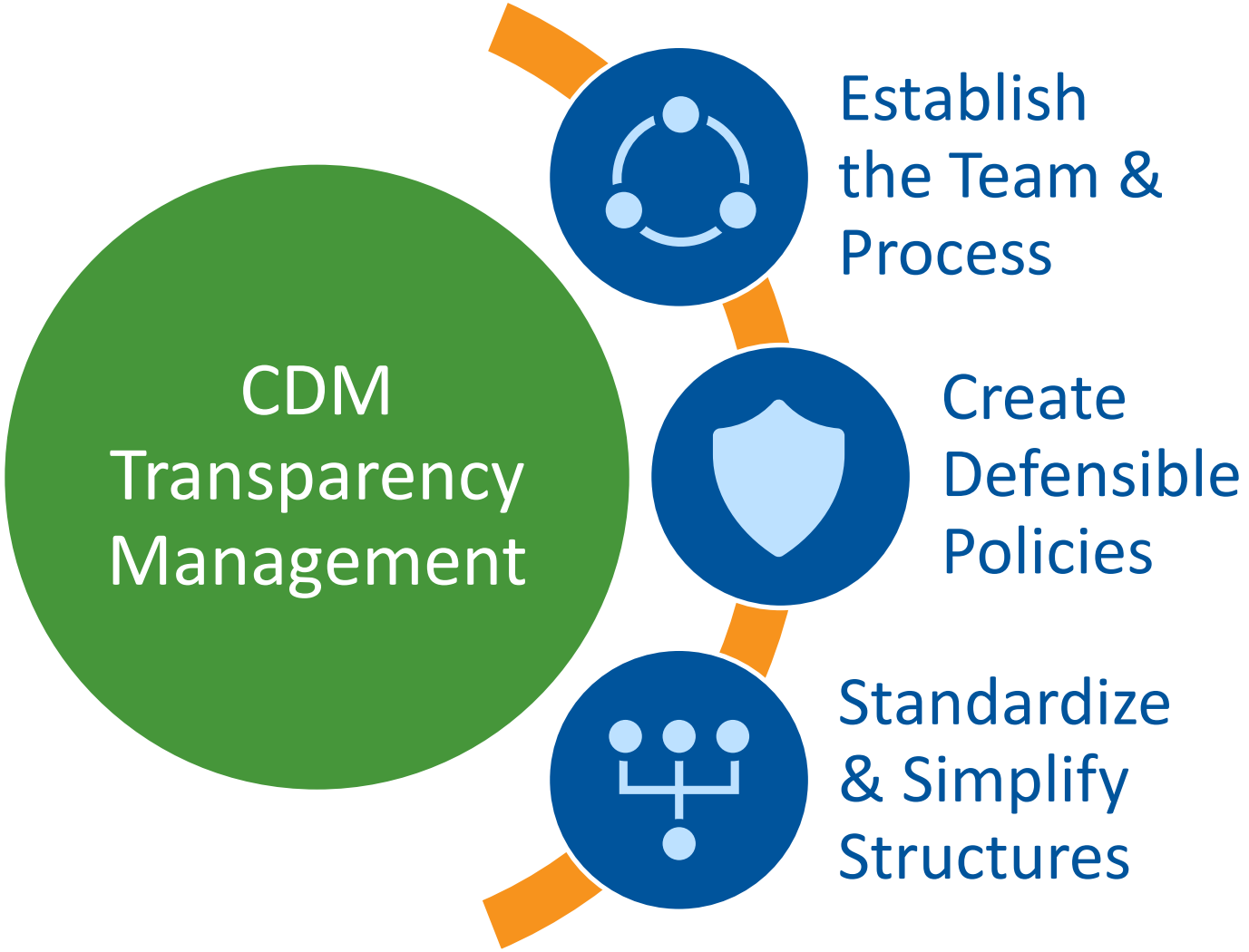
3) Run claims through inpatient and outpatient "groupers" to assign a MSDRG and primary APC to each claim – regardless of differing payment methodologies

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

Managing the Chargemaster with transparency

Managing the CDM with Transparency



Managing the CDM with Transparency

- Building a Cross Functional Team
  - Pricing Transparency Project Team
  - Price Transparency Steering Committee
- Make Pricing Review a requirement, not an option.
  - Annual price adjustments
    - Fiscal Year, Budgets
    - Limit midyear adjustments

Managing the CDM with Transparency

Create Defensible Policies

- Pricing Policies for Codes and Services
  - Focus on Compliance
  - Establish Guardrails
- Annual Market-Based Pricing & Defensibility Assessments

Managing the CDM with Transparency

Three areas of CDM Work that LEAN into Transparency

- Charge Standardization
  - Consistent Charge Methodology
    - Labor/Delivery
    - Supplies
    - Pharmacy
    - Operating Room Minutes

Managing the CDM with Transparency

Three areas of CDM Work that LEAN into Transparency

- Simplification of Charge Structures
  - Appropriate aggregation of charges
    - Pulse Oximetry
    - Anesthesia and OR minutes
    - Bedside Supplies

Managing the CDM with Transparency

Three areas of CDM Work that LEAN into Transparency

Standardize & Simplify Structures

- Fee Schedule Review
  - Strategic Fee Schedule Design
  - Consolidation of unnecessary Fee Schedules
  - Fee Structure alignment for commodity services.
    - Separate OP Fee Schedule for certain commodity services in competitive markets.
    - Criteria / Considerations

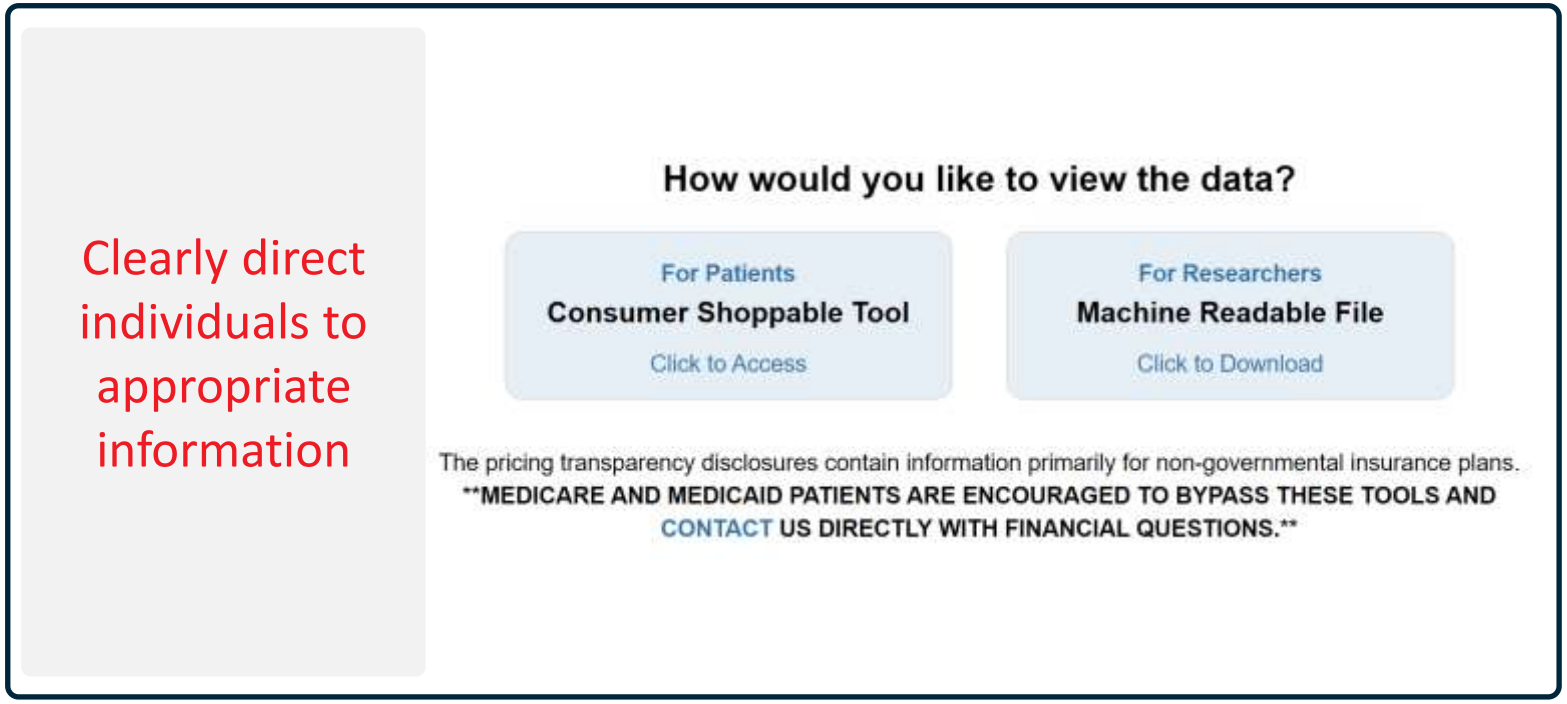
What are our next steps in transparency?

Next steps in transparency

EVALUATE YOUR COMPLIANCE POSITION:

1) **Are you fully satisfying all components of the transparency rule?**
2) **How accessible and helpful is the information?**

Clearly direct individuals to appropriate information



Source: Cleverley + Associates Hospital Price Disclosure solution

Next steps in transparency

EVALUATE YOUR COMPLIANCE POSITION:

1) Are you fully satisfying all components of the transparency rule?
2) How accessible and helpful is the information?

Here is your estimate for Emergency Dept Visit, CPT® 99283:

UNDERSTANDING YOUR VISIT:
The charge profile below details the primary procedure and other common additional services that might accompany your visit. Often your visit will only include your primary service. Other times, the primary service might be accompanied by supporting services. You can see the percentage of times patients typically utilize these additional services.

Main Service Description	Average Gross Charges	Patient Utilization %
Emergency dept visit	$932	100%

Supporting Service Description	Average Gross Charges	Patient Utilization %
General supporting services	$8	51%
Ther/proph/diag inj iv push	$352	14%
Complete cbc w/auto diff wbc	$111	13%
Ther/proph/diag inj sc/im	$118	13%
Comprehen metabolic panel	$174	11%

UNDERSTANDING YOUR PAYMENT:
Hospitals bill "gross charges" that are the same for all patients. The hospital will then work with payers and patients to discount these "gross charges" based on different types of coverage and eligibility. The table below will help you understand the **estimated payment** for your visit.

Average Gross Charge / Visit	$1,492
Average Negotiated Charge (Payment) / Visit	$1,399

Your Estimated Out-of-Pocket Cost: $1,399

Applied to Deductible	$1,399
Applied to Out-of-Pocket Max	$1,399

Educate patients and consider encounter (claim) level displays to provide a more complete picture of responsibility

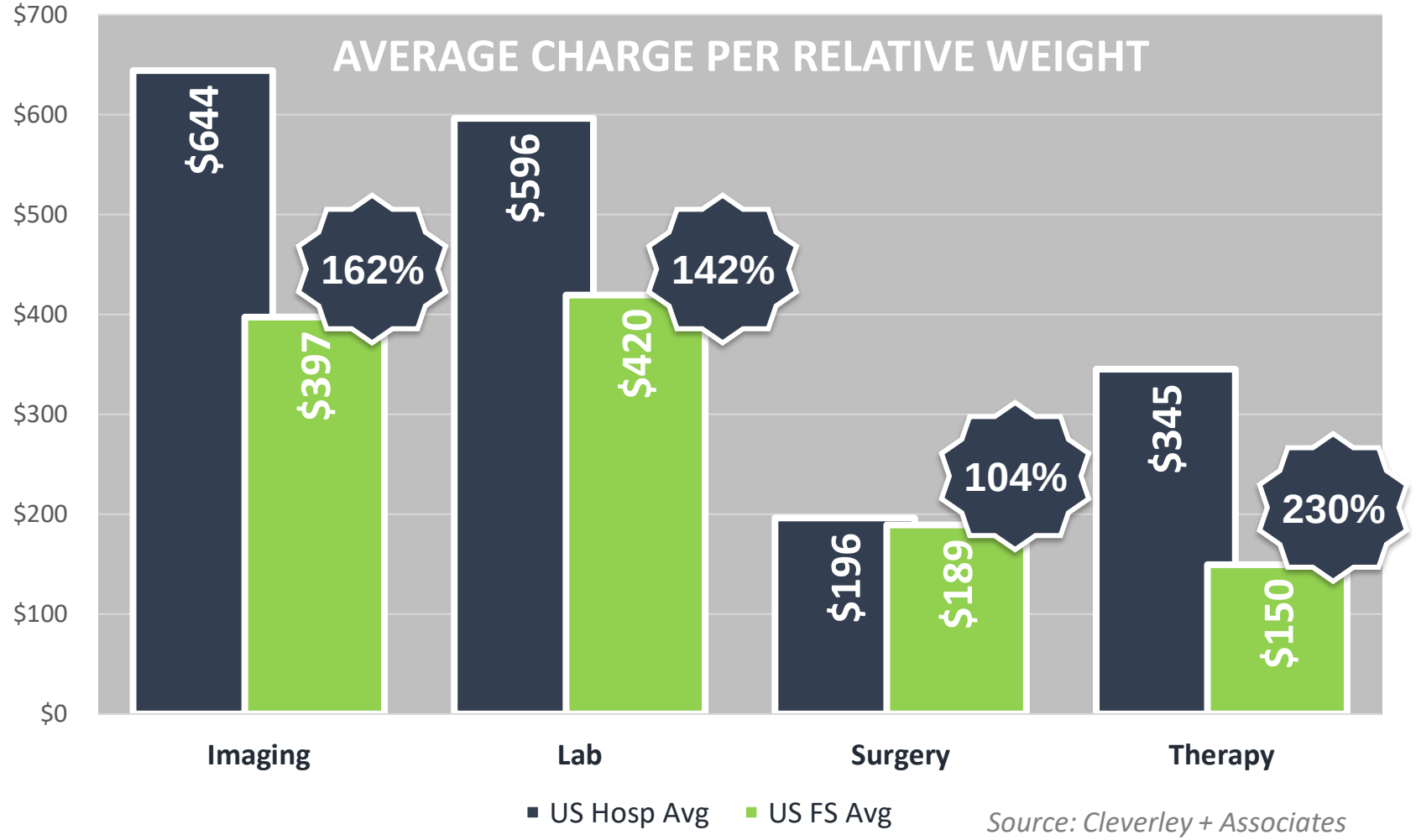
Source: Cleverley + Associates Hospital Price Disclosure solution

Next steps in transparency

CREATE MEANINGFUL COMPARISONS:

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)

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.

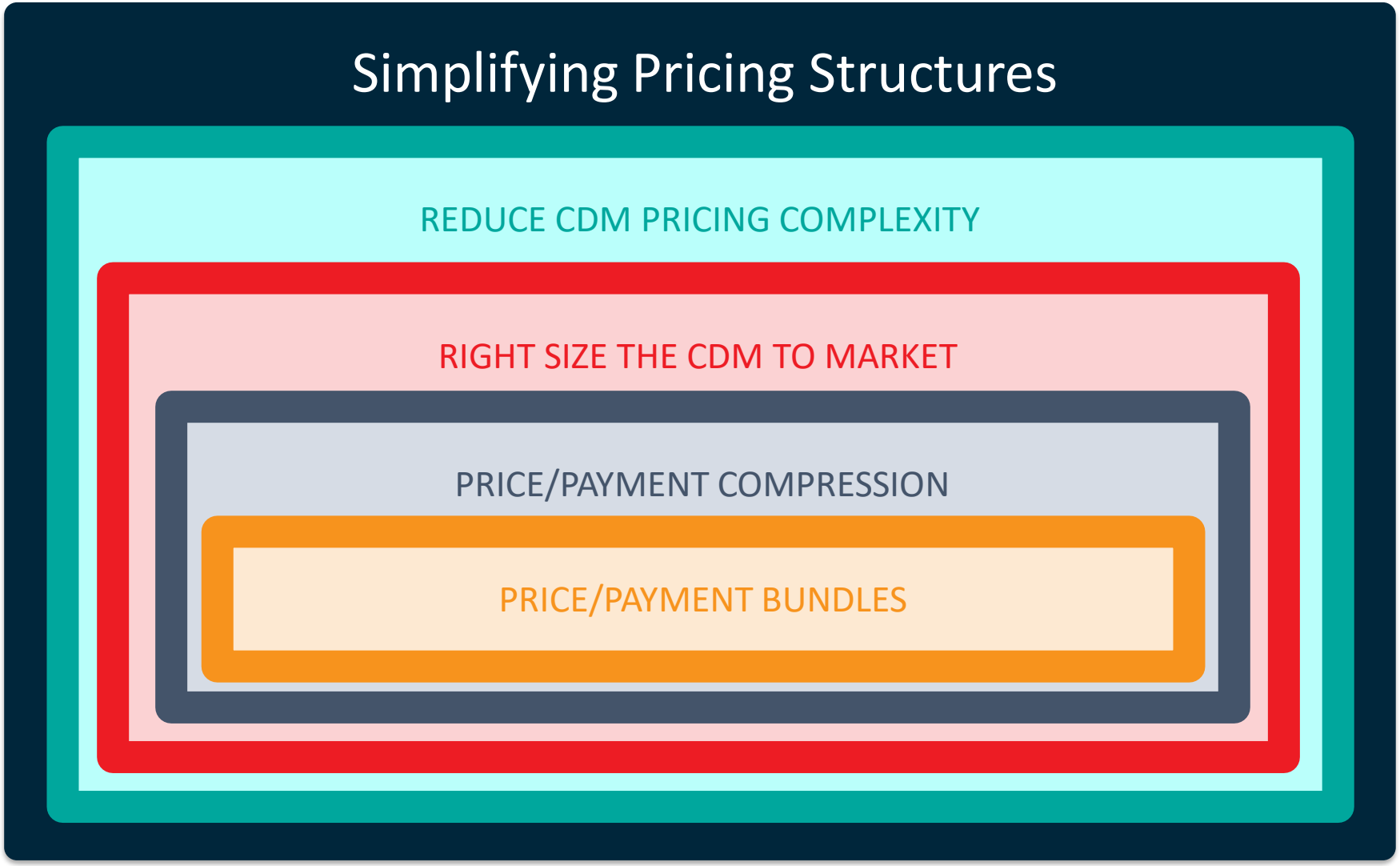


Source: Cleverley + Associates

Next steps in transparency

ADDRESS VARIATIONS:

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

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

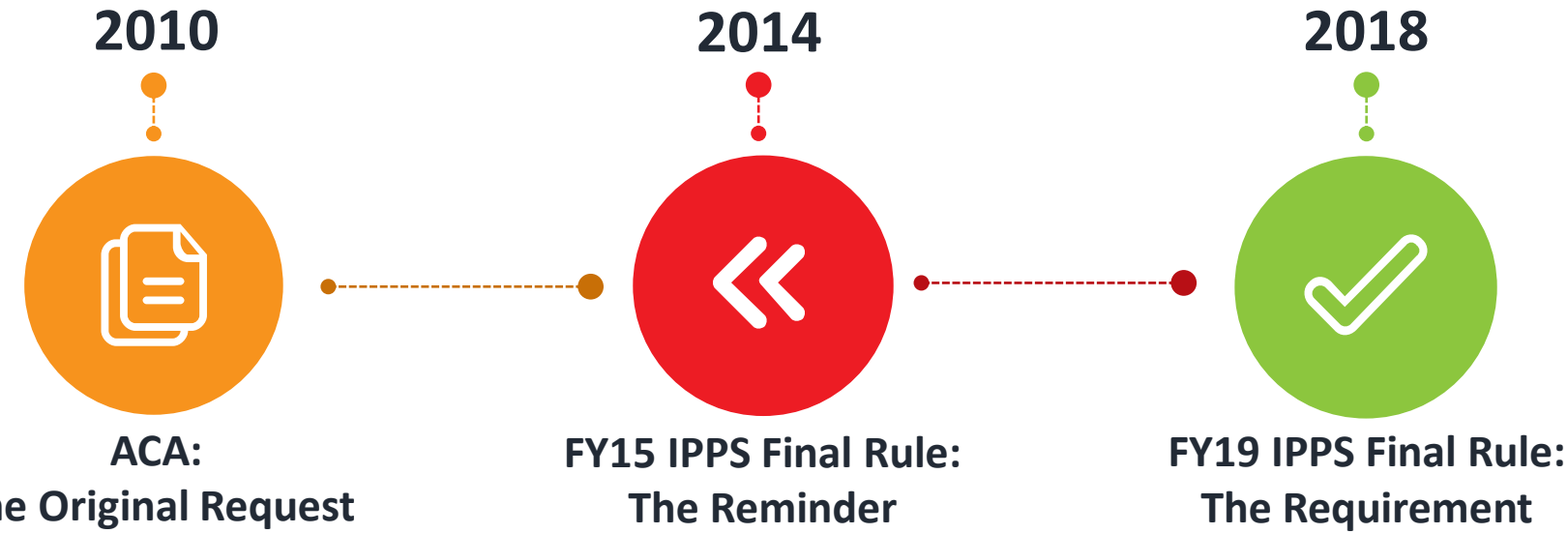
Following a few key actions will help keep efforts focused on meaningful variances and increase the likelihood of a successful outcome. Some variances did not develop overnight and will not be unwound that quickly either.

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.

Next steps in transparency

HELP PATIENTS

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



Speakers & 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.

Monica Hoch

About Monica

Monica Hoch is AVP of Revenue Integrity Chargemaster functions for Providence Health, where she leads mid cycle activities for 60+ hospitals. Monica currently leads teams engaged in Revenue Integrity, Chargemaster, Epic RI/CDM Deployment, Charge Capture/Specialty Coding for Emergency services and Cardiovascular CCL/IR areas.

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