Price Transparency

How to Comply and Flourish Under the New Rules

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Learning Objectives

- Outline current price transparency rules and proposed changes to rules, as outlined in the 2024 OPPS Proposed Rule
- Describe the impact of proposed regulatory changes on ability of 3rd party data aggregators to analyze and publicize provider pricing
- Apply the understanding of price transparency regulations and enforcement to evaluate a hospital's risk level

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Agenda

- Current rules and enforcement activity
- 2024 proposed rules
- Developing price transparency ecosystem and interaction with No Surprises Act
- Using price transparency to support your patient-centric strategy
- Internal audit considerations
- Q&A

Why are we here?

KFF Health News

KHN & POLITIFACT HEALTHCHECK

Rapper Fat Joe Says No One Is Making Sure Hospitals Post Their Prices

RESEARCH ARTICLE | HOSPITALS

HEALTH AFFAIRS > VOL. 42, NO. 8: PRESCRIPTION DRUGS, HOSPITALS & MORE

Hospital Prices For Commercial Plans Are Twice Those For Medicare Advantage Plans When Negotiated By The Same Insurer

Mark Katz Meiselbach, Yang Wang, Jianhui Xu, Ge Bai, and Gerard F. Anderson

AFFILIATIONS

PUBLISHED: AUGUST 2023 No Access https://doi.org/10.1377/hlthaff.2023.00039

OPINION

Readers respond: Enforce hospital price transparency

Published: Aug. 07, 2023, 7:00 a.m.

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Current rules and enforcement activity

CMS increasing enforcement and pushing for more consistent data

Pre-implementation of payer-specific files

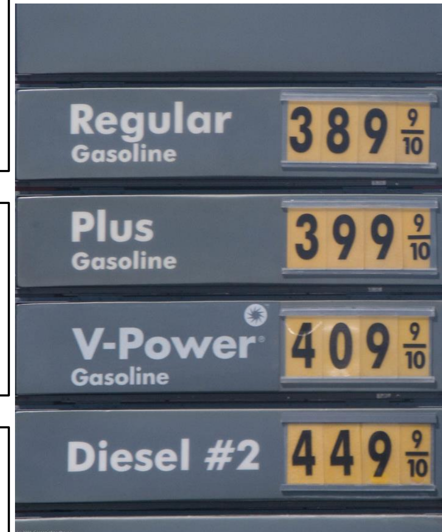
- **ACA passes, 2010:** establishing requirement for price transparency required U.S. hospitals to make public "a list of the hospital's standard charges for items and services provided by the hospital."
- **Chargemaster posting, 2018:** CMS announced it would require hospitals to post chargemasters in a machine-readable format
- **Executive Order, June 2019:** Pres Trump issued executive order on price transparency
- **Lawsuits, 2020-2021:** Definition of "charges" Administrative Procedures Act, first amendment (under principle that prices are a trade secret)

CMS assuming good faith effort; compliance increasing; data inconsistent

- **Payer negotiated rates, January 2021:** Hospitals required to post negotiated rates, with penalty of $300 per day for non-compliance (~$100k/year)
- **Increased penalties, Jan 2022:** Increased penalty for non-compliance, with scaling based on hospital size: between $300 and $5,500 per day (~$2M/year for large hospitals)
- **Penalties assessed, June 2022:** First Civil Monetary Penalty assessed
- **Payer requirements, July 2022:** Payer transparency file requirements begin (Transparency in Coverage)

Enforcement increasing; increased data consistency; standard formatting

- **Enforcement increases, April 2023:** CMS announced stepped up enforcement
- **Proposed updates, Jan 2024:** Proposed updates may take effect
- **End of grace period, March 2024:** Proposed end of grace period for adoption of the new CMS template and encoding additional data elements



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Current rules for all hospitals, including CAHs

Machine-Readable File (MRF)

- Data components: Description, Gross Charge, Payer-Specific Charge, De-identified Min & Max Charge, Discounted Cash Price
- File name: [EIN]_[Hospital Name]_[standardcharges].[json|xml|csv]

Consumer Friendly Format

- Patient friendly shoppable file (at least 300 services), or
- Patient Estimator Tool
  - At least 300 services
  - Estimates self pay cost

Posting Details

- Posted on website in a prominent manner and digitally searchable
- Free of charge
- Accessible without registering, establishing user account, or entering Personally Identifiable Information (PII)
- Updated annually

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Common issues, cited by CMS or 3rd party orgs

Completeness	Price estimator tool	Other
• Blank payer-specific values in MRF • Excluding cash prices for some procedures • Excluding major payers • Excluding some procedures known to be provided based on public Medicare data	• Not calculating patient liability • Not including all required procedures	• Mis-naming files • No date indicating most recent update or greater than 12 months since date listed • Lack of payer-specific information in MRF

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Under current rules, Machine-Readable Files and CMS communication pose challenges

Machine-Readable File format and payer-specific calculations

- No standard format for machine readable files
- Ambiguity about acceptable method to calculate payer-specific rates (claims or contract based)
- Not clear what the actual calculation basis is for allowed amount / payer-specific amount (e.g., percent of charges, per diem, DRG)

Machine-Readable File creation and posting

- No standard location for files on hospital websites
- No materiality threshold for inclusion of payer-specific rates
- Lack of consistent payer / plan naming conventions and crosswalks for payer-specific data

Communication

- Warning notices sent via US Mail to hospital CEO; may not be forwarded to appropriate person to respond
- In the case of health systems, CMS required authorization from hospital CEO to discuss case with system representative

Based on CMS evaluation of hospital websites, compliance has significantly increased

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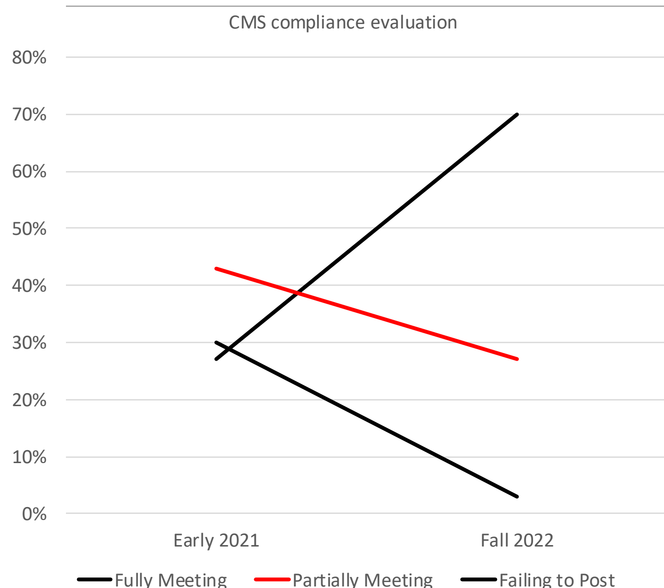

Based on a website assessment conducted by CMS in early 2021:

- **27%** of hospitals were **fully meeting** display criteria for the machine-readable file
- **43%** were **partially meeting** display criteria
- **30%** were **failing to post any** of the required information online

CMS assessed in the fall of 2022:

- Approximately **70%** of hospitals were **fully meeting** display criteria for the machine-readable file
- **27%** were **partially meeting** display criteria
- **3%** were **failing to post any** of the required information online

CMS has imposed Civil Monetary Penalties on thirteen hospitals through 9/6/2023

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Enforcement actions publicized by CMS, as of 9/6/2023

Date Action Taken	Hospital Name	CMP Amount	Effective Date
2022-06-07	Northside Hospital Atlanta	$883,180	2021-09-02
2022-06-07	Northside Hospital Cherokee	$214,320	2021-09-09
2023-04-19	Frisbie Memorial Hospital	$102,660	2022-10-24
2023-04-19	Kell West Regional Hospital - Under Review	$117,260	2022-07-08
2023-07-20	Falls Community Hospital & Clinic	$70,560	2023-01-06
2023-07-20	Fulton County Hospital	$63,900	2022-12-22
2023-07-24	Community First Medical Center	$847,740	2022-06-22
2023-08-22	Hospital General Castaner	$101,400	2022-09-19
2023-08-22	Samaritan Hospital - Albany Memorial Campus	$56,940	2023-06-06
2023-08-23	Betsy Johnson Hospital	$99,540	2023-06-06
2023-08-23	UF Health North	$979,000	2023-02-27
2023-09-05	Holy Cross Hospital	$325,710	2023-06-21
2023-09-05	Saint Elizabeths Hospital	$677,440	2023-01-17

CMP Notice letters are made public with detail of violations. For example, Northside Atlanta's letter states the following timeline:

3/24/21: CMS initially reviewed website

4/19/21: Initial warning notice

9/2/21: CMS reviewed their website again

9/30/21: Request for CAP

11/15/21: Northside responded by email, stating in part that potential patients were to "request specific price estimate quotes by either calling the Price Estimate Line…" or emailing

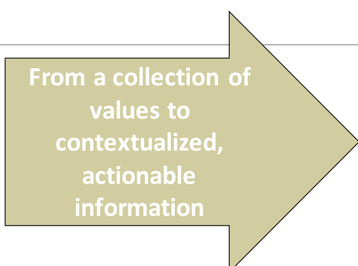
12/20/21: Request for revised CAP, due 1/4/22

1/11/22: CMS conducted a technical assistance call. Northside confirmed the previous violations had not been corrected and that the hospital had removed all previously posted pricing files.

1/24/22: Requested a revised CAP within 10 days

2024 Proposed Rules

The proposed rule would dramatically increase MRF data consistency and usability



Proposed MRF changes - Effective 1/1/2024, with two months enforcement discretion

- Standard format for MRFs
- Encode general data elements (hosp name, lic num, location name, address, file version, date of update)
- Hospitals certify that file is complete and accurate
- Validation tool that would be available to hospitals

Proposed MRF expanded fields

- Require that data must be at payer and plan name level
- Specify type of contracting method used
- Indicate if the "standard charge" should be interpreted as a dollar amount, percentage, or algorithm; if percentage or algorithm, specify calculation factors and expected payment
- Description of item or service that corresponds to standard charge, if item or service is provided with inpatient admission or outpatient department visit; and for drugs, the drug unit and type of measurement
- Other codes used for accounting and billing, such as modifiers
- Consumer-friendly expected allowed amount

CMS is proposing standard MRF templates, a complex transition for providers

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CMS would require hospitals to use one of three templates: Wide CSV, Tall CSV, and JSON.

Example of per diem with variable rate (Wide CSV Format)

Description	standard_charge | Payer_A | Plan_1	standard_charge | Payer_A | Plan_1 | contracting_method	additional_payer_notes | Payer A | Plan_1
Procedure X days 1-3	5000	per diem	Per diem cost for the first three days of hospitalization.
Procedure X days 4-7	6000	per diem	Per diem cost for days 4-7.
Procedure X days 8+	7000	per diem	Per diem cost for 8+ days.

Example of case rate with implant carve-out (Wide CSV Format)

Description	standard_charge | gross	standard_charge | Payer_A | Plan_1	standard_charge | Payer_A | Plan_1 | contracting_method	additional_payer_notes | Payer_A | Plan_1
Procedure X		5000	case rate	+ 50% of total implant cost
Procedure Y		5000	case rate	+ 60% of total implant cost
Implantable device 1	500			
Implantable device 2	750			

Because of ambiguity in current regulations, CMS has given **flexibility** in providers' display approach. Providers have generally taken one of three options for creating line items in these files:

1) By **chargemaster line item**
2) Using a **standard grouping**, such as MS-DRG and APC
3) Based on **payment terms** in each **contract**

With these proposed standard templates and inclusion of the expected allowed amount, CMS is looking to have providers switch to approach a new approach, most similar to option 3), which may be **complex and time consuming**.

Under proposed rule, CMS trying to improve communication and hold providers accountable

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Certification	CMS may require submission of certification by an authorized hospital official as to the accuracy and completeness of the data in the machine-readable file and submission of additional documentation as may be necessary to determine hospital compliance.
Acknowledgement of warning notices	Require hospitals to submit an acknowledgement of receipt of the warning notice in the form and manner and by the deadline specified in the notice of violation issued by CMS to the hospital.
Communication with health systems	In the event CMS takes an action to address hospital noncompliance and the hospital is determined by CMS to be part of a health system, CMS may notify health system leadership of the action and may work with health system leadership to address similar deficiencies for hospitals across the health system.
Publicize compliance information	CMS may publicize on the CMS website information related to: 1) CMS's assessment of a hospital's compliance; 2) Any compliance action taken against a hospital, status, and outcome of such compliance action; and 3) Notifications sent to health system leadership.

New enforcement under the proposed rule, began in April 2023

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	Previous	Updated
Website reviews	30-40 / month	>200 / month
Required CAP completion deadline	Within 45 days	Within 45 days
Required to be in full compliance after CAP request	Not stated	90 days
Consequence of failure to submit a CAP	None	Automatically impose CMP after 45 days
Approach with hospitals that have not "made any attempt to satisfy the requirements"	Warning notice issued	Immediately request that hospital submit a CAP

As of April 2023, 730 warning notices and 269 requests for CAPs had been issued

Timeline for hospitals who have not "made any attempt to satisfy the requirements"

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	Days since identified by CMS	
	Northside Atlanta Example	New Timeline
CMS determines posting is out of compliance	0	0
Initial Warning Notice	36	
Updated review of website	135	
Issue request for CAP	163	7[1]
CAP submission deadline	208	59
Second request for CAP	243	
Second CAP submission deadline	258	
Third request for CAP	279	
Impose CMP	299	97[2]

CMS plans to continue issuing an initial warning letter, with a 90-day window, for hospitals who have posted files.

CMS has stated that the average time to complete a case cycle under pre-April timeline was 195 to 220 days

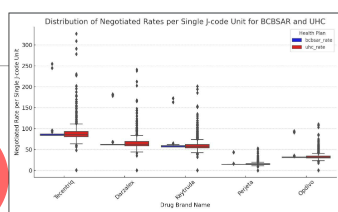
Notes:

1: estimate – not explicitly stated

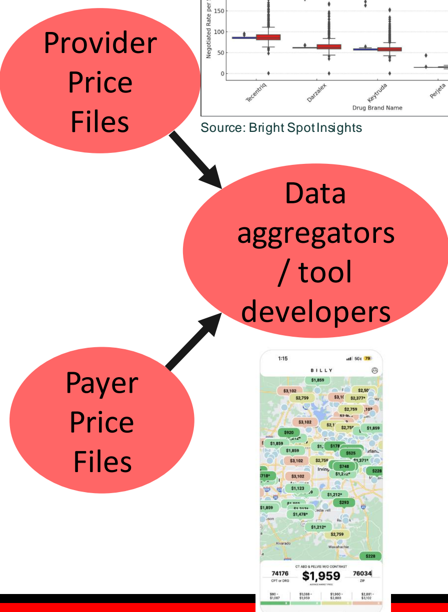
2: max of 90 days from issue of CAP request

Developing price transparency ecosystem and interaction with No Surprises Act

An ecosystem is beginning to form and it may have significant impact on providers



Source: Bright Spot Insights



Stakeholder	Actions
Employers	• Negotiate self insured rates with employers • Negotiate directly with employers
Payers	• Negotiate rates with providers • NSA / contracting strategies
Providers	• Understand rates vis a vis market • Incorporate into patient-centric strategy
Patients / Consumers	• Evaluate cost vs quality • health insurance decisions (co-insurance, deductible) • Plan upcoming care
Advocates / regulators / lawmakers	• Evaluate drivers of rate variation • Assess impact of provider consolidation • Advocate for rate controls to control healthcare cost increases

Possible outcomes

- Employer pressure to reduce self insured rates
- Commercial rates facing a possible "race to the bottom"
- Accelerate shift to outpatient / ASC and payment parity
- Patient pressure for more rational and simple rates
- Changing patient expectations about availability and firmness of price estimates
- Pressure for more linkage between price and quality / outcomes
- Advocate / regulator work toward narrowing gap between commercial and gov't payers

No Surprises Act and Price Transparency significantly change payer/provider dynamics

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No Surprises Act

- Establish IDR process to resolve out-of-network disputes between providers and payers
- Require good faith estimates for uninsured / self pay individuals
- Establish patient-provider dispute process for uninsured / self pay individuals
- Provide a way to appeal certain health plan decisions

Combined Impact

- Full pricing information disclosed, which allows payers to pressure providers for the most advantageous peer payer's rates
- Establishes a default price if no agreement, while still being litigated, may be beneficial to payers
- Removes patients from the middle of payer / provider disputes as there is not risk of balance billing
- The cost and friction of submitting a claim for IDR reduces the value for the initiating party, generally the provider
- Network adequacy requirements remain important, and may become more important in the future

Price Transparency

- Publish all payer rates
- Provide patients with rate information via either shoppable service list or patient estimator tool

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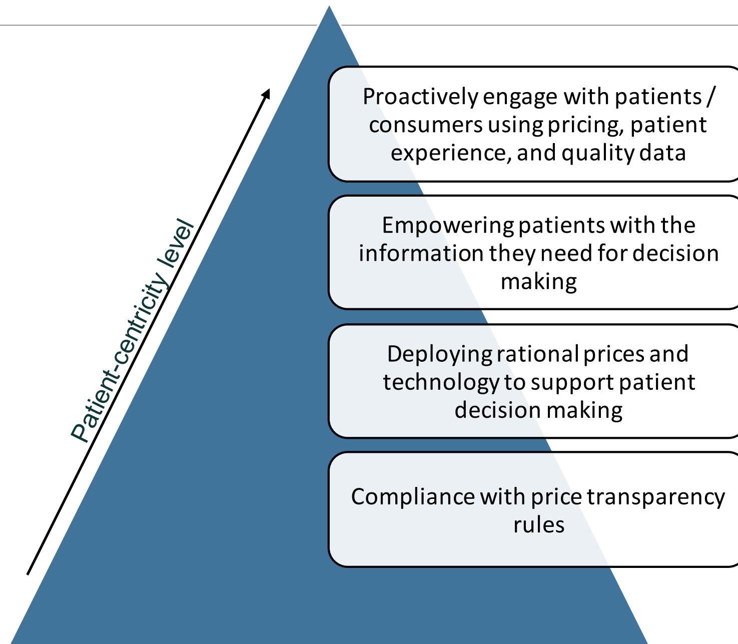
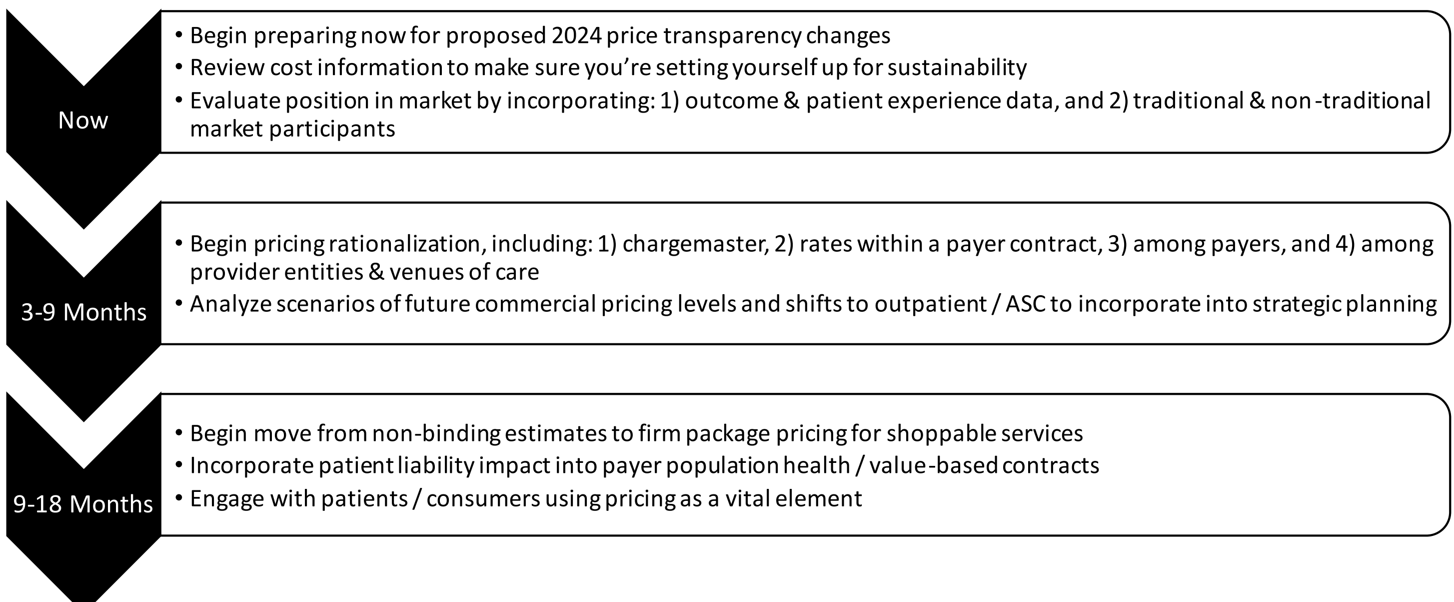
Using price transparency to support your patient-centric strategy

Pricing is a vital element as providers deploy patient-centric strategies

Many **traditional providers** are still **struggling with compliance**, while **non-traditional players** are making in-roads with **patient-centric strategies** that capture the most financially advantageous patient populations.



Providers should begin preparing now



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Internal Audit considerations

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Price transparency introduces new risks

Risk type	Nature of risk
Compliance	• Regulatory review of disclosures, resulting in warning letters and/or civil monetary penalties
Reputational	• CMS disclosure of warning letters or non-compliance • 3rd party notifications to general public, legislators, or regulators • Patient dis-satisfaction based on expectations set using transparency data • Relationship of reimbursement rates among payers and/or services is identified as being irrational
Strategic / Competition	• Other health systems using transparency data to improve their competitive position • Payers using transparency data in negotiation process to negatively impact rates • Non-traditional providers using price transparency data to more aggressively pursue most profitable business • Self funded employers using data to pressure payers or switch to payer with lower rates

Examples of Internal Audit driven activities

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- Define clear accountability for maintaining compliance and responding to regulators, 3rd party organizations, or the general public
- Maintain lines of communication to facilitate receipt of warning letters with team responsible for managing compliance
- Because the EHR is frequently being used to satisfy the patient friendly estimate requirements, involve the IT teams in planning and testing
- Monitor other providers in market and nationally to evaluate their approach to compliance and patient engagement
- Conduct periodic independent reviews of compliance
- Validate that reputational and strategic / competitive risks are taken into account

Resources

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