Ensuring Compliance with the Price Transparency Final Rule

September 15, 2020

Agenda

- Final Rule Requirements
- Implementation Considerations
- Legal Considerations
- Hospital Panel
- Q & A

Final Rule Requirements

Illinois Health and Hospital Association

Price Transparency

In healthcare, readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.

HFMA Price Transparency Task Force

Final Price Transparency Rule

"Today's transparency announcement may be a more significant change to American healthcare markets than any other single thing we've done, by shining light on the costs of our shadowy system and finally putting the American patient in control". HHS Secretary Alex Azar

- Printed in *Federal Register* Nov. 27

Hospital Final Rule – Price Transparency requirements for hospitals to make standard charges public

Health Plan Proposed rule – Transparency in coverage

Price Transparency Requirements

- All licensed hospitals (except federal)
- On the internet, updated at least annually with date of last update
- Two files:
  - Machine-readable file with all hospital items and services
  - Consumer friendly file with 300 “shoppable” services
    - ➢70 listed by CMS
    - ➢Others based on utilization or billing rate
- Easily accessible and free of access barriers
- Identify hospital location(s) associated with files
- Implementation date: January 1, 2021

File 1: Machine Readable File

- All hospital items and services
- Description of each item, service, and service package
- Standard charges
  - Gross charge
  - Payer-specific negotiated rate, identifying each payer by name
  - De-identified min/max negotiated rate
  - Discounted cash price

File 2: 300 “Shoppable” Services

- 70 services determined by CMS
- Remaining 230 based on hospital-specific utilization or billing rate
- Include all ancillary items/services with corresponding charges
- Consumer-friendly format
  - Plain language description of services
  - File should be searchable
- Include all standard charges **except** for gross charge
  - Gross charge **should** be posted if no discounted cash price
- Include billing code (CPT, HCPCS, etc.)
- Include location where service is provided
- **A web-based price estimator may fulfill this requirement**

Not Required

- Charges for individual items/services within a service package
- Medicare fee-for-service charges
- Medicaid charges

Expected Resource Requirement

CMS Estimate

- Year One: 150 hours, $4,700-$19,800
- Subsequent Years: 46 hours, $3,600

January 2020 IHA Member Survey

- Stand-alone hospital: 350 hours, $35,000 (median)
- System: 1,200 hours, $133,000 (median)

Transparency in Coverage Proposed Rule

- Goal: enable informed health care decisions by providing consumers with information on health care costs
- Group health plans and health insurers in individual/group markets would have to:
  - Provide cost-sharing information through an online tool and in paper form
  - Disclose negotiated rates for in-network providers and historical out-of-network allowed amounts
  - Could offer new plans and claim credit toward their MLR for “shared savings”
- Not finalized yet

FFY 2021 IPPS Final Rule

- Requirement for hospitals to report median, payer-specific negotiated charges for inpatient services by MS-DRG for MA plans on the Medicare cost report
- Data collection begins with Medicare cost reporting periods ending on or after Jan. 1, 2021
- These “market-based” charges will be used to create a new market-based MS-DRG relative weight methodology beginning FFY 2024

Implementation Considerations

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Chargemaster (CDM) Review Activities

- Critical review of all services listed in your CDM
- Inactivation of zero volume items
- Critical review of non-chargeable items that may flag further review or scrutiny
- Procedure code standardization (i.e. CPT/HCPCS codes)
- Fee schedule consolidation, as appropriate, maintaining revenue neutrality and payer price increases in contractual language
- Engagement of clinicians in validating CDM services whether review is done by an internal team (Revenue Integrity) or external vendor

Comprehensive Machine-Readable File: Sample Display of Gross Charges[1]

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes]

Description	CPT/HCPCS Code	NDC	OP/Default Gross Charge	IP/ER Gross Charge	ERx Charge Quantity
HB IV INFUS HYDRATION 31-60 MIN	96360		$1,000.13	$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		$251.13	$383.97	
HB IV INFUSION THERAPY 1ST HR	96365		$1,061.85	$1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				$2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				$2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				$2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				$2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			$3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			$1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			$6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	$251.13	$383.97	12 Each
PHENYLEPHRINE HCL 10 % OP DROP		17478020605	$926.40	$1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	$0.00	$0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		$185.00		
GENETIC COUNSEL 15 MINS	S0265		$94.00		
DIALYSIS TRAINING/COMPLETE	90989		$988.00		
ANESTH, PROCEDURE ON MOUTH	170		$87.00		

Considerations – 300 Shoppable Services

- 70 services determined by CMS
- For the remaining 230 consider the following:
  - Volume is key driver, but should not be the only metric (i.e. common labs and x-rays are voluminous)
  - Top service lines that are recognized at your facility on an "honor roll" or national recognition
  - Ambulatory surgery (packages for high volume procedures such as orthopedic joint replacements, GI procedures)
  - Focus on consumer inquiries of what is commonly requested in financial clearance areas
- Include "plain language" for the services to allow consumers to identify the services easily
- Link the accompanying associated charges to the primary procedure

Sample Display of Shoppable Services

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes or disclaimers]

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
Colonoscopy	Primary Diagnostic Procedure	45378	$750
	Anesthesia (Medication Only)	[Code(s)]	$122
	Physician Services	Not provided by hospital (may be billed separately)	
	Pathology/Interpretation of Results	Not provided by hospital (may be billed separately)	
	Facility Fee	[Code(s)]	$500
Office Visit	New Patient Outpatient Visit, 30 Min	99203	$54
Vaginal Delivery	Primary Procedure	59400	[$]
	Hospital Services	[Code(s)]	[$]
	Physician Services	Not provided by hospital (may be billed separately)	
	General Anesthesia	Not provided by hospital (may be billed separately)	
	Pain Control	Not provided by hospital (may be billed separately)	
	Two Day Hospital Stay	[Code(s)]	[$]
	Monitoring After Delivery	[Code(s)]	[$]

Display and Define the Price List

- Display the information clearly and prominently on a public website
- Price list is per facility: hospital systems that have individual hospitals with different fee schedules will need to publish distinct price lists (machine readable files AND shoppable services) for each location
- Location should be clearly marked on each price file allowing the consumer to easily find location-specific information
- Update the list annually with the date indicated

Considerations - Comparability

- Ambiguity does exist in the final rule with how to show "comparability" in the data presented
  - Facilities will need to make internal decisions of how data will be presented and document their methodology to show compliance
- Consider grouping payers by specific payment methodology. **If being done internally then it may be a multiple tab excel file.**
- Explore solutions to analyze actual claim data with outside tools
- IHA, along with 36 other states consider "average payment" as the data element when presenting comparability files

Considerations – Comparability, *continued…*

- Use a consistent data set (most recent fiscal year)
- Machine Readable File
  - Inclusive of any code used by the hospital for purposes of billing: CPT, HCPCS, DRG, NDC, or other common payer identifier

- Determine what you will do with “one-time” contracts that may present outliers in your data set

Document and Define Information Posted

- Document the data sources utilized for your listings, and develop a policy that can be provided in the event of an audit
- Develop patient education materials to supplement your listing with the following goals:
  - Defines what is in your CDM list
  - Explains why charges are not always the same for each packaged service (i.e. variability exists in time and resource consumption)
  - What is not included in your listing (i.e. professional fees for unemployed physicians)
  - Explains that the gross charge is not the same as out-of-pocket costs
  - Disclaimer on cost estimates and uses of average charges for comparability

Legal Considerations

Illinois Health and Hospital Association

Price Transparency Final Rule Litigation

- **11/27/19 -** HHS's CMS publishes Final Rule.
- **12/04/19 -** AHA (with others) sue HHS in the U.S. District Court for the District of Columbia (D.C.).
- **02/28/20 –** IHA, along with 36 other State Hospital Associations, file an Amicus brief in support of AHA, et al.'s motion for a summary judgment**.**
- **06/23/20 -** U.S. District Court for D.C. denied AHA, et al.'s motion for summary judgment and granted HHS' motion for summary judgment – dismissing the suit.

Price Transparency Final Rule Litigation, *continued…*

- **06/29/20** - AHA urges CMS in a letter to delay implementation. (IHA and 39 other state/metro hospital associations separately sent an identical request).
- **09/03/20** - CMS publishes the FFY 2021 IPPS Final Rule which includes price transparency requirements.
- **10/15/20 -** Oral argument in AHA, et al.'s appeal to the US Court of Appeals for the D.C. Circuit.
- **01/01/21 -** Final Rule Effective Date.

Non-Compliance

Monitoring

- Evaluation of complaints by individuals and entities
- Audit of hospitals' websites

General Sequence

- Written warning notice including specific violation(s)
- Request a Corrective Action Plan ("CAP") from the hospital if noncompliance constitutes a material violation of one or more requirements
- Impose a Civil Monetary Penalty ("CMP") on the hospital and publicize the penalty on a CMS website.

Non-Compliance, *continued…*

CMPs

A CMP for each violation up to a maximum of $300.00 per day (updated annually with a cost-of-living adjustment multiplier according to the rule.) - $109,500 per year

- CMS – "…we believe it is important to consistently apply the…enforcement provisions…regardless of factors such as hospital size, revenue, or location." 84 F.R. 65524 at 65582, 65588
- CMS – "We appreciate the commenters' concerns that some hospitals [may forgo compliance and just pay CMPs]…we intend to monitor for such occurrences, and may revisit the need to adjust the amount of the CMP in future rulemaking." 84 F.R. 65524 at 65589

Legal Considerations

Disclosure of Payer-Specific Negotiated Charges

CMS – “Even if a contract between a hospital and a payer contained a provision prohibiting the public disclosure of its terms, it is our understanding that such contracts typically include exceptions where a particular disclosure is required by Federal law.” 84 F.R. 65524 at 65544

Legal Considerations, *continued…*

"Items and Services" include services of employed physicians and non-physician practitioners.

CMS – "Given such variation and complexity, we believe it is important to preserve flexibility for hospitals to identify employed physicians or non-physician practitioners under their organizational structure, and we decline at this time to codify a definition of 'employment.'" 84 F.R. 65524 at 65535

Hospital Panel

Kenny Koerner, Director of Revenue Cycle, CGH Medical Center
Nikki Stackhouse, Assistant Vice President, Revenue Cycle, NorthShore University Health System
Miguel Vigo IV, Administrative Director, Revenue Cycle, Silver Cross Hospital

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Q & A

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