IHA Price Transparency Webinar Q & A
September 15, 2020

1. Posting Medicare Advantage and Medicaid MCO rates
   If Medicaid MCO's pay Medicaid rates do you have to include?

   Do we have to list MCO rates for Medicare and Medicaid plans if they do not differ from the CMS or state fee schedule?

   As a Critical Access Hospital, we did not negotiate rates with Medicare HMO's and Medicaid HMO's - these rates are specified by the governments to be the same as Medicare and Medicaid rates. So they would NOT be included, correct?

   Answer: The final rule requires posting of all payer-specific negotiated charges that hospitals have negotiated with third party payers including charges negotiated by third party payer managed care plans such as Medicare Advantage plans, Medicaid MCOs, and other Medicaid managed care plans. Medicare Advantage and Medicaid MCOs pay a hospital based on a negotiated contract with the hospital even if the result of the negotiation was a default to the Medicare or Medicaid FFS rate. Therefore, Medicaid or Medicare FFS rates should be included in the file.

2. Employed Physicians
   One consultant said during a webinar that if you have employed physicians in a hospital based rural health clinic, then the posted charges have to include those physician clinic charges as well, even if those are in a different system and charge item master. Is that correct from your interpretation of the regulations?

   We were under the impression that pulling in our physicians was optional, even when employed. Does this group feel strongly that we do need to include the providers in all parts of the pricing transparency (ie.300 shoppable and machine readable)?

   Answer: The final rule requires posting of all items and services for which the hospital has a standard charge including, among other examples provided in the final rule, the services of employed physicians and non-physician practitioners. Therefore, if a hospital's standard charges are inclusive of employed physicians or non-physician practitioners, those rates would need to be included in the files. CMS declined to define "employment" in the final rule to preserve flexibility for hospitals to identify employed physicians or non-physician practitioners under their own unique organizational structure. A hospital should consider documenting their method of identifying employed physicians and non-physician practitioners and apply it consistently.

3. Are some using only top 5-10 payers?

   Answer: The final rule requires posting of all payer-specific negotiated charges that the hospital has negotiated with third party payers including charges negotiated by third

party payer managed care plans such as Medicare Advantage plans, Medicaid MCOs, and other Medicaid managed care plans.

4. Do you have an example of how we would portray inpatient charges for payors with a per diem reimbursement on File 1?

   Answer: In the absence of exact guidance on how to operationalize this requirement, hospitals might consider utilizing an average payment with a percent allocation at the line item level, to display the various methods of reimbursement as you cannot tie back a per diem rate to individual chargemaster lines. Consider "grouping" those payers that pay using a "per diem" methodology on the file output to address the comparability requirement.

5. How are CPT codes that charged differently depending on time (ex. therapy eval) to be handled when there are different prices associated with a single code based on time spent? These are not unit based.

   Answer: As we understand the question, a hospital could standardize CPT code prices at the unique CPT code line based on the AMA description of the code intent. If the code includes a time-increment, then a hospital could consider standardization among the defined CPT code. If the code does not include a time-increment, then a hospital could standardization should be based off of code content.

6. In the previous rule hospitals not paid on IPPS (e.g., children's) did not have to post DRG's. Did that change for CY21?

   Answer: If you do not bill by DRG, and none of the plans you negotiate utilize DRGs, then it would seem you do not need to post by DRG. However, if you do negotiate with certain payers using DRGs, then you should post your negotiated charges by DRG.

7. How soon after January 1 might CMS begin to audit?

   Answer: There is no stated timeframe in the final rule for CMS to conduct an audit. The final rule only states that CMS will investigate based on complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance and auditing hospitals' websites.

8. Does the state of Illinois have any issues/concerns about hospitals publicly posting contracted rates?

   Answer: Hospitals do not have to post Medicaid FFS rates, only payer-specific negotiated charges that they have negotiated with third party payers including Medicaid MCOs and other Medicaid managed care plans. At this time, we are not aware of any

issues/concerns expressed by Illinois Department of Healthcare and Family Services on the disclosure of Medicaid MCO rates.

9. Medicaid & MCO rates are in 3M's system. We do not calculate these on our own. Due to this will 3M publish their calculation?

   Has anyone heard if 3M will provide details on APG grouping methodology to show reimbursement rates for the payers who reimburse via APG?

   Answer: Hospitals, as defined under the final rule, not their contractors are responsible to make public a machine-readable file of standard charges for all items and services and a consumer-friendly list of standard charges for 300 shoppable services. Hospitals that have the 3M pricer/grouper should work with 3M or the third party payer directly for access to the applicable rates and also any contractual information that differs from the baseline HFS fee schedule. For hospitals who do not have access to a 3M pricer/grouper, the method currently used to calculate contractual allowance could be used.