Price Transparency: The Provider Perspective

Shawn Stack, HFMA and Erin Weber, CAQH CORE

July 13, 2023

Webinar Logistics

- Accessing webinar materials:
  - Download the presentation slides from the “Handouts” section of the GoToWebinar menu.
  - An e-mail will be sent to all attendees and registrants in the next 1-2 business days with information on how to access slides and today’s recording.
- Have a question?
  - Submit your question **at any time** using the Questions panel on your GoToWebinar menu.

Agenda

- CAQH CORE Price Transparency Overview
- HFMA Price Transparency Overview
  - Hospitals
  - CMS Provider Transparency Monitoring
  - Health Plans
  - Price Transparency in the News
  - Patient Advocacy
- Questions

Today’s Speaker

Shawn Stack
Director, Perspectives & Analysis
Healthcare Financial Management Association (HFMA)

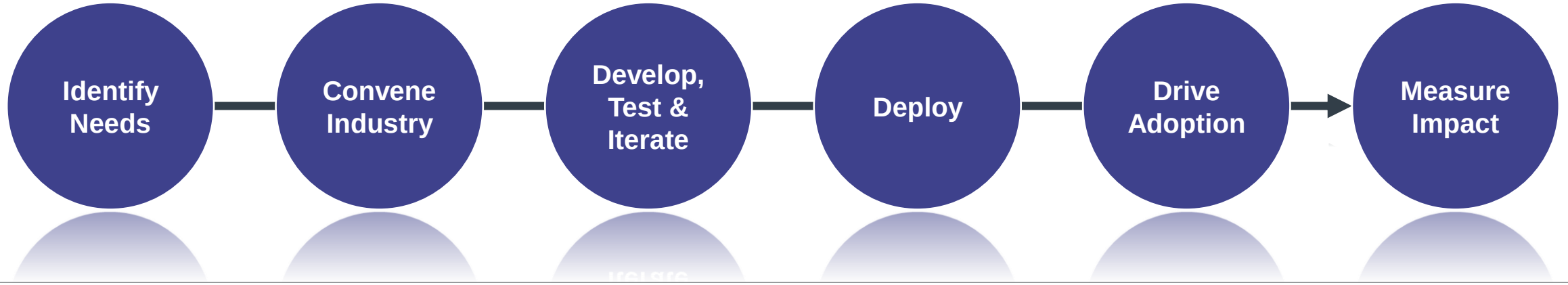
CAQH CORE Mission & Vision

Mission

Drive the creation and adoption of healthcare operating rules that **support standards, accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

Vision

An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.



CORE Engagement on GFE and AEOB

CORE engages the healthcare industry in developing consistent business processes for patients, providers, and health plans to **deliver administrative efficiency and value to the industry**.

- Convened CORE Advanced EOB Advisory Group in August 2021.
- Published Guidance Document in November 2021: Establishing the Building Blocks for Price Transparency: Industry Guidance on Provider to Payer Approaches for Good Faith Estimate Exchanges.
  - Recommendations for industry implementation of **connectivity protocols**, **messaging standards**, and **related data content** to support provider to payer exchanges of Good Faith Estimates.
- CORE continues to provide industry education on the NSA requirements via a Price Transparency Webinar Series including:
  - 7/13/23: The Provider Perspective (Link to be available after today's presentation)
  - 10/5/22: Industry Perspectives on GFE Requirements
  - 6/23/22: Regulatory Landscape & Industry Progress
  - 11/17/21: Recommendations from the CAQH CORE AEOB Advisory Group

HFMA

PRICE TRANSPARENCY:

The Provider Perspective

July 13, 2023

Shawn Stack, Perspectives & Analysis, HFMA

hfma™

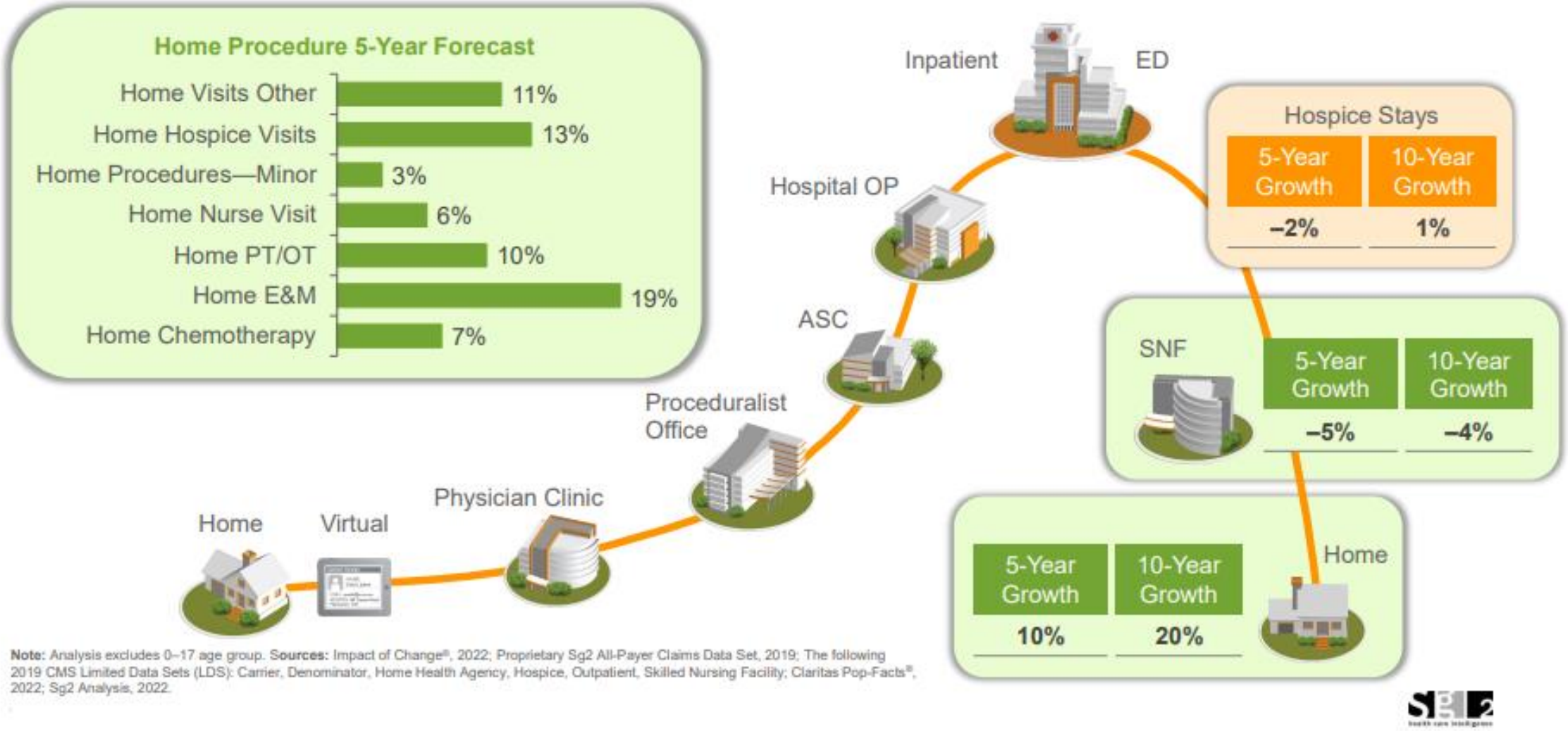
What's Top of Mind for Health Executives?

- Double-digit pharmacy trends driven by specialty drugs (ex. GLP-1, new cell & gene therapies)
- Behavioral Health – responding to the behavioral health emergency impacting our youth, families and communities. Access, outcomes and reduced stigma across generations.
- Medicaid redetermination – communication to impacted individuals across the country. How do we these projected 15 million people covered?
- Workforce: burnout, return to office strategies, engagement, staying in front of the rapid pace of innovation
- Health Equity – the continued focus on social determinants of health and DE&I performance measures
- Transparency – Federal and state price transparency regulations continue to mount

Length of Stay

- Co-Morbidities
- Delayed Discharges
- Post Care Availability
- Acuity and Intensity
- Capacity Constraints
- Hospital at Home

Shift of Medical Volumes to Home Gains Speed



Note: Analysis excludes 0–17 age group. **Sources:** Impact of Change®, 2022; Proprietary Sg2 All-Payer Claims Data Set, 2019; The following 2019 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2022; Sg2 Analysis, 2022.

Looking to the Future

In 2030, U.S. health systems will be larger, with a greater non-acute focus, more centralized decision-making and increased exposure to value-based care

Priorities for 2030 health system supply chain

1 Predictive and prescriptive supply chain analytics leveraging clinical data

2 Talent to support forward-looking supply chain needs

3 Deeper strategic partnerships with suppliers

SOURCE: https://www.lek.com/sites/default/files/PDFs/smi-lek-healthcare-supply-chain-2030.pdf

Healthcare Price Transparency

- Fed Regs & Enforcement
- State Regs & Enforcement
- The Press Impact
- Patient Advocacy Groups


HOSPITAL

Hospital – Federal Rule Facts: Jan. 1, 2021

Machine-Readable Files

- Publish to their website in an easy-to-find location
- Free to access
- Each individual hospital MUST have its own MRF
- MRF must be updated “at least” annually
- MRF’s must report five types of standard charges
  - Gross Charges: individual items/services reflected in the chargemaster
  - Discounted Cash Price: items/services furnished to a cash-paying patient
  - Payer-Specific Negotiated Charge: the charge negotiated with a third-party payer for an item or service
  - De-Identified Min/Max Negotiated Charge: the lowest/highest charge a hospital has negotiated with all third-party payers for an item or service

Hospital – Federal Rule Facts: Jan. 1, 2021

Machine-Readable Files Continued…

- The MRF must also include:
  - Charge descriptions
  - Codes used for billing: DRG, CPT, HCPC, NDC & other common identifiers
  - Revenue Codes
  - Supplies, implantable devices, and pharmaceuticals
  - Service packages (per diems, DRG case rates, CPT per unit cases)
  - If the hospital directly employees professionals, the professional fees must be disclosed
- Exclusions:
  - Medicaid, Medicare, Tricare – they are already publicly available
  - Federally-owned hospitals – VA Hospitals, Indian Health Program Hospitals, U.S. Department of Defense Hospitals
  - Freestanding Ambulatory Centers (ASCs, Imaging Centers, Labs, etc.)

Hospital – Federal Rule Facts: Jan. 1, 2021

Shoppable Services

- Publish all core & ancillary charges associated with 300 shoppable services.
  - 70 CMS-specified shoppable services
  - At min, 230 of the hospital's most common shoppable services
- Shoppable services: any service that can be planned, allowing consumers to shop around for the service.
- Charges must be posting in a patient-friendly manner.
- Hospitals are exempt from the publishing of shoppable services if they already employ a patient estimator tool that
  - Patients can access out-of-pocket cost estimates
  - Estimates are available for all 300 shoppable services
  - The estimation tool is prominently displayed on the hospital's websi with no barriers to access (i.e., logins or requiring personal info)

Hospital – Federal Rule Facts: Jan. 1, 2021

File Compliance Enforcement Measures

- Issues a Warning Notice
- Requests a Corrective Action Plan
- Publicize the Penalty On CMS Website
- Impose Civil Monetary Penalty
  - The penalty for a full year of noncompliance ranges from $109,500 to $2,007,500 pursuant to a sliding scale based on hospital bed count.

NEWS

Georgia hospitals fined over $1 million for violating price transparency law – June 2022

The CMS fines were issued the same day a JAMA study found hospital systems across the country were largely ignoring the law.

"Penalizing only two hospitals almost 18 months in is not nearly enough enforcement"
– Cynthia Fisher

Common Mistakes with Hospital Compliance

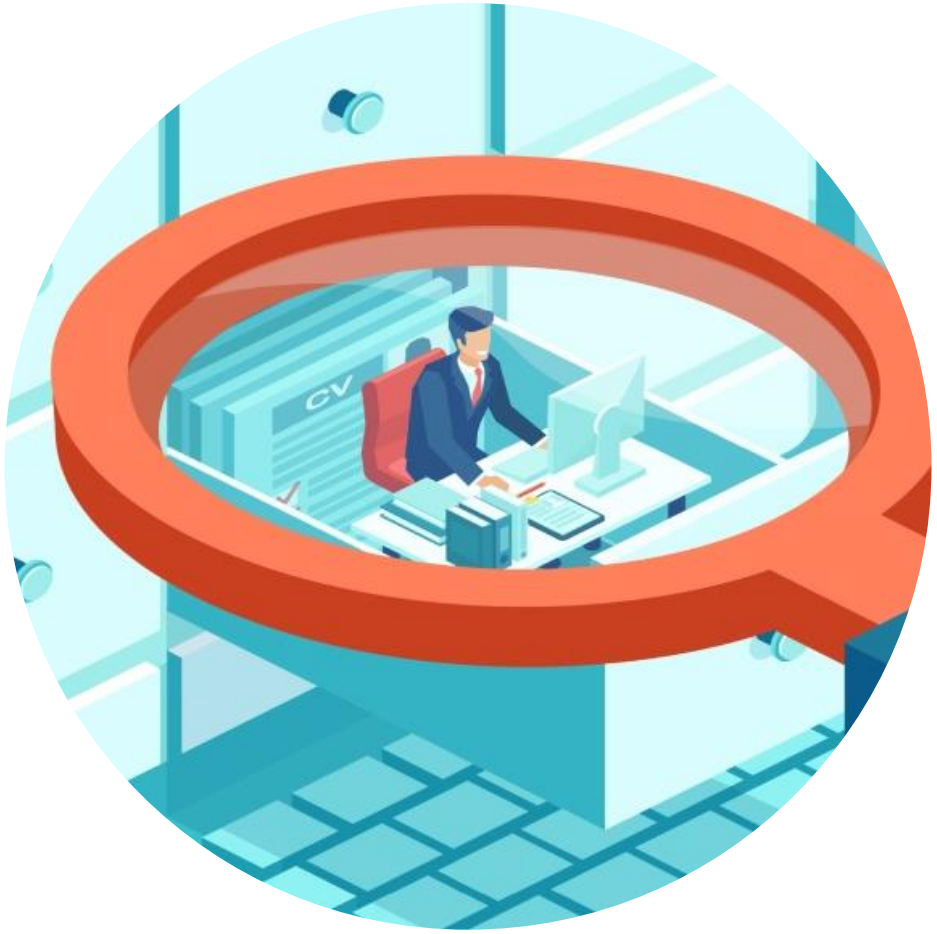
MRF Issues

- MRF not displayed in an easy to find location of the hospital website
- Broken links to MRF files
- Limited or no inclusion of service packages
  (ex. DRG, case rates, per diem)
- No differentiation of inpatient vs. outpatient standard charges.
- No clear indication of the date last updated
- Exclusion of negotiated Medicare and Medicaid managed care rates
- Average contracted rates being published instead of contracted base rates
- Vendors not following the CMS rules and regulations

Estimator Tool Issues

- Estimator Tool not displayed in an easy to
  find location on the hospital website
- Requiring consumer to enter information in order to access the estimator tool.
- Exclusion of DRGs included in CMS-specified list of 70 shoppable services
- Tool does not provide single dollar amount tailored to individual seeking estimate.
- Disclaimers are not appropriately displayed:
  - Clarify your charges only include hospital
    services and not professional fees from non-hospital providers
  - Clarify the list price is not necessarily what the insurer or patient will pay.
  - Clarify single item doesn’t represent an entire medical service.

CMS Transparency Monitoring



CMS methods of monitoring the charge posting requirements may include, but are not limited to:

- CMS evaluation of complaints made by individuals or entities to CMS
- CMS audit of hospitals' websites

CMS Provider Transparency Enforcement

If a hospital is found to be noncompliant, CMS may take the following steps:

1. Provide a written warning notice to the hospital of the specific violation
2. Request a corrective action plan (CAP) from the hospital if its noncompliance constitutes a material violation of one or more requirements
3. Issue a civil monetary penalty (CMP) on the hospital of noncompliance
4. Publicize the penalty on a CMS website

CMS Provider Transparency Monitoring & Enforcement

April 26, 2023 Update

CMS updates enforcement process with the following changes:

1. Requiring CAP completion deadlines: Submit a CAP within 45 days of CAP Request & require hospitals to be fully compliant within 90 days of that CAP Request.
2. Impose CMPS earlier and automatically: impose a CMP on hospitals who fail to submit a CAP within 45-days or those who fail to become compliant within the 90-day mark of the CAP request.
3. Streamlining the compliance process: for hospitals who have made no attempt to satisfy transparency requirements, CMS will no longer issue a warning notice and will move to issuing a CAP notice.

What's Next

- More Regulations?
- Higher Civil Monetary Penalties?
- More Mandatory Requirements?
- More Local Enforcement?
- Stripping of Hospital Tax-Exempt Status?
- More Public Shaming?


SURPRISES

No Surprises Act

CMS Issuing Non-Compliance Letters

- Hospital-based (not employed) anesthesiologist sent bill to patient for balance of claim for emergency service
- Hospital received notice and requested to provide information
- Request came from CMS Center for Consumer Information & Insurance Oversight

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

June 22, 2022

[redacted]
Chief Financial Officer
[redacted]

[redacted]
Compliance Officer
[redacted]

Re: Request for Additional Information to Resolve Complaint Case ID: #000[redacted]

Dear Mr. [redacted] and Ms. [redacted]

In the conference call between [redacted] and the Centers for Medicare & Medicaid Services (CMS) on [redacted] we discussed Case #000[redacted] a complaint alleging a violation of the requirements of the PHS Act, as amended by the No Surprises Act, involving [redacted] A more complete description of the complaint details can be found in Exhibit A.

Within the timelines specified below, please provide CMS with the information requested to continue the review of the complaint. You may also include any additional information you would like CMS to consider as part of the review of this case. A detailed list of information and documents that CMS requests can be found in Exhibit B. Please include the case ID in the email subject line of your response, and share all requested information through secure email to NSAproviderinvestigations@cms.hhs.gov and Ryisha.Conway@cms.hhs.gov, as mutually agreed upon by CMS and executives of [redacted] and [redacted] during the call.

Thank you for your cooperation.

Sincerely,

Ryisha Conway
Health Insurance Specialist
Compliance and Enforcement Division
Oversight Group
Center for Consumer Information and Insurance Oversight

Cc: Miriam Felder, Esq. (CMS)
John Iannacone (CMS Provider Enforcement Contractor)
Joanna Smith (CMS Provider Enforcement Contractor)

No Surprises Act

CMS Center for Consumer Information & Insurance Oversight Details

- Within 10 days of the date of this letter:

➢ Provide documentation that demonstrates the workflows HOSPITAL had in place to catch and prevent violations of the No Surprise Act balance billing prohibitions at 45 CFR §149.410 prior to receipt of the CMS notice of a Possible Violation of the Public Health Services (PHS) Act.

➢ Provide documentation that demonstrates the corrective actions HOSPITAL has taken in response to this complaint, including a timeline and nature of improvements to current business practices to eliminate future complaints.

➢ Provide documentation that demonstrates the extent of compliance to date with the requirements of 45 CFR §149.410, Balance billing in cases of emergency services; specifically, the results of an impact analysis to determine how many individuals received emergency services from HOSPITAL since 1/1/2022 to the present in this manner.


health
insurance.

Health Plan – Final Rule Facts: July 1, 2022

Transparency in Coverage (TiC)

- Plans and Insurers required to publish two free and publicly accessible online machine-readable files (MRFs) using a CMS mandatory format.
- MRFs must include prices for all providers/care including:
  - Primary Care Clinics
  - Imaging Centers
  - Ambulatory Surgical Care Centers
  - Professional Rates

Plans & Insurers MRF Element Requirements: July 1, 2022

File Name:	Description	Required Elements	Details
In-Network Rates	Information for In-Network Plans & Insurers	- HIOS ID or EIN - Billing Code - POS Code, TIN, NPI - In-Network Amounts	- Applicable Amounts May Be Negotiated Rates, Fee Schedules, or Derived Amounts - Bundled Rates Included
Allowed Amounts	Information for Out-of-Network Plans & Insurers	- HIOS ID or EIN - Billing Code - POS Code, TIN, NPI - Unique Allowed Amounts - Historical Billed Charges	- Unique allowed amounts are amounts plan or issuer will likely contribute to the costs of items or services obtained from out-of-network providers - Historical billed charges calculated based on 90-day lookback period beginning 180 days before file publication date - Only out-of-network providers with > 20 claims are included

Health Plan – Final Rule Facts: July 1, 2023

Transparency in Coverage (TiC)

- Upon request, Plans and Insurers are required to disclose cost-sharing information in plain language to enrollees via an online self-service tool (patient estimate tool) that provides the following information:
  - Estimated Cost Sharing Liability
  - Accumulated Amounts
  - In-Network Rates
  - Out-of-Network Allowed Amount
  - List of Items/Services Subject to bundled payment
  - Notice of prerequisites, if applicable
  - Disclosure Notice

***CMS published a list of 500 pre-determined CPT codes required to be included in every patient estimator tool.*

Health Plan – Final Rule Facts: July 1, 2024

Transparency in Coverage (TiC)

- *Shopping tools with be required to show the OOP costs for all remaining procedures, drugs, DME and any other item or service the consumer may need.*

Common Mistakes with Payer Compliance

MRF Issues

- In some regions, only 5% of the contracted TINS are displayed in the payer MRFs
- Internal payer identifiers are being used to identify contracted providers instead of the provider's NPIs or TINS
- Payer website links are being embedded into the MRFs to direct viewers to contracted provider lists instead of listing the providers who have received the contracted rate.
- Payer/Provider contracted rates are missing from the payer MRFs
- Payer MRFs are posting contrasting rates for same services
- Payer MRF's are posting min/max contracted rates for same services at same sites
- Contracted provider rates are blatantly incorrect in the MRFs (Less than 5% of Medicare reimbursement)

Enforcement and Good Faith Special Applicability

"The preamble to the proposed rules did not discuss how the proposed rules would be enforced. State regulators, in their comments to the proposed rules, sought greater clarity on how the proposed rules' requirements would be enforced as specifically applied to health issuers in the individual and group markets. Section 1311(e)(3) is located in title I of PPACA and, under section 1321(c)(2) of PPACA is subject to the enforcement scheme set forth in section 2723 of the PHS Act. Similarly, section 2715A of the PHS Act is subject to the enforcement scheme set forth in section 2723 of the PHS Act. ***Therefore, states will generally be the primary enforcers of the requirements imposed upon health insurance issuers by the final rules.*** *The Departments expect to work closely with state regulators to design effective processes and partnerships for enforcing the final rules."*


BREAKING
NEWS

Price Transparency in the News

MANY HOSPITALS STILL NOT POSTING PRICES DESPITE FEDERAL LAW

NBC NEWS

As of January 2021, federal price transparency became federal law requiring hospitals to post prices of their procedures. But patient advocates say change isn't happening fast enough and are challenging findings from a report from the Center for Medicare and Medicaid Services stating a majority of hospitals they sampled were in full compliance. NBC News' Marissa Parra asks a CMS administrator why enforcement has been lacking.

Bloomberg February 9, 2022

Most Hospitals Break Price Transparency Requirement Rules

- Trump-era rule backed by Biden requires price transparency
- 14.3% of surveyed hospitals are compliant, advocacy group says

WLOS Asheville/Greenville + Follow View Profile

Patient advocate group calls for more price transparency from hospitals following report

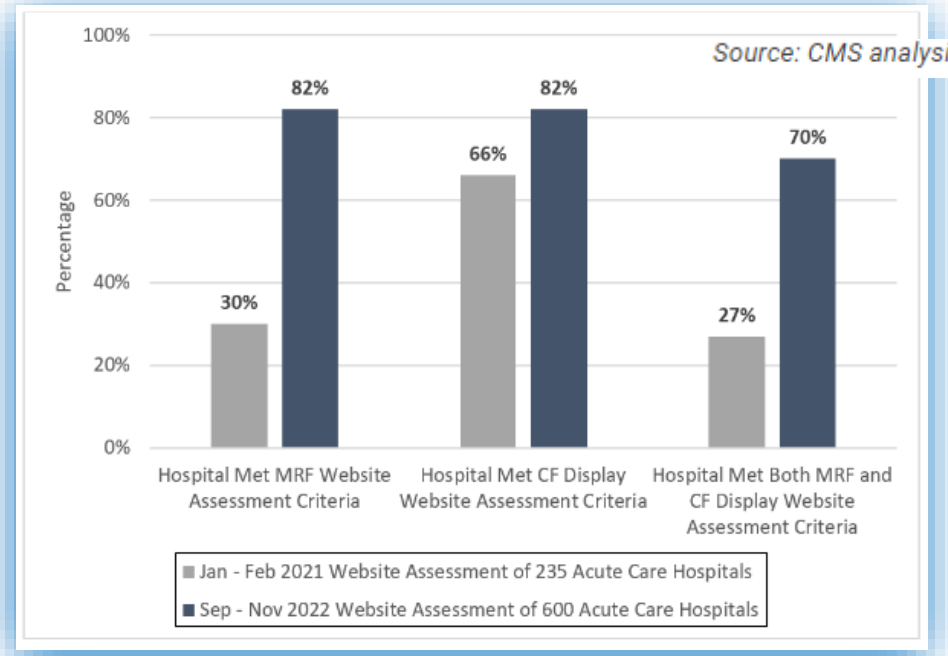
Story by Andrew James • Feb 7

"We find only 25% of the largest hospitals in the country are in full compliance with the law," said Cynthia Fisher, founder of PatientRightsAdvocate.org.

HEALTH

Only 16% of US Hospitals Complying With Federal Price Transparency Rule, Says Advocacy Group

Eunice Alpasan | November 2, 2022 10:26 pm



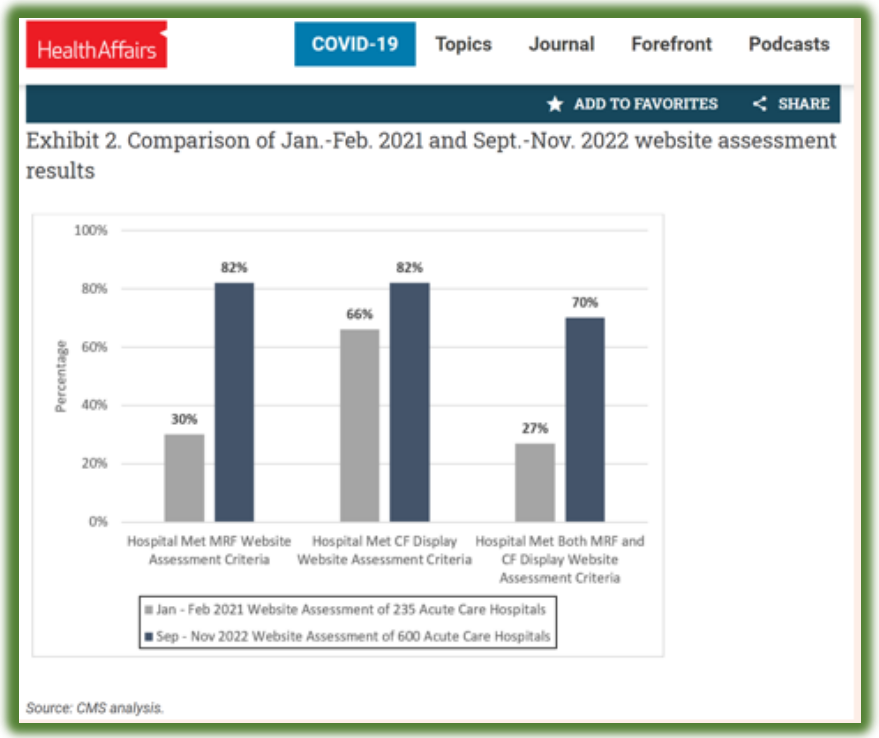

PATIENT
ADVOCACY

Federal Agency vs. Patient Advocacy Assessments

Two Different Pictures in February 2023

Patient Rights Advocate

CMS/Health Affairs

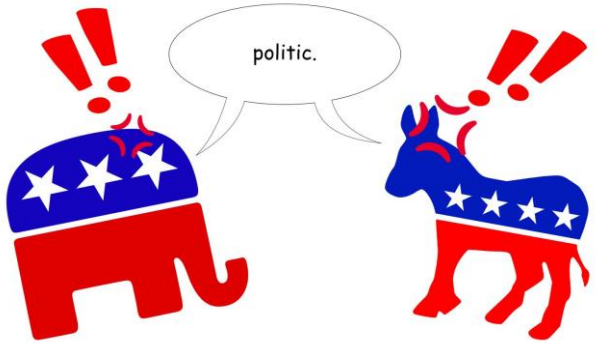


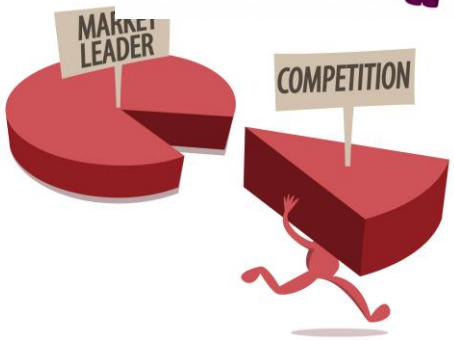
Patient Rights Advocate vs. CMS Regulations

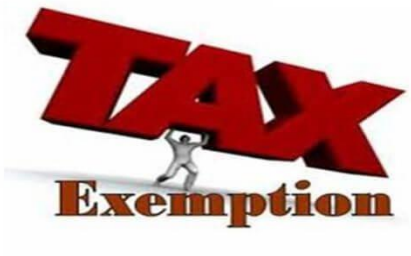
Why the significant differences in compliance rates?

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	

What Do You Prioritize?







Strategic MRF Analysis:

Provider

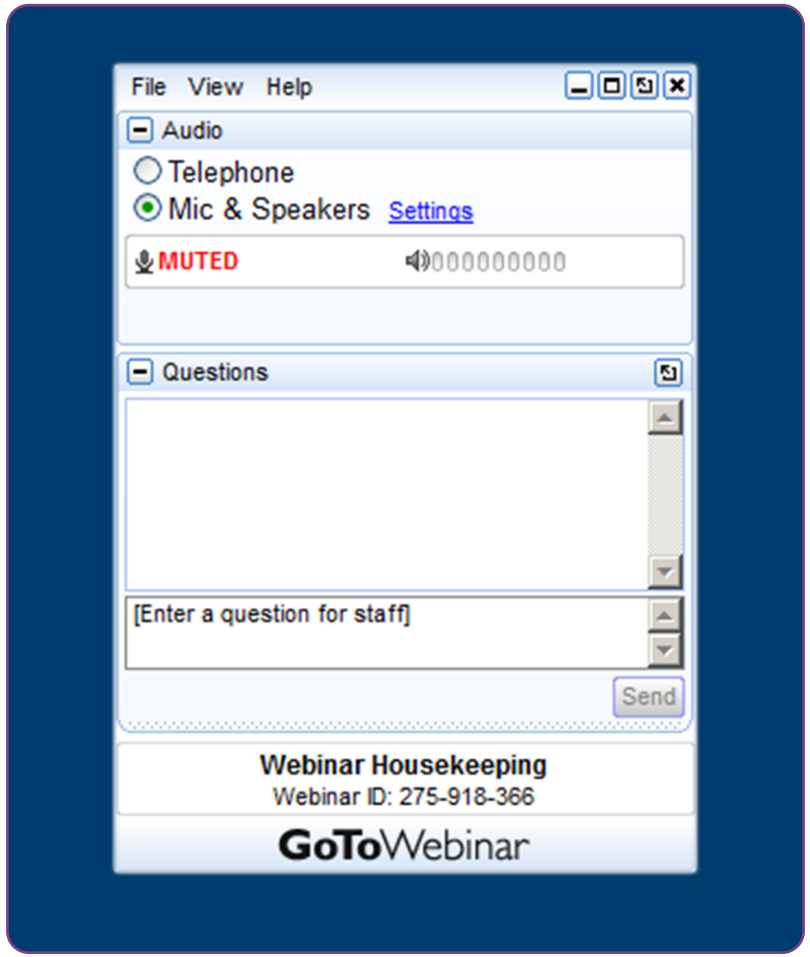
Payer

Employer

Data Considerations	Participant Focus
• Item and/or Service • Service Line • Provider Type • Facility Type • Payer Grouping • Payer • Contract Type	• Community • Region • State • Peer Group • National • Legacy/Non-Legacy

Questions

Reminder: Ask our speakers your questions by typing in the “Questions” pane on the lower right hand corner of your screen.



Call to Action

Become a CAQH CORE Participant: ***E-mail CORE@CAQH.ORG***

Join us for **CAQH Connect 2023**, an event bringing together healthcare industry experts, thought leaders, and executives from the nation's government, health plans, and industry associations.

September 27-29, 2023, *Westin Georgetown, Washington, D.C.* **Register Here**!