Preparing for healthcare price transparency:

What providers and payers need to know

Oct. 8, 2020

bakertilly
now, for tomorrow

HEALTHCARE PRICE TRANSPARENCY

Agenda

- History of CMS price transparency
- Price transparency mandate
- CMS requirements
- Provider preparation
- Charge Description Master (CDM) assessment and recommendations
- Providers and payers: price transparency issues for consideration
- Transparency as an opportunity
- Medicare Advantage Final Rule FY 2021
- “Surprise Billing” Executive Order

HEALTHCARE PRICE TRANSPARENCY

History of CMS price transparency

June 24, 2019

Presidential executive order on pricing and quality transparency to encourage competition among providers and decrease healthcare costs.

Dec. 3, 2019

CMS Final Rule released regarding price transparency requirements.

Dec. 4, 2019

AHA files lawsuit against CMS.

January – May, 2020

Legal proceedings.

June 23, 2020

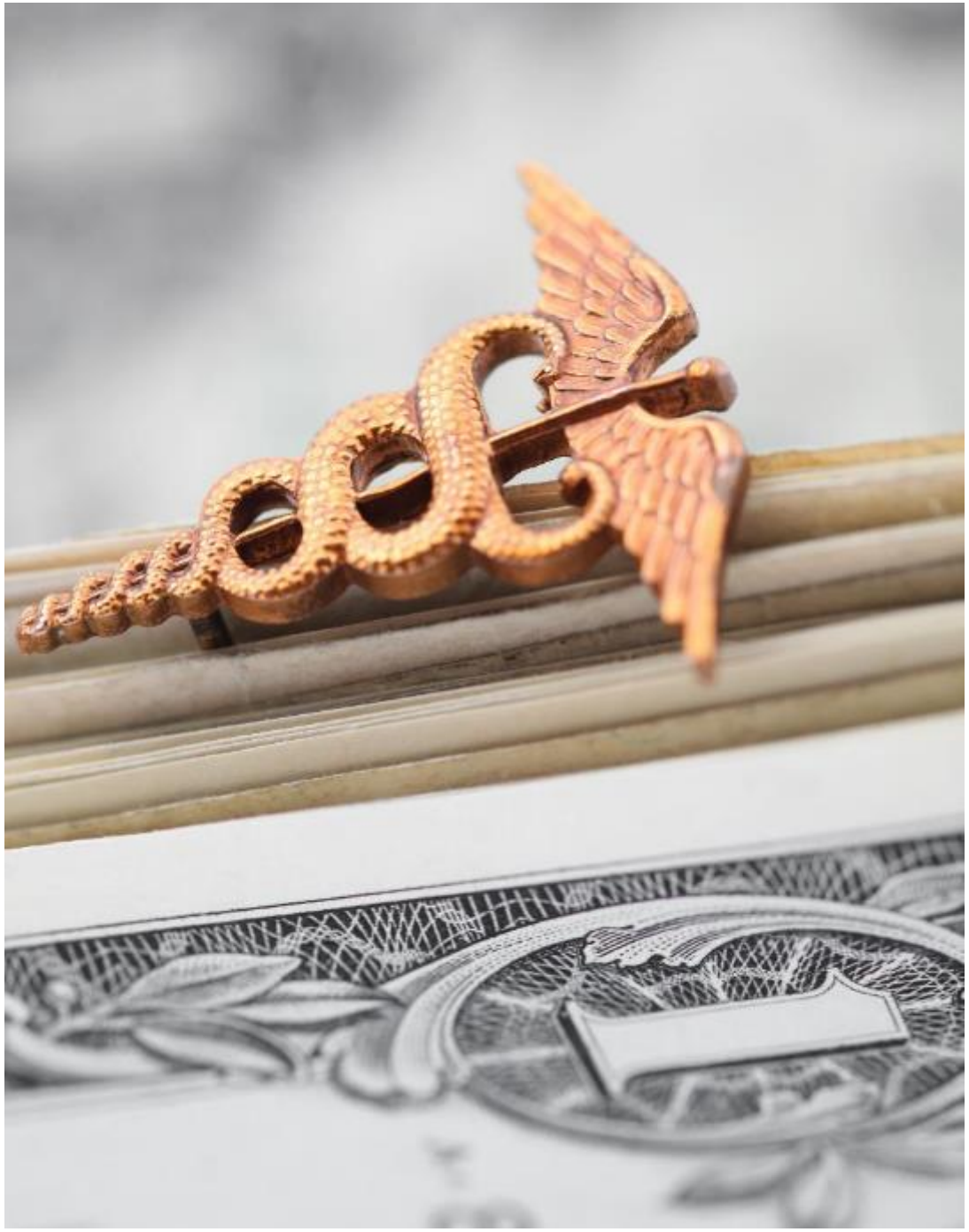
Summary judgement against AHA.

June 30, 2020

Healthcare PRICE Transparency Act introduced.

Jan. 1, 2021

Effective date of final ruling.



HEALTHCARE PRICE TRANSPARENCY

Price transparency mandate

- **EO intention:** Hospital price transparency helps Americans know the cost of a hospital item or service before receiving it and make it easier for consumers to shop and compare prices
- Starting Jan. 1, 2021, each hospital operating in the United States will be required to provide clear, accessible pricing information online about the items and services they provide in two ways:
  - As a comprehensive machine-readable file with all items and services
  - In a display of “shoppable services” in a consumer-friendly format

HEALTHCARE PRICE TRANSPARENCY

Provider preparation

Requirement one:

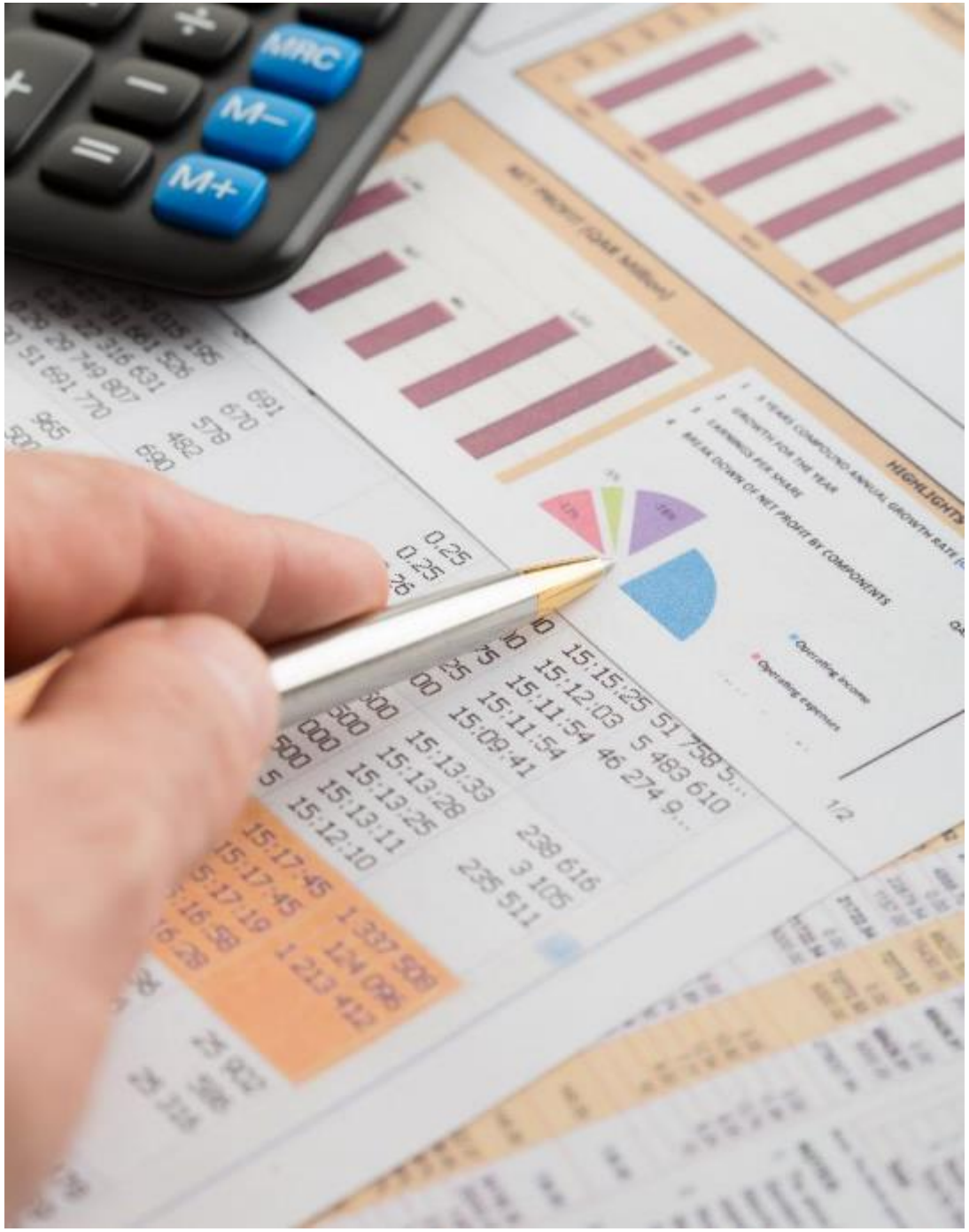
Post standard charges for all hospitals' items and services online in a single machine readable file, easily accessible on the facility public website, including the following five data points:

- Gross charges
- Discounted cash prices
- Payer-specific negotiated charges
- De-identified minimum negotiated charges
- De-identified maximum negotiated charges

Requirement two:

Post 230 hospital-selected and 70 CMS-required "shoppable services" including payer-specific negotiated rates online in a searchable and consumer-friendly manner on the facility public website

Note: Conducting a review/assessment of a hospital's CDM to ensure accuracy and market competitiveness is an important basis for preparation



HEALTHCARE PRICE TRANSPARENCY

CDM assessment

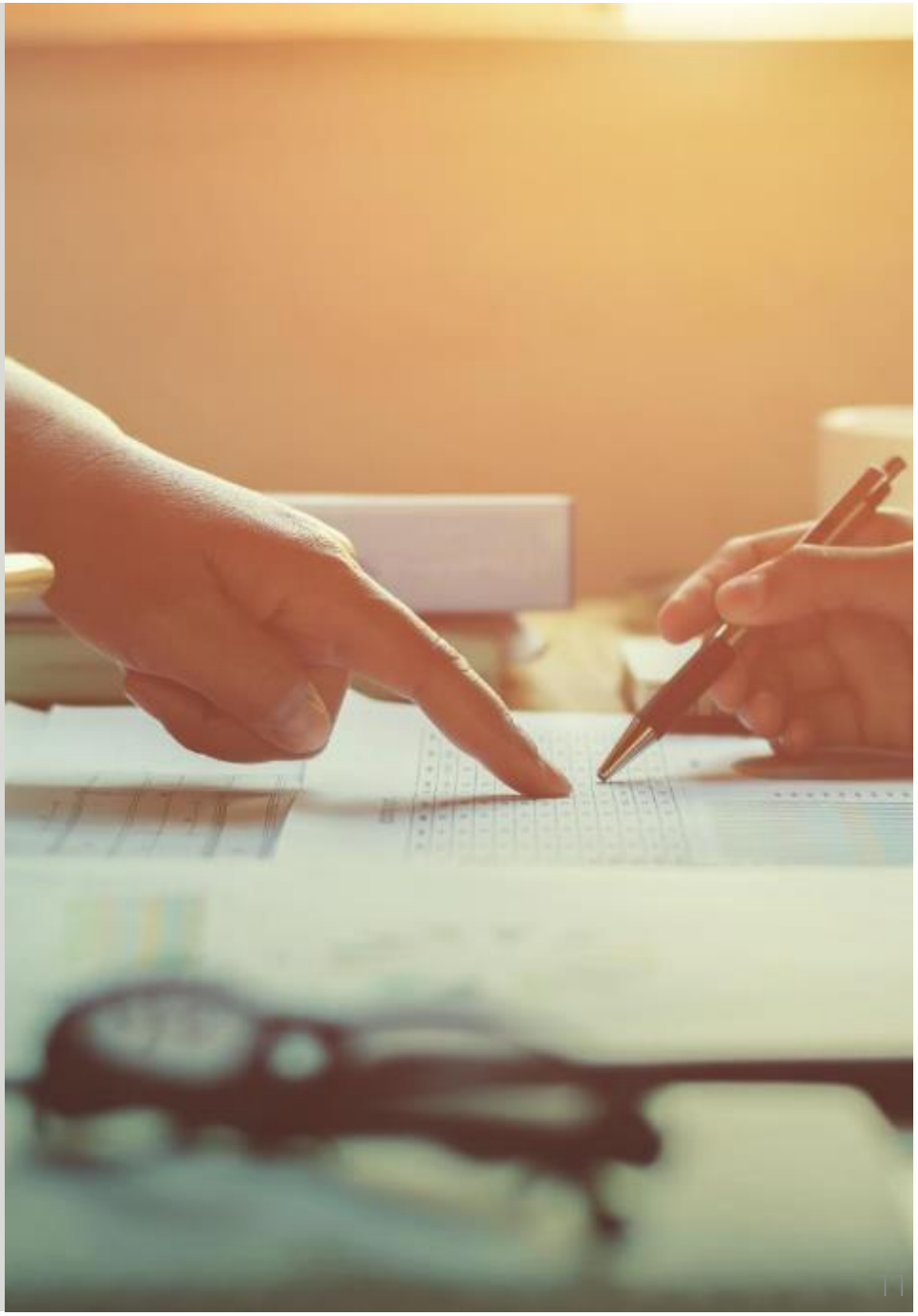
- Identify invalid coding on the CDMs providing updates/replacement coding with recommendations for improving charge capture
- Provide recommendations for CDMs' coding updates, additions and deletions, updating charges
- Create master working files for analysis utilizing the CDM, revenue and usage reports
- Compare current CDM charges to peer hospitals' benchmark charge levels
- Contrast current CDM charges against estimated or actual costs for individual items/services

HEALTHCARE PRICE TRANSPARENCY

CDM recommendations

Develop detailed strategic and rational prices with respect to appropriate item CDM modifications to assure adequate reimbursement levels related to:

- Market charge levels (for transparency initiatives and consumer engagement)
- Medicare and Medicaid allowable amounts and Cost Reports
- Charity care guidelines and parameters
- Managed care contractual reimbursement compared to market allowable reimbursement to optimize performance
- Provide an overall strategic risk/compliance analysis on the CDM



HEALTHCARE PRICE TRANSPARENCY

Meeting provider requirement one:

Identify standard charges

- Gross charges
- Discounted cash prices (reference hospital's self-pay policy)
- Payer-specific negotiated charges (for all contract /products)
- De-identified minimum negotiated charges
- De-identified maximum negotiated charges

HEALTHCARE PRICE TRANSPARENCY

Meeting provider requirement two:

Identify standard charges for 300 shoppable services

Data elements for shoppable services:

- Plain language description
- Indicator if CMS-specified shoppable service is not offered by hospital (hospital may replace with service provided)
- Payer-specific negotiated charge to service, including ancillary services as applicable
- Discounted cash price (or undiscounted gross charge)
- De-identified minimum and maximum negotiated charges
- Service location (in/outpatient) with payer-specific charges
- Primary codes for billing (e.g., HCPCS, DRGs)

HEALTHCARE PRICE TRANSPARENCY

Provider final preparation

- Develop website narrative and presentation
- Confirm compliance with CMS requirements
- Test files' posting

Note: Should CMS conclude a hospital is noncompliant with requirements to make public standard charges, CMS may assess a monetary penalty after providing a warning notice to the hospital, or after requesting a corrective action plan from the hospital if its noncompliance constitutes a material violation of requirements; if the hospital fails to respond to CMS, CMS may impose a civil monetary penalty on the hospital not in excess of $300 per day, and publicize the penalty on a CMS website

HEALTHCARE PRICE TRANSPARENCY

Issues for consideration

How will providers explain pricing discrepancies and “value”?

Why are plans paying more (or less) than other plans for the same service at the same facility?

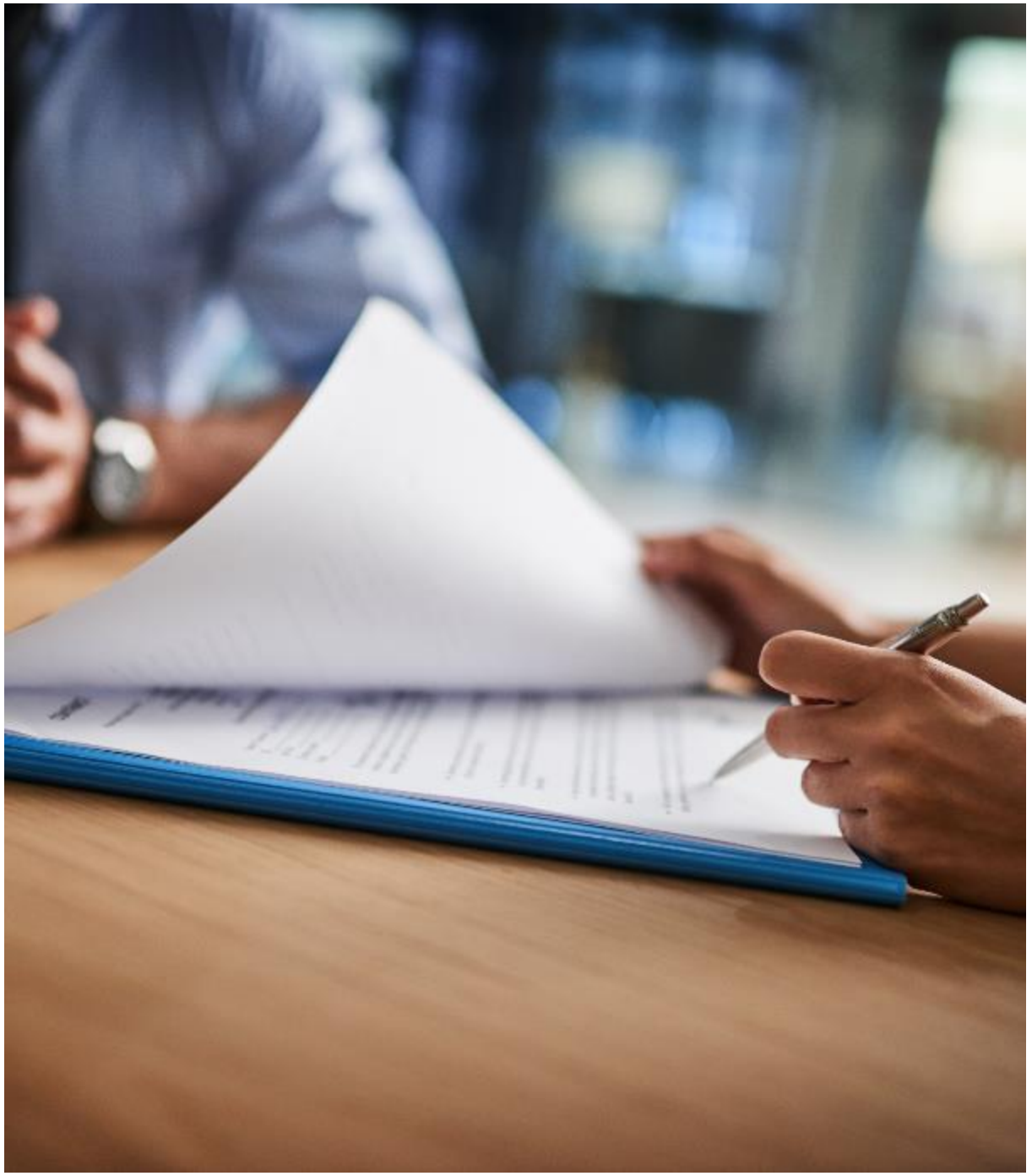
What about quality differences? Cost must be combined with quality to make value-driven decisions.

HEALTHCARE PRICE TRANSPARENCY

How will it impact profitability going forward?

For providers, is the right pricing strategy in place to survive/thrive in a marketplace where payment models are evolving towards more transparent, value-based and quality payment models?

- Is this congruent with the long-term market strategy?
- In consideration of price competitiveness and transparency, should all current service lines be maintained?



HEALTHCARE PRICE TRANSPARENCY

Impact to existing managed care contracts

- Most managed care contracts are complex, focused on FFS reimbursement with minimal attention to quality and cost metrics
- Transparency and value-orientation necessitate a strategic adjustment for health systems
  - Review of current reimbursement methodologies for “shoppable services”
  - Development of value-based care arrangements
  - Update/modernize existing contracts
  - Understand how data is collected, shared and released in preparation for data sharing standards

HEALTHCARE PRICING TRANSPARENCY

How will transparency impact future operational efficiency?

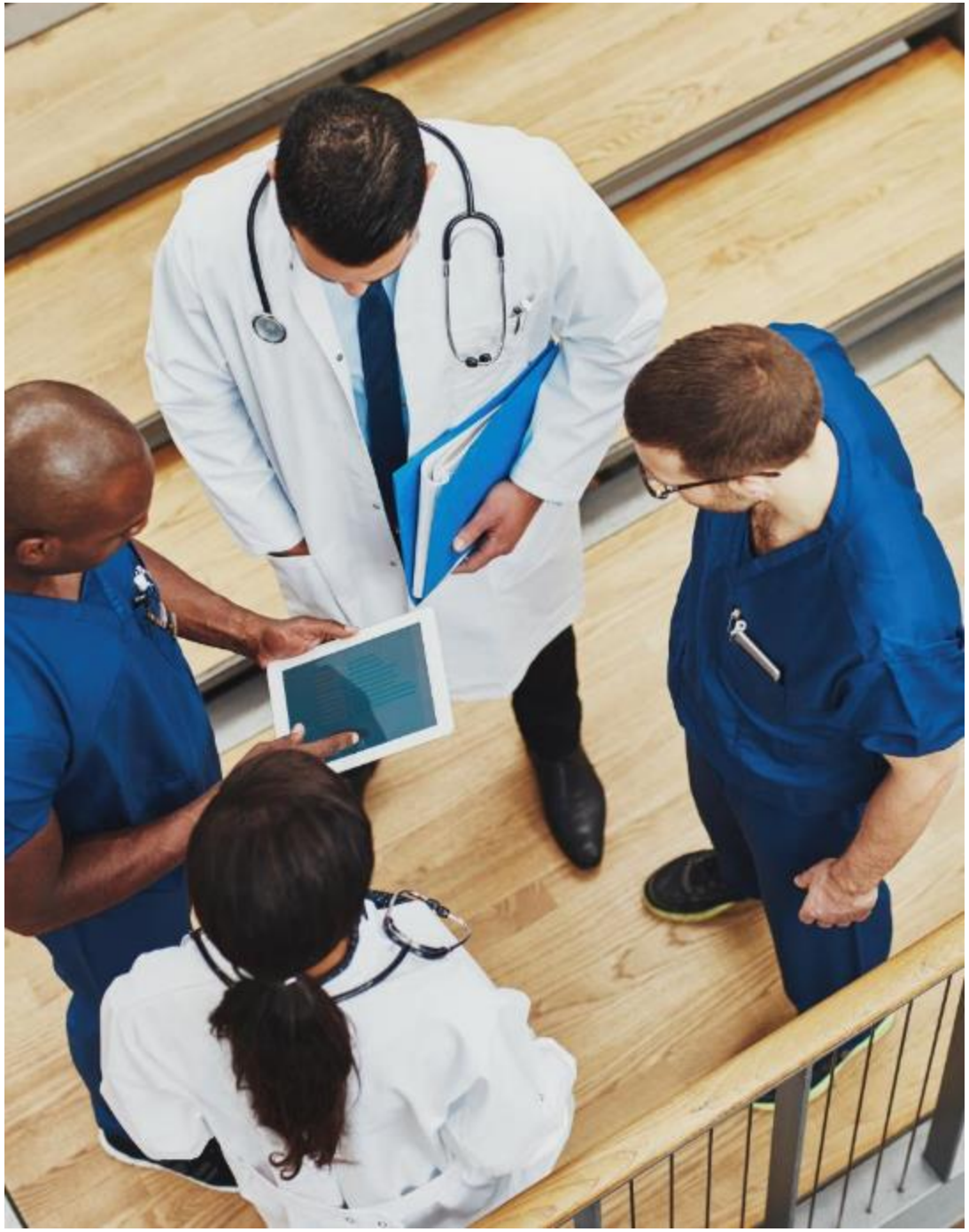
View the Transparency EO as a catalyst to increased automation and technology enablement

- Rethink/revise organizational processes
- Data control and collaboration across key functions
- Price transparency can expedite financial risk transfer from payers to providers, deploying resources more efficiently for both payers and providers

HEALTHCARE PRICE TRANSPARENCY

Implications for providers

- Cost comparisons across providers can impact patient and service utilization volumes and flow patterns as patients can select providers based on price and quality
- Ability for providers to evaluate their pricing and reimbursement compared to competitors can impact the entire healthcare market
- As patients make differentiated decisions based on price, non-monetary aspects (e.g., wait times, patient outcomes, advanced technology/equipment) will become increasingly important
- Patient engagement and education are key
- Resource allocation, e.g., medical personnel, technology, capital investment



HEALTHCARE PRICE TRANSPARENCY

Implications for healthcare payers /self-funded plans; the downstream impacts

- Driver toward value-based provider contracts: Transparency supports outcome, efficiency and quality data in calculating reimbursement, educates consumers on value, complementing the focus on pricing for individual services
- Payers comparing their service payment costs to their competitors at the same provider systems may lead to renegotiation of provider contracts to optimize their performance
- New benefit designs enabled by price transparency promote steerage to cost-effective providers

HEALTHCARE PRICE TRANSPARENCY

Transparency as an opportunity, not a burden

May provide a competitive advantage by meeting consumer expectations

Delivering easily understandable pre- and post-visit financial information increases patient satisfaction

Element to include that provides value: quality indicators, hospital specialization and awards, physician credentials

Provide follow-up steps for patients to facilitate the care journey, e.g., scheduling an appointments, emailing service quotes to patient, paying a bill

HEALTHCARE PRICE TRANSPARENCY

Medicare Advantage – Final Rule FY 2021

- IPPS Final Rule FY 2021 requires that hospitals must provide on their Medicare Cost Report their median negotiated rates by MS-DRG with Medicare Advantage private insurance plans or they could/will be denied Medicare payment
- Potential risk: Estimated 18% of hospital revenue from Medicare payment (Definitive Healthcare, 2019)
- Reporting begins with Medicare Cost Reports ending on or after Jan. 1, 2021; for calendar year hospitals, that means CY2021
- CMS is adopting a market-based MS-DRG relative weight methodology for calculating the MS-DRG relative weights, beginning in FY 2024

HEALTHCARE PRICE TRANSPARENCY

“Surprise Billing” Executive Order

- In-network hospital, unexpected out-of-network provider billing
- April 10, 2020: Providers receiving supplemental COVID-19 funding could not collect OOP expenses greater than in-network rates
- Congress has made progress towards ending surprise billing; HHS shall work with Congress to reach a legislative solution by Dec. 31, 2021
- If legislative solution not reached by Dec. 31, 2021, HHS to take administrative action to prevent patients from receiving bills for OOP expenses patients could not have reasonably foreseen

Disclosure

The information provided here is of a general nature and is not intended to address the specific circumstances of any individual or entity. In specific circumstances, the services of a professional should be sought.