Pricing Concerns in an Era of Pricing Transparency

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Pricing Transparency 2019

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- Per the 2019 Inpatient Prospective Payment System Final Rule, effective 1/1/2019 CMS required hospitals to “make public a list of standard charges for all items and services provided by the organization” in an effort to promote pricing transparency
- Applied to all hospitals operating within the United States

What does that mean for my hospital?

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- Required hospitals to publish a machine readable file on their website with
  - All items and services provided by the organization
  - The chargemaster itself or in another form of your choice
  - All DRGs (diagnosis-related groups)
  - ➢ *The file must be updated at least annually*

Proposed Rule 2020

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- CMS Proposed Rule requires *all hospitals* to publish all published charges and reimbursement by payor for all payors with negotiated charges
- CAHs not excluded
- Suggests all payors and competitors will be encouraged to contact patients and steer them to the option that provides the least expense to the patient

2020 OPPS and ASC Proposed Rule Listening Session

- Discrepancy between CMS proposal to publish negotiated charges and Director Verma clarification to publish negotiated rates
  - Charges are gross and rates are net
  - CMS representative reiterated intent required negotiated charges
  - Indicated all commenters must submit requests for clarification in writing
- CMS Representatives suggested all hospitals should be "steered toward DRG reimbursement" to benefit patients and allow for easy comparison
- CMS must consider how to handle Reasonable and Customary reimbursement, or no negotiated rates

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- CMS indicates hospitals are encouraged to undertake efforts to engage in consumer friendly communication to help patients understand their potential financial liability
  - Enable patients to compare charges for similar services across hospitals

Pricing Transparency

- This presents both an opportunity and a challenge to develop compliant, cost-effective processes that add value for patients, and promote fair and accurate comparisons.
- Prepare to assist patients through this change and mitigate any damage to revenue or reputation

Descriptions

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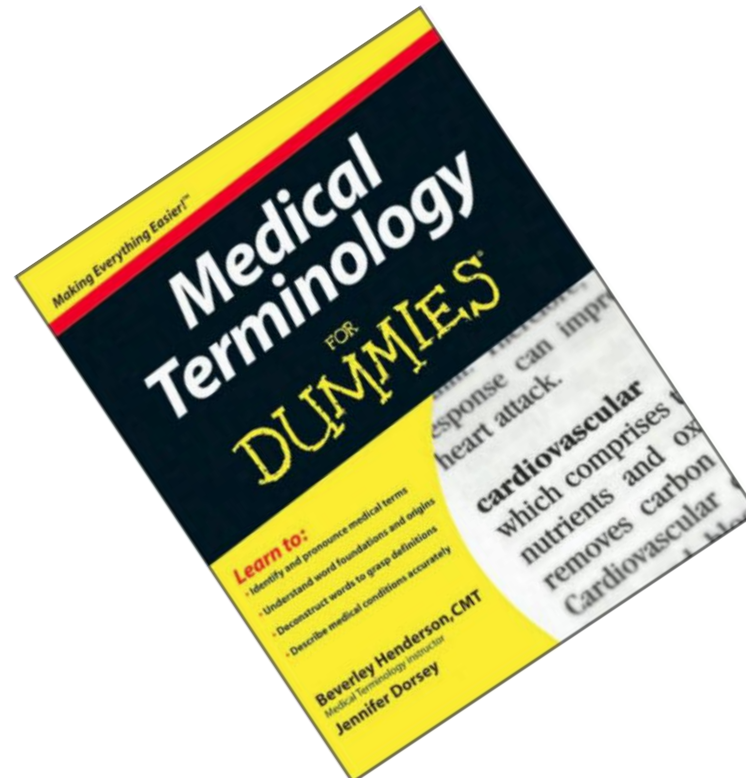
- Patients must understand the service to understand the price
- The Chargemaster descriptions should make sense to an average, non-medical person



CDM Review - Descriptions

- What do your current descriptions tell patients?

CDM#	Description	CPT	Fee
	LEVEL III	99283	$454.00
	LEVEL IV	99284	$700.00
	LEVEL II	99282	$267.00
	LEVEL V	99285	$987.36
	LEVEL I	99281	$167.00
	KUB	74000	$254.83
	IVP	74400	$702.34
	HERNIA REPAIRS IN LOWER ABDOMEN	00830	$1,038.16
	VENTRAL AND INCISIONAL HERNIAS	00832	$1,427.47
	VENTRAL AND INCISIONAL HERNIAS	00832	$624.00
	HERNIA REPAIRS IN LOWER ABDOMEN	00830	$1,297.70

Challenges of Pricing Transparency

- Chargemaster data can be confusing to patients.
- A direct interpretation of CDM pricing is misleading, since many payors bundle charges and reimburse contractual allowed amounts rather than retail prices.
- Patients are responsible for the copay, deductible or coinsurance
  - Based on the allowed amounts for commercial payors
  - Charges for Medicare in CAH
- The published chargemaster will not provide this information to your patients.
- Outdated pricing or sliding scale markups can also contribute to confusion for your patients and their families.

Challenges - DRGs

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- How are DRGs
  - Prices/payments determined
  - Displayed on your website?
  - Explained to patients?

CMS 2017 Inpatient Charge Data DRG Definition	Provider Name	Average Covered Charges	Average Total Payments	Average Medicare Payments
062 - ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROM	PROVIDENCE HEALTH CENTER	$43,732.45	$10,924.36	$9,819.18
092 - OTHER DISORDERS OF NERVOUS SYSTEM W CC	UNITED REGIONAL HEALTH CARE SYSTEM	$20,938.85	$6,662.69	$5,695.77
101 - SEIZURES W/O MCC	VHS HARLINGEN HOSPITAL COMPANY LLC	$40,261.70	$5,919.85	$4,869.74
103 - HEADACHES W/O MCC	EAST TEXAS MEDICAL CENTER	$52,352.09	$4,632.22	$3,222.00
177 - RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	VALLEY REGIONAL MEDICAL CENTER	$208,872.41	$15,731.47	$13,685.41
190 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	TITUS REGIONAL MEDICAL CENTER	$16,509.46	$7,691.34	$6,455.55
191 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	LONGVIEW REGIONAL MEDICAL CENTER	$46,045.59	$5,232.28	$3,974.57
193 - SIMPLE PNEUMONIA & PLEURISY W MCC	CITIZENS MEDICAL CENTER	$36,412.37	$7,512.03	$6,813.21
194 - SIMPLE PNEUMONIA & PLEURISY W CC	HILL REGIONAL HOSPITAL	$28,442.75	$6,661.83	$5,796.17
291 - HEART FAILURE & SHOCK W MCC	TYLER COUNTY HOSPITAL	$12,305.95	$10,048.36	$9,431.73

Challenges - Supplies

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- How are supplies reported?
  - Medically necessary only?
  - Convenience items?
- How do they look in the CDM?
  - Sliding scale mark up
  - Accurately priced at "each"

Challenges of Pricing Transparency

- Chargemasters shared between PPS and non-PPS (CAH hospitals) tend to meet the needs of the parent hospital
- Medicare coinsurance at CAH is based on charges
- How does pricing affect patient perception?
- Patient reality?

Patient Questions

- The "menu" provided online doesn't necessarily answer patient questions
  - What are "hidden" add-on costs?
  - What is ***my*** cost??
  - How does this compare to other facilities?

June 2016 MedPac Report

- “Medicare beneficiary coinsurance at CAHs is based on charges and the Medicare program’s reimbursement to CAHs is cost-based, the relationship between costs and charges is critical. If the growth in charges outpaces the growth in costs, the coinsurance burden increases for beneficiaries”
- NEED FOR A POLICY CHANGE FOR BENEFICIARY COINSURANCE

Tales from the Field – CT Scan & MRI

- Assumes 50% Cost to Charge Ratio: ((Fee*.5)*.2)

CPT	DESCRIPTION	CHARGE	Potential CAH COINS	OPPS PAYMENT	OPPS COINS
70460	CT HEAD W CONTRAST	$1875.00	$187.50	$201.74	$40.35
70470	CT HEAD W WO CONTRAST	$2400.00	$240.00	$201.748	$40.35
72196	MRI PELVIS	$2300.00	$230.00	$385.88	$77.18
73720	MRI LOW EXT NON-JT W WO RIGHT	$1725.00	$172.50	$385.88	$77.18
73721	MRI LOW EXT JOINT RT	$1700.00	$170.00	$230.56	$46.12
73723	MRI LOW EXT JOINT RIGHT W/WO	$2100.00	$210.00	$385.88	$77.18
74181	MRI ABD WO CONTRAST	$2000.00	$200.00	$230.56	$46.12
74183	MRI ABD WO AND W CONTRAST	$2400.00	$240.00	$385.88	$77.18

Tales from the Field - ER

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- Assumes 50% Cost to Charge Ratio: ((Fee*.5)*.2)

CPT	DESCRIPTION	CHARGE	Potential CAH COINS	OPPS PAYMENT	OPPS COINS
39225	ECG MONITOR	$551.00	$55.10	$106.48	$21.30
41252	RPR LAC TONGUE >2.6CM	$1,193.00	$119.30	$206.14	$41.23
41250	RPR LAC MOUTH <2.5CM	$520.00	$52.00	$106.48	$21.30
31605	TRACHEOSTOMY	$1,290.00	$129.00	$206.14	$41.23
30905	CONTROL NASAL HEMMORG INIT	$723.00	$72.30	$106.48	$21.30
27750	CLSD TIB SHAFT FX WO MANIP	$1,152.00	$115.20	$225.09	$45.02
12057	LYR CLOSURE FACE 30.00CM	$1,750.00	$175.00	$314.08	$62.82

MedPac Report

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- Diagnostic Radiology, CT Scan, and MRI have the greatest regional variation in coinsurance Cost to Charge Ration (CCR)
- The Western States consistently have the lowest percentages
- Northeast and South the highest
- CT Scans show the sharpest decrease in visits
- Most CAHs report CT and MRI as Diagnostic Radiology on the Cost report

Tales From the Field

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Represents recent pricing reviews from 10 CAHs

- 6 departments noted with prices set at $0.00
- 64, or 52%, of departments noted with prices set lower than Medicare rates
- 98, or 79%, of departments noted with prices set lower than 2X Medicare
- 92, or 74%, of departments noted with prices set higher than 5X Medicare rates

Overall:

- 8.77% of all codes examined were set lower than Medicare
- 19.31% of all codes examined were set lower than 2X Medicare
- 27.01% of all codes examined were set higher than 5X Medicare

Fallout

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- Medicare is already advertising the benefits of having elective procedures at ASCs vs. OPPS hospitals
- Will they do the same to CAHs?
- How will you measure up?
- What will your message be? Are you prepared?

Procedure Price Look-up

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Pricing Transparency CDM Review

- Review viability and consistency of the current pricing methodology
- Examine the contents of each chargemaster to include areas such as pricing, description, inclusion of deleted codes, etc.
- To identify pricing variability payable codes were compared to published Medicare rates

Pricing Transparency

- Patients seek clarity from staff with which they have the most contact, but who may be the least prepared to answer financial questions:
    - Medical staff
    - Technicians
    - Nurses
- The best person for patients to speak with is a Financial Counselor.

Pricing Transparency- Next steps

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- Still time to get it right
- Per statement from CMS Administrator Seema Verma on Thursday, January 10, 2019
  - The agency has no means of enforcing its new price transparency rule
  - There are no penalties at this time
  - There is no timeline for penalty implementation
  - Seeking information on what the enforcement mechanism for the rule should be

Take Steps

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- Review and clean up CDM
  - Implement a patient centric, defensible pricing methodology
  - Update CDM to reflect current service provision
  - Review chargemaster and pricing through the patient's eyes
- Use website to guide patients to Financial Counselors
  - "Itemized charges may not reflect the payor or patient responsibility for services or supplies provided as part of a service or surgical package. Bundled rates apply that reflect significant discounts. Patients are encouraged to contact a Financial Counselor to review expected services and to obtain an accurate quote."
  - Contact Financial Counselor Link to Financial Counselor email and/or extension
  - Frequently Asked Questions Link to FAQs page
- Educate staff to refer all questions to Financial Counselors
- Train Financial Counselors
  - Read CDM
  - Know payor guidelines
  - Understand reimbursement structures
  - Create effective and accurate estimates

Website Design

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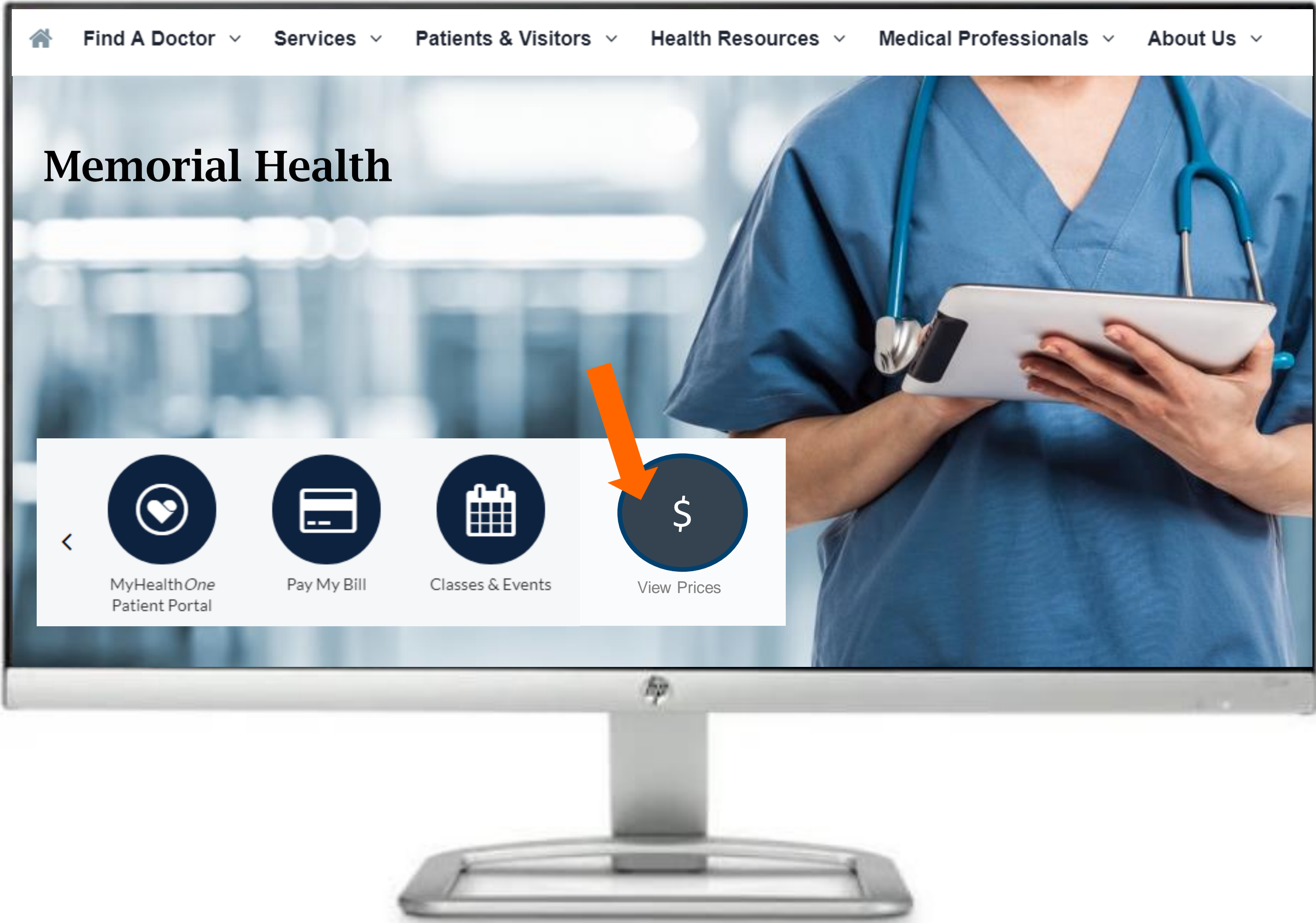

Sample Language

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Itemized charges may not reflect the payor or patient responsibility for services or supplies provided as part of a service or surgical package.

Contact a Financial Counselor to review expected services and to obtain an accurate quote.

Contact Financial Counselor
Frequently Asked Questions

FAQ Page

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FAQs

Will I be charged the published rates?

It is unlikely that you will be charged the published rate for services.

1. *Insurance first applies discounts before applying patient copays, coinsurance or deductibles*
2. *Guidelines exist that require bundling of certain services when performed together*
3. *Self Pay discounts are available*
4. *Financial assistance is available for those who qualify*

FAQ Page contd.

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How do I compare to price match?

The price you pay is set by your insurance. Our Financial Counselors can work with you and your insurance to determine your responsibilities.

How will I be charged for drugs and supplies?

Drugs and supplies may be bundled into payment for primary services, if so, there will be no additional patient responsibility after the primary service. Please see a Financial Counselor to learn more about your responsibility after insurance

What if my planned procedure changes after the procedure starts?

Pricing for similar or expanded services can be anticipated and accurate estimates can be created.

Contact a Financial Counselor for more information on these and other questions

Proceed to additional pricing information

Financial Advocates

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- Ambassadors for the hospital
- Train staff to understand patient responsibilities and *have the correct conversation*
- **Capture correct insurance information**
- Listen to the patient
- Ask clarifying questions
- Restate the patient's needs or concerns to ensure accuracy
- Communicate with the CDM coordinator, or Finance for clarification

Financial Advocates

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- Understand payor specific guidelines
  - Bundling rules
  - Payor specific NCCI guidelines, MUEs
  - Supply and medications
- Medicare
  - Understand the total cost of patient-responsible charges
  - Able to explain charges to patients
- Self Pay
  - Qualify for Medicaid
  - Qualify for Financial Assistance
  - Discuss prepayment discounts, payment plans, payment options
- Create accurate estimates, assist in next steps
  - Get services scheduled, authorized, approved
- Collect deposit in advance for high dollar deductibles, or self-pay

Summary

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- Scrutinize the CDM
- Update accurate, defensible pricing
- Create understandable descriptions
  - Provide clarity around Charge components
    - Professional
    - Facility
    - Anesthesia
- Evaluate DRG explanations and pricing
- Steer patients to Financial Counselors
- Train Financial Counselors
- Prepare for annual update process

Resources

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- http://www.medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0
- http://www.medpac.gov/docs/default-source/contractor-reports/medicare-copayments-for-critical-access-hospital-outpatient-services-update.pdf?sfvrsn=0

Thank You

- Stroudwater Revenue Cycle Solutions was established to help our clients navigate through uncertain times and financial stress. Increased denials, expanding regulatory guidelines and billing complexities have combined to challenge the financial footing of all providers.
- Our goal is to provide resources, advice and solutions that make sense and allow you to take action.
- We focus on foundational aspects which contribute to consistent gross revenue, facilitate representative net reimbursement and mitigate compliance concerns. Stroudwater Revenue Cycle Solutions helps our clients to build processes which ensure ownership and accountability within your revenue cycle while exceeding customer demands.
- **Contact us to see how we can help.**

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