
Price Transparency – Using the Data

Ohio Rural Health Conference

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- Requirement of the Affordable Care Act
- Effective January 1, 2019
- Requirement: hospitals must post standard charges for all items and services on a public-facing website in a machine-readable format
 - Applies to all hospitals, including critical access, inpatient rehab, and inpatient psych
 - Revenue codes and charge codes not required
 - Concern regarding use of CPT/HCPCS codes (AMA copyright)
- Subsection (d) hospitals (those paid under IPPS) also required to publish charges by DRG

Executive Order Issued June 24, 2019

Order Expands Transparency

**Goal: Reduce Cost of Care by Increasing Price
Competition**



Requirements: Part 1



- Compliance required January 1, 2021
- Requires charge data to be posted in a single machine-readable file
 - No barriers to access
 - Free of charge, no account or password required
 - No PHI required to access
 - Individual charge level – both actual charge and payer-negotiated charge
 - Five types of “standard charges”
 - Updated at least annually and show date of last update on file
 - Required of each hospital location if there is a different set of standard charges
 - Information not expected to be used by consumers, but rather by employers, other providers, and tool developers

- Displaying shoppable services
 - Standard charges for at least 300 shoppable services or bundles
 - Includes the five types of standard charges
 - Defined as a service that can be scheduled by a health care consumer in advance
 - Services selected for display should be those commonly provided to that hospital's patients
 - 70 bundles identified by CMS – provider must have total of at least 300 even if not all 70 are offered at facility
 - Easily searchable and consumer-friendly
- No barriers to access
- Information updated at least annually

- Providers deemed to meet this requirement if it maintains an Internet-based price estimator tool
 - Must include estimates for any of the 70 identified services as are provided by the hospital plus additional services to total at least 300 shoppable services
 - Estimator would allow consumer to determine what **they will be expected to pay for the service**
 - Prominently displayed on hospital website
 - Without barriers to access such as a fee, registration or establishing user account
- Providers still required to post machine-readable file tied to chargemaster detailing “standard charges”

“Identified” Errors in the Data



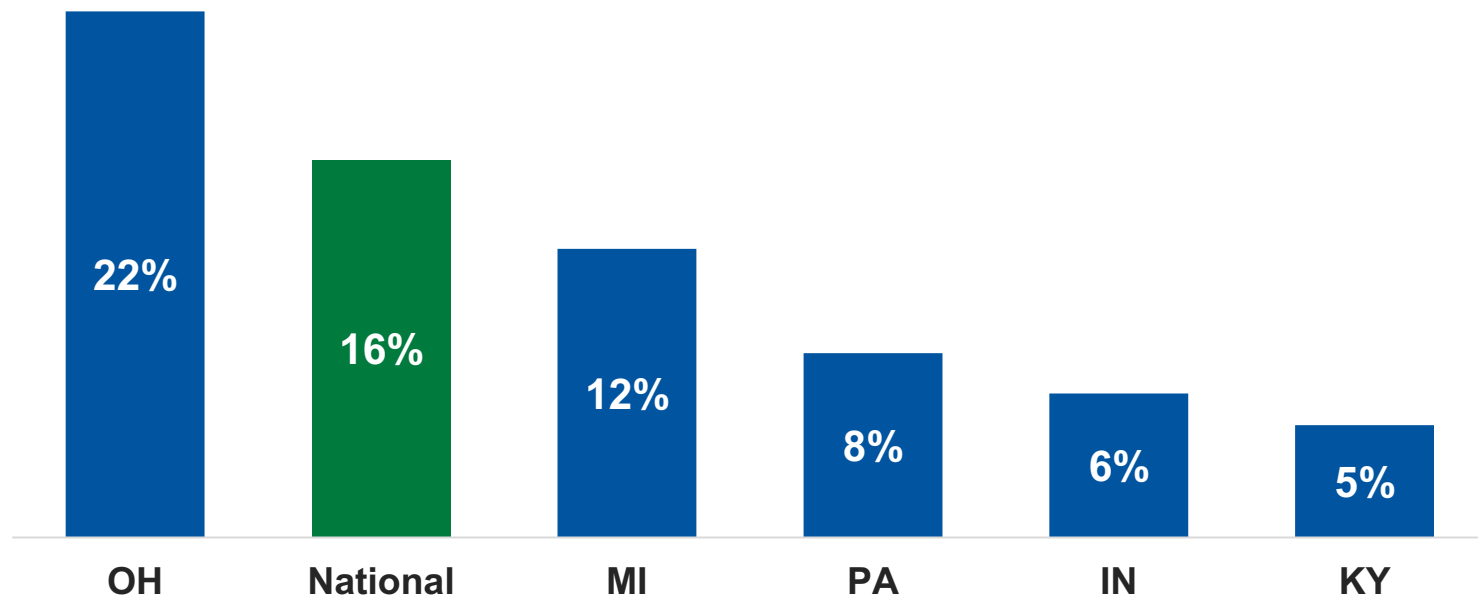
- Failure to provide payer-specific rates
- Posting payer names but no rates
- Posting payer names but no plan names
- Unclear if professional fees were included
- Use of estimates, averages, medians
- Use of rates based on historical payments
- Failure to update the data
- Discrepancy in prices between the machine-readable file and shoppable services
- Failure to include applicable billing codes
- Difficulty to access – multiple clicks

- Rule requires that each of the rates is clearly presented with the name of the third-party payer and the plan with which it is associated
 - Example –
 - Insurer has multiple distinct plans –
 - Private plan HMO
 - Private plan PPO
 - Medicare Advantage plan
 - Medicaid managed care plan

And the Data Show -



% of Hospitals NOT Posting Plan Name



Data source: Turquoise Health Co.

Penalty for Non-compliance



Noncompliance for CMPs Assessed in CY 2022 and Subsequent Years.

Number of Beds	Penalty Applied Per Day	Total Penalty Amount for full Calendar Year of Noncompliance
30 or less	\$300 per hospital	\$109,500 per hospital
31 up to 550	\$310 - \$5,500 per hospital (number of beds times \$10)	\$113,150 - \$2,007,500 per hospital
>550	\$5,500 per hospital	\$2,007,500 per hospital

Note: In subsequent years, amounts adjusted according to 45 CFR 180.90(c)(3).

- Semi-Annual Hospital Price Transparency Compliance Report – February 2022
- Errors identified –
 - Number of insurance plans includes less than those listed on hospital's website
 - Issue of personally identifiable information
 - Use of price ranges
 - Use of blank fields or N/A: NOT ERRORS

Surprise Billing and Good Faith Estimates



Surprise Billing



- Emergency Services

- Applies to emergency services furnished –
 - At out-of-network facility, and/or
 - By out-of-network provider furnishing services at facility (regardless if facility in-network or out-of-network)
- “Emergency services”
 - EMTALA definition +
 - Post-stabilization services (observation, inpatient, outpatient) if treating physician determines patient cannot be safely moved to another facility using non-medical transport)
 - Potential issues with downstream providers

Surprise Billing



- Non-emergency services
 - Applies to services furnished at in-network facility by out-of-network provider
 - Does not apply to any non-emergency services furnished at out-of-network facility
- Consent to balance billing
 - ONLY if patient has opportunity to select provider in advance (surgeon)
 - Hospital-based physicians cannot obtain consent to balance bill

Good Faith Estimate



- Any provider furnishing healthcare services to self-pay patient
 - Self-pay patient requests GFE (i.e., “any discussion or inquiry regarding potential costs of items or services under consideration”)
 - Services scheduled at least 3 business days in advance for self-pay patient (regardless of request for pricing information)
- GFE applies to “healthcare facilities” and “healthcare providers”
 - State-licensed institutions such as hospitals, ASCs, RHCs, FQHCs, laboratories, imaging centers
 - Physician or other healthcare provider who is acting within scope of practice of that provider’s state-issued license or certification (including air ambulance provider)

Convening Provider and Co-provider



- Who is who?
 - Convening provider = scheduling provider
 - Co-provider = furnishes services directly related to primary service
- Beginning January 1, 2023, what is the consequence of –
 - Failure to request co-provider information?
 - Failure of co-provider to provide information?

Completing the GFE



- Through 2022, include all items and services for which provider bills (including purchased services)
- Self-pay rates
 - List charges inclusive of discounts (even if 100% discount)
 - Opportunity to re-evaluate self-pay rates, chargemaster?

Using the Data



It is imperative that the current FFS payment systems be managed carefully and continuously improved. Medicare is likely to continue using its current FFS payment systems for some years into the future. This fact alone makes unit prices—their overall level, the relative prices of different services within a sector, and the relative prices of the same service across sectors—of critical importance. Constraining unit price increases can induce providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

March Report to Congress 2022

Some states (Hawaii, Arkansas, and Washington) had relative prices below 175 percent of Medicare prices, while other states (Florida, West Virginia, and South Carolina) had relative prices that were at or above 310 percent of Medicare prices.

In 2020, across all hospital inpatient and outpatient services (including both facility and related professional charges), employers and private insurers paid 224 percent of what Medicare would have paid for the same services at the same facilities.

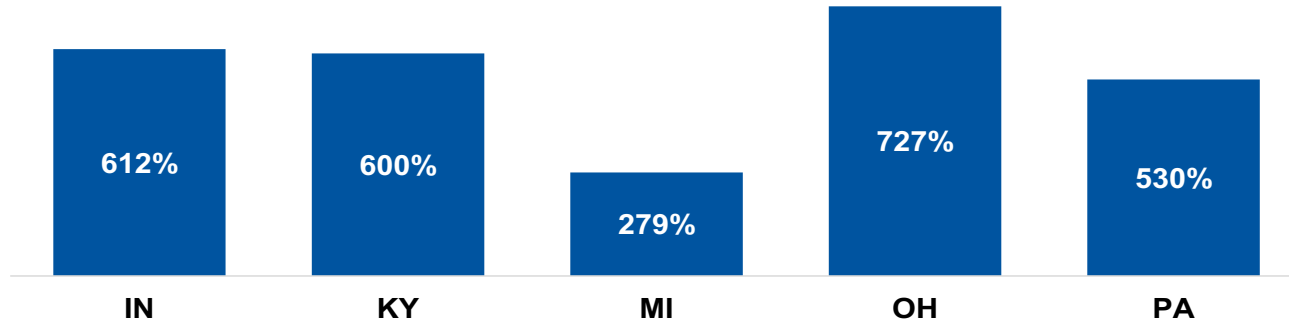
Prices Paid to Hospitals by Private Health Plans, 5/17/22

And the Data Show -



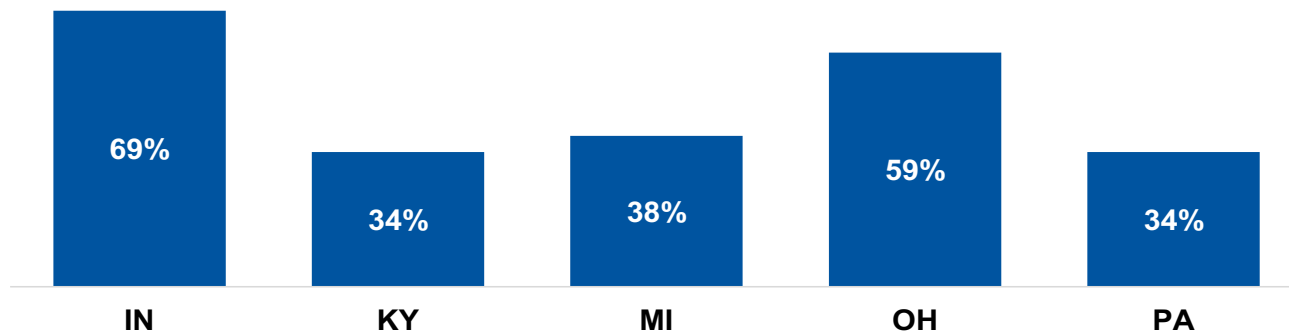
Average Negotiated Commercial Rate as a % of Medicare

CT of the Head/Brain without Contrast (70450)



Average Negotiated Commercial Rate as a % of Billed Charges

CT of the Head/Brain without Contrast (70450)



Data source: Turquoise Health Co.

Price Analysis



- Show how prices (billed charges) vary across markets
- Billed charges by state:

CT of the Head/Brain without Contrast (70450)

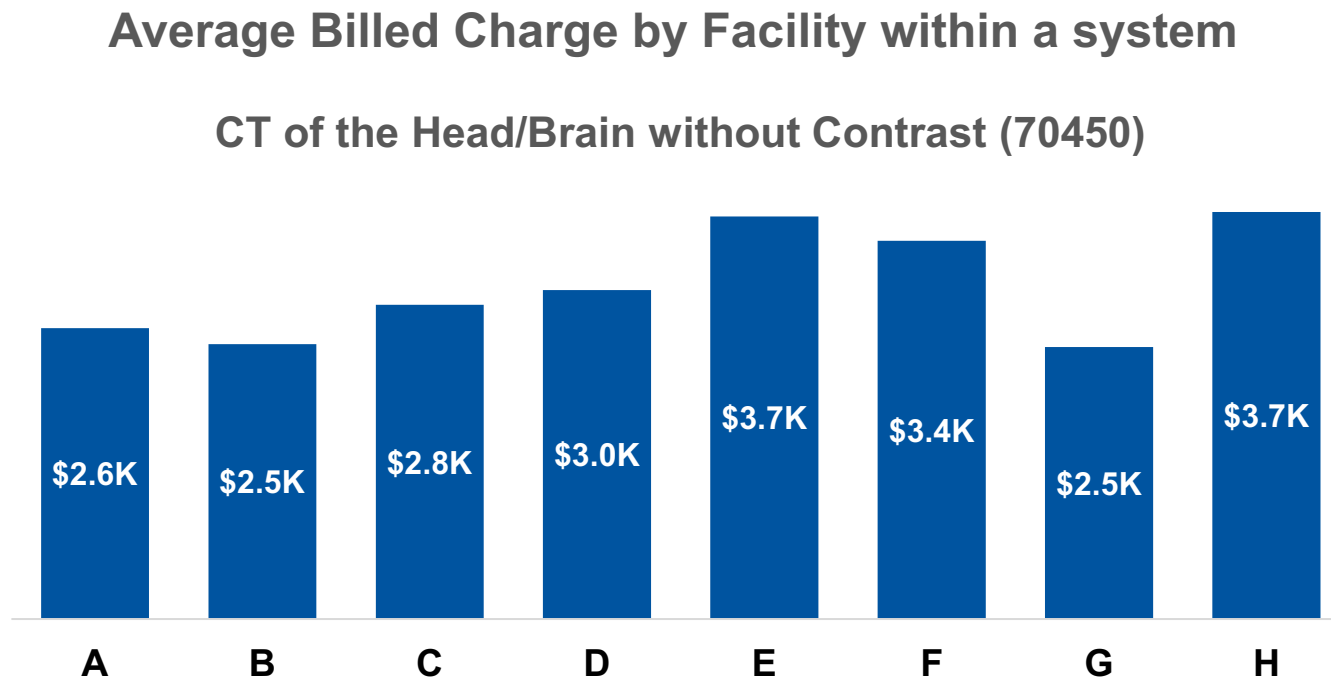
State	Low	High	Median	Average
KY	\$336	\$6,103	\$1,857	\$1,826
PA	\$94	\$6,318	\$1,622	\$1,672
OH	\$196	\$4,893	\$1,239	\$1,272
IN	\$108	\$3,397	\$837	\$957
MI	\$157	\$2,942	\$234	\$779

EKG 12-lead (93005)

State	Low	High	Median	Average
KY	\$20	\$1,031	\$301	\$300
PA	\$15	\$1,131	\$194	\$285
IN	\$2	\$519	\$251	\$266
OH	\$27	\$668	\$171	\$189
MI	\$7	\$393	\$71	\$91

Data source: Turquoise Health Co.

- Show how prices vary within a hospital or across a single system

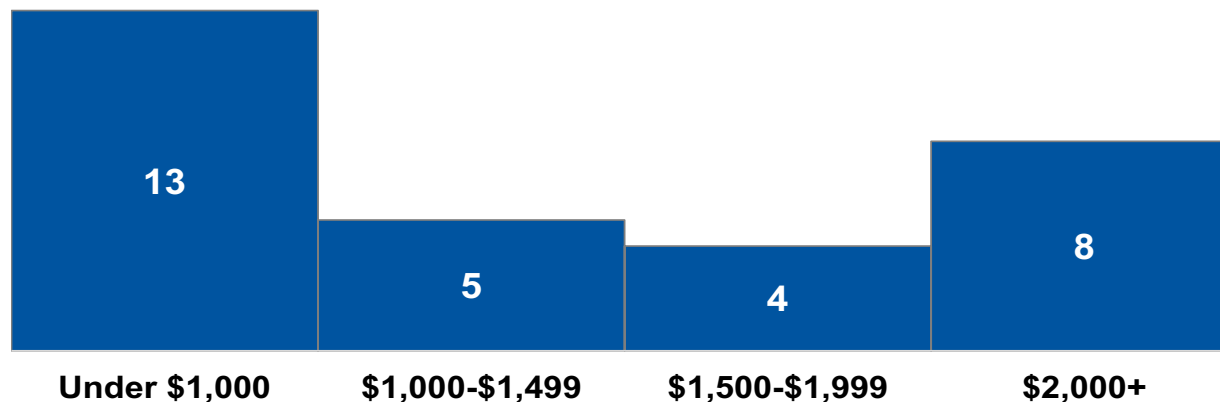


Data source: Turquoise Health Co.

- Allow for the identification of lower-priced providers
 - Good faith estimate for self-pay “shoppers”
 - GoodBill, as reported in *Crain’s Detroit Business*
 - Initially COVID tests only
 - Allows consumers to compare prices

Hospital Billed Charges Histogram (Detroit, MI)

CT of the Head/Brain without Contrast (70450)



Data source: Turquoise Health Co.

- Show how negotiated rates vary across markets
 - Data could be used by plans or providers in future negotiations
 - Use in Independent Dispute Resolution process

Negotiated rates by state for Pneumonia (DRG 195)¹

State	Minimum	Maximum	Average
IN	\$3,893	\$17,977	\$9,907
KY	\$4,108	\$19,913	\$8,935
MI	\$3,987	\$13,645	\$8,085
OH	\$4,734	\$10,381	\$7,534
PA	\$3,523	\$17,043	\$7,187

¹Filtered for commercial payers

Data source: Turquoise Health Co.

Rate Analysis – Indiana



Shoppable Service

195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

Negotiated Rate:

Minimum	Maximum	Average
\$3,893	\$17,977	\$9,907

State:
 Payer Name:
 Code Type:

Service:
 Confidence Interval: -

Shoppable Service Summary (Negotiated Rate)

● Aetna ● BCBS ● Cigna ● Humana ● Other Payers ● UHC



Data source: Turquoise Health Co.

Rate Analysis – Kentucky



Shoppable Service

195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

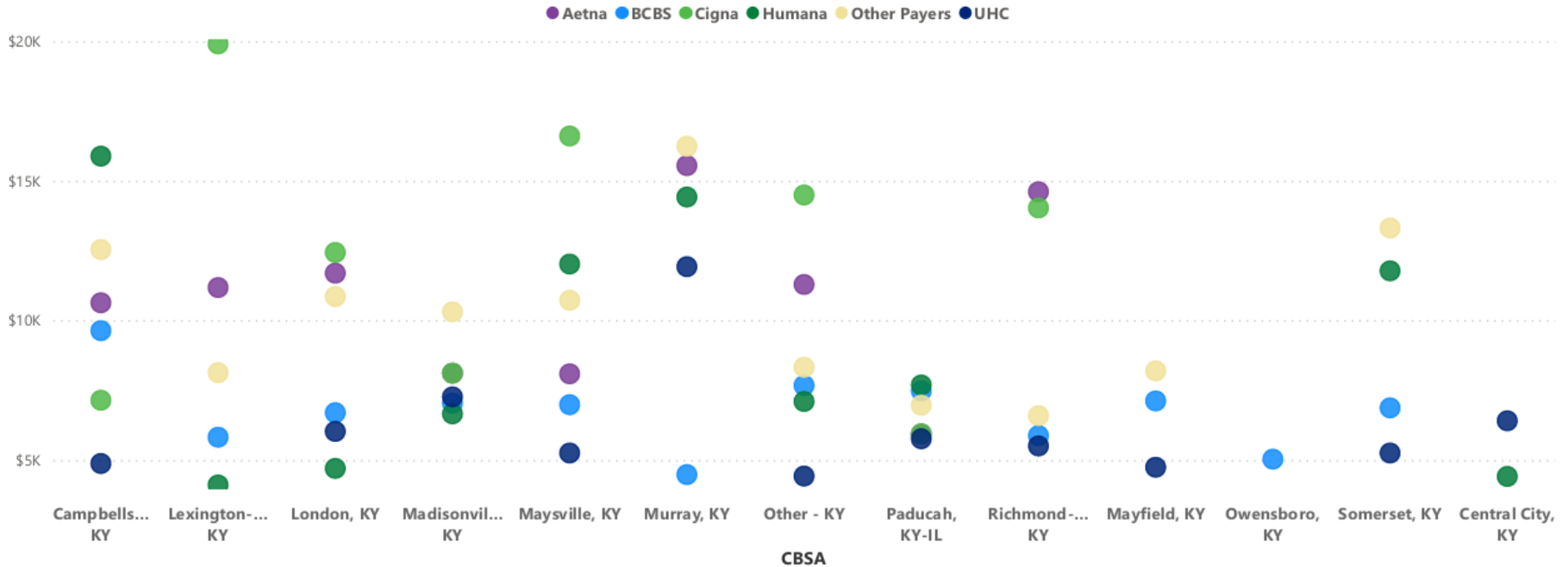
Negotiated Rate:

Minimum	Maximum	Average
\$4,108	\$19,913	\$8,935

State:
 Payer Name:
 Code Type:

Service:
 Confidence Interval: -

Shoppable Service Summary (Negotiated Rate)



Data source: Turquoise Health Co.

Rate Analysis – Michigan



Shoppable Service

195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

Negotiated Rate:

Minimum	Maximum	Average
\$3,987	\$13,645	\$8,085

State: Michigan
 Payer Name: All
 Code Type: All
 Service: Pneumonia
 Confidence Interval: 0 to 85

Shoppable Service Summary (Negotiated Rate)



Data source: Turquoise Health Co.

Rate Analysis – Ohio



Shoppable Service

195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

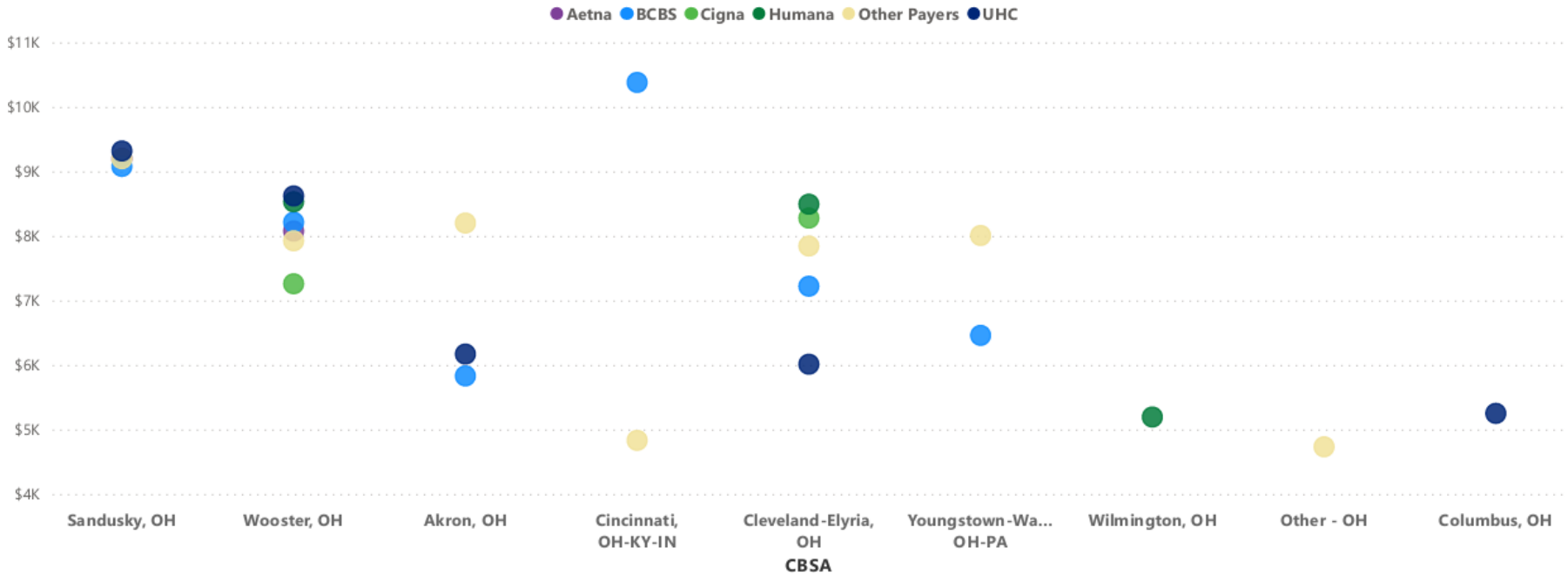
Negotiated Rate:

Minimum	Maximum	Average
\$4,734	\$10,381	\$7,534

State:
 Payer Name:
 Code Type:

Service:
 Confidence Interval: to

Shoppable Service Summary (Negotiated Rate)



Data source: Turquoise Health Co.

Rate Analysis – Pennsylvania



Shoppable Service

195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

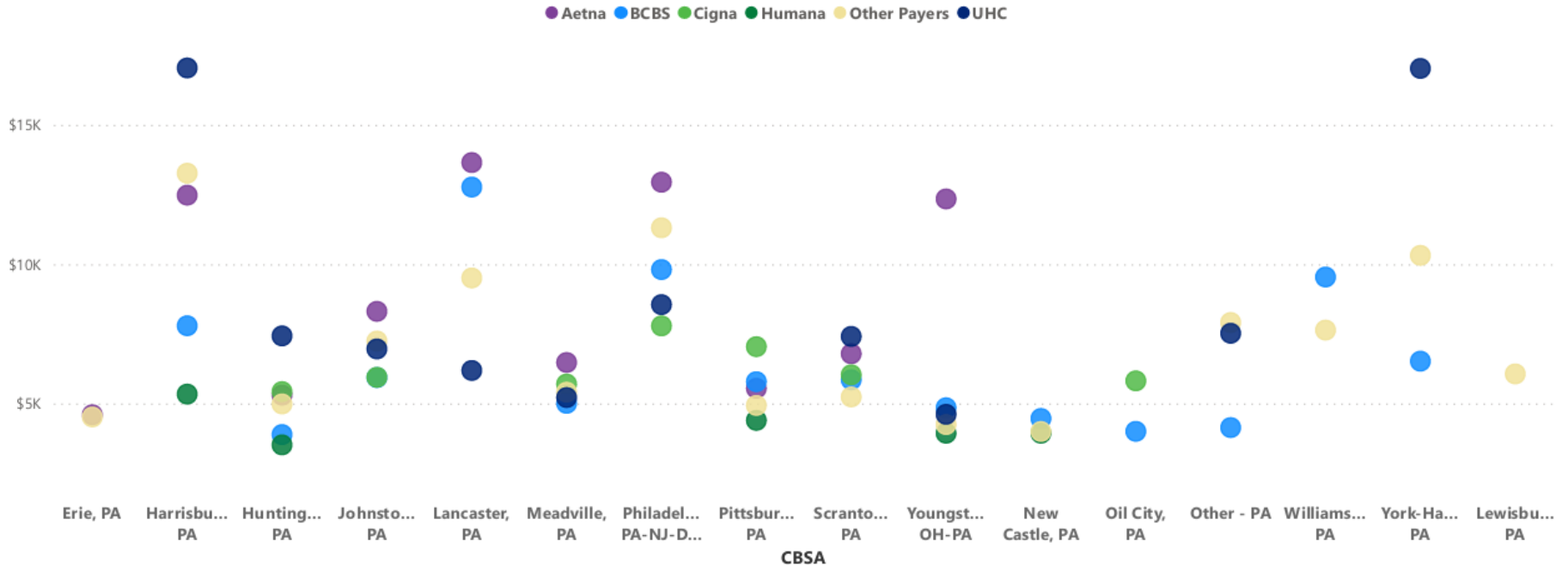
Negotiated Rate:

Minimum	Maximum	Average
\$3,523	\$17,043	\$7,187

State:
 Payer Name:
 Code Type:

Service:
 Confidence Interval:

Shoppable Service Summary (Negotiated Rate)



Data source: Turquoise Health Co.

- Show the comparison of negotiated commercial rates in urban vs. rural areas
 - Question of financial pressures on rural areas

Negotiated rates by state for Pneumonia (DRG 195)

	Average		
State	Urban	Rural	Rural/Urban
PA	\$8,471	\$5,627	66%
IN	\$11,321	\$10,971	97%
MI	\$7,855	\$7,945	101%
KY	\$8,234	\$9,189	112%
OH	\$7,075	\$8,095	114%

	Median		
State	Urban	Rural	Rural/Urban
PA	\$6,981	\$5,705	82%
IN	\$11,987	\$11,180	93%
MI	\$7,480	\$7,757	104%
OH	\$6,795	\$8,441	124%
KY	\$4,184	\$9,058	216%

Rate Analysis – Kentucky



Shoppable Service

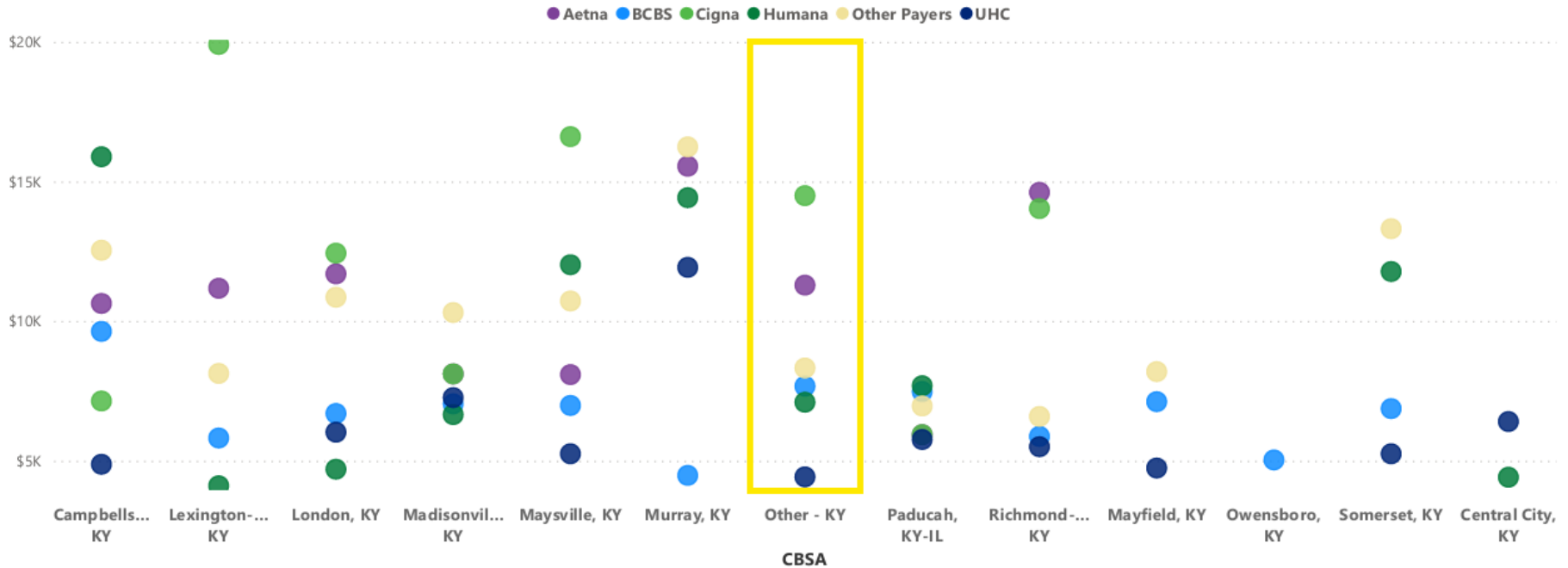
195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

Negotiated Rate:

Minimum	Maximum	Average
\$4,108	\$19,913	\$8,935

State: Kentucky | Payer Name: All | Code Type: All
 Service: Pneumonia | Confidence Interval: 0 - 85

Shoppable Service Summary (Negotiated Rate)



Data source: Turquoise Health Co.

Rate Analysis – Ohio



Shoppable Service

195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

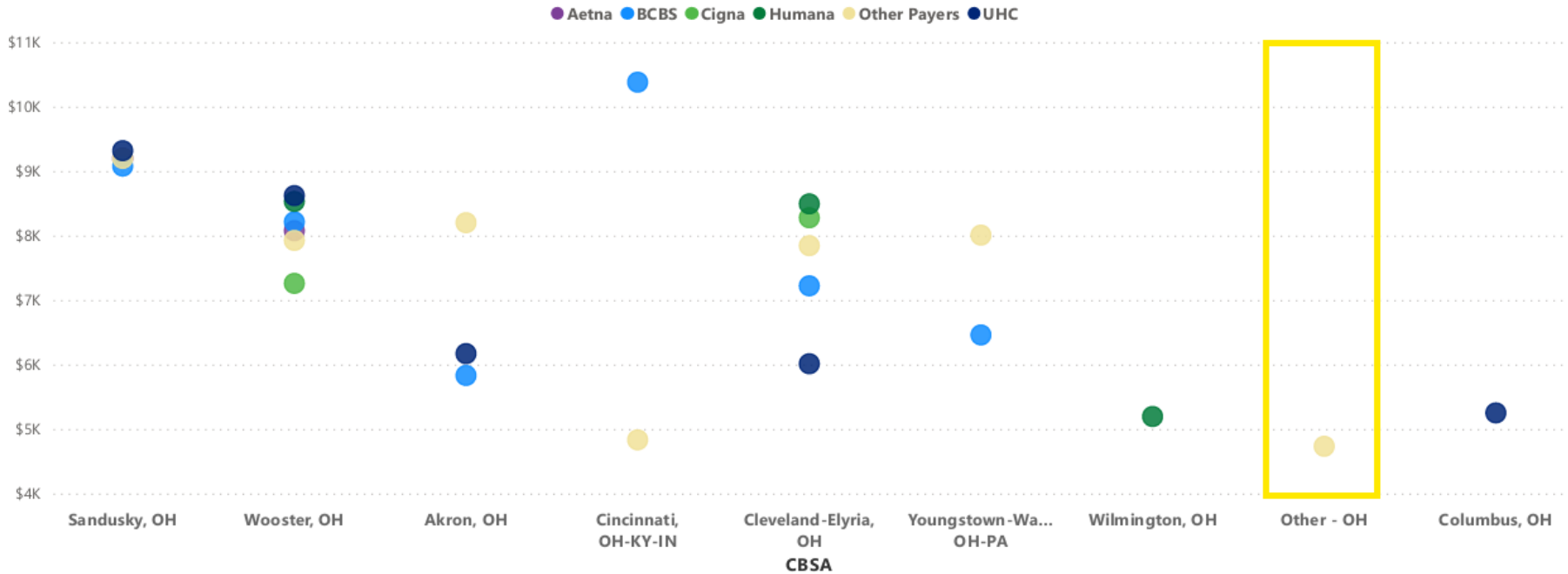
Negotiated Rate:

Minimum	Maximum	Average
\$4,734	\$10,381	\$7,534

State:
 Payer Name:
 Code Type:

Service:
 Confidence Interval: to

Shoppable Service Summary (Negotiated Rate)



Data source: Turquoise Health Co.

Rate Analysis – Pennsylvania



Shoppable Service

195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

Negotiated Rate:

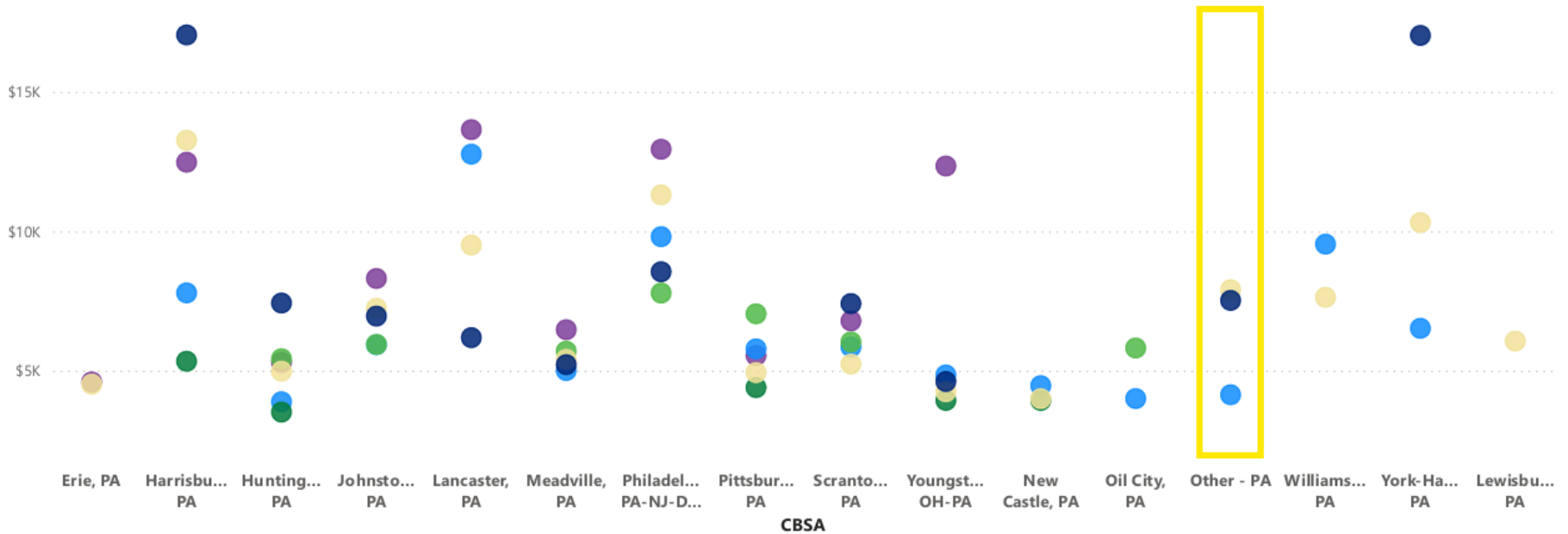
Minimum	Maximum	Average
\$3,523	\$17,043	\$7,187

State:
 Payer Name:
 Code Type:

Service:
 Confidence Interval: to

Shoppable Service Summary (Negotiated Rate)

● Aetna
 ● BCBS
 ● Cigna
 ● Humana
 ● Other Payers
 ● UHC



Data source: Turquoise Health Co.

■ Pricing and rate analysis



Payer Pricing
Detail

Shoppable Service

470 - Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (MCC).

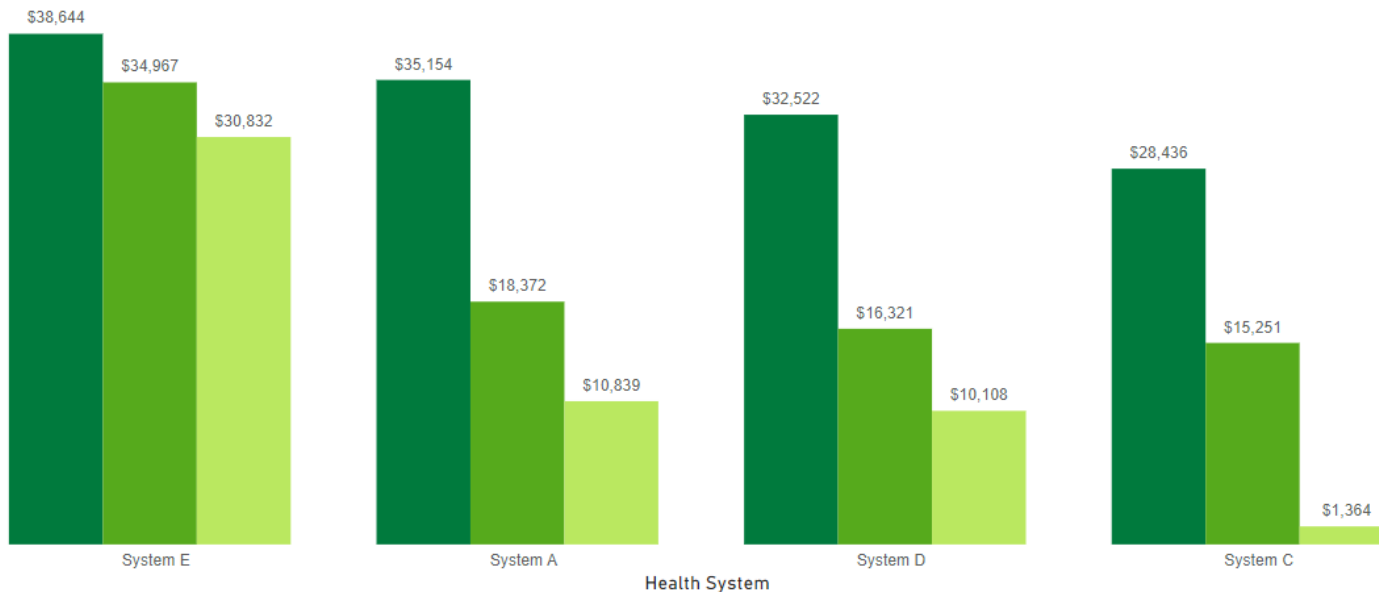
Health System: All | Facility: All | Payer Class: Commercial | Payer Group: All

Code Type: MSDRG | Shoppable Service Category: All | Shoppable Service: 470 - Major joint replacement or reattachment of lower extremity wit...

System Pricing Summary (Negotiated Rates)

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● Maximum ● Average ● Minimum



Data source: Turquoise Health Co.

Peer Analysis – Children’s Hosp



Payer Pricing Detail

Selected Service

195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC (26)

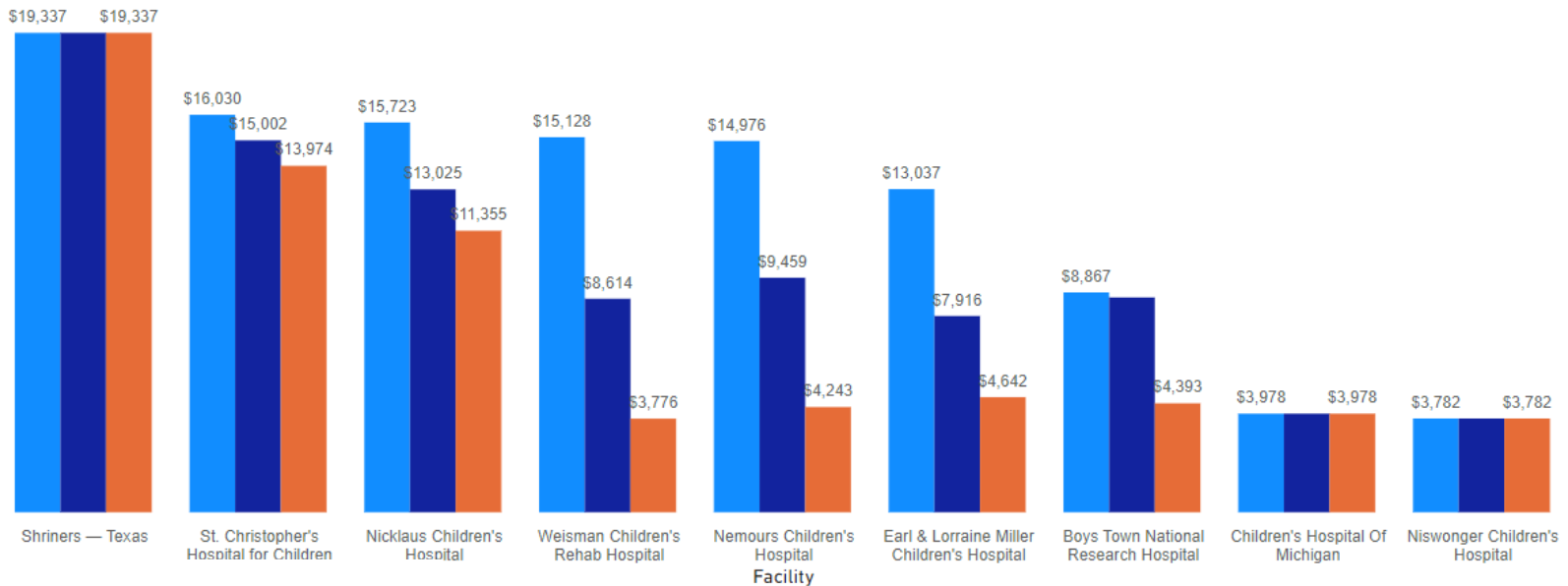
Service Category: All | Facility Name: All | State: All | Payer Name: All

Payer Class: Commercial | Code Type: MSDRG | Service Description: 195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC (26)

Region: Midwest | Northeast | South | West | >100 Occurrences: No | Confidence Interval: 0 to 85

System Pricing Summary (Negotiated Rates)

● Maximum ● Average ● Minimum



Data source: Turquoise Health Co.

Questions

Visit our Public
Negotiated Pricing
Dashboard for your
state:



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