



HEALTHCARE REGULATORY ROUND-UP #38

# Hospital Price Transparency – Where Do We Go From Here?

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November 1, 2022

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WE ARE AN INDEPENDENT MEMBER OF HLB—THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

# Introductions

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# Agenda



1. Regulatory Requirements
2. Compliance and Enforcement
3. Pressures on Hospital Charges
4. Using the Data – Hospital Price and Rate Analysis

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# 1. Regulatory Requirements

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# #1 - Standard Charges



- For each hospital location, generate and *update annually* machine-readable file (MRF) listing each individual item and service and service package for which there is established standard charge
  - List common billing and accounting codes, if available
  - Includes services furnished by employed physicians and NPPs
- For each item or service or service package, list 5 standard charges, as applicable
  1. Gross charge (no discounts)
  2. Discounted cash price
  3. Payer-specific *negotiated* charges
  4. De-identified minimum negotiated charge
  5. De-identified maximum negotiated charge
- No barriers to access
  - Free of charge, no account or password required
  - No PHI required to access

## #2 - Shoppable Services



- For each hospital location, generate and update annually charges for at least 300 shoppable services including 70 CMS-specified services
  - Plain language description of service
  - Discounted cash price (or gross charge)
  - List of payer-specific negotiated charges (associated with name of 3<sup>rd</sup> party payer and plan)
  - De-identified minimum and maximum negotiated charges
- Post prominently on website in consumer-friendly format with no barriers to access (e.g., fees, registration)

## #2A – Price Estimator Tool

In lieu of posting standard charges for shoppable services, hospital may maintain internet-based price estimator tool

- Provides consumer with expected out-of-pocket liability for 70/300 shoppable services based on insurance coverage
- Prominently displayed on hospital's website with no barriers to access (e.g., fees, registration)
- Updated annually

Most hospitals utilizing price estimator tools instead of posting charges

# No Surprises Act - Good Faith Estimate

- Healthcare facilities and providers must provide GFE to self-pay patient when -
  - 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 (regardless of request for pricing information)
- Written GFE must include specific information regarding services to be provided by convening provider (responsible for scheduling) and co-providers (effective 01/01/23)
  - Refer 'shopper' to price estimator tool?
  - Use tool to obtain co-provider pricing?



# Transparency In Coverage (TiC)



- Effective July 1, 2022, plans and issuers must post and update monthly two separate MRFs on public website
  - In-network rates for covered items and services
  - Out-of-network allowed amounts and billed charges for covered items and services
- Effective January 1, 2023, plans and must provide members with real-time benefit cost estimator tools to compare out-of-pocket costs for covered in-network and out-of-network services

# Advanced Explanation of Benefits



- AEOB requirements
  - For individuals enrolled in plan or coverage, providers and facilities must provide plan or issuer with GFE of expected charges for furnishing scheduled item or service
  - Within one business day of receiving GFE, plan or issuer must provide individual with advanced explanation of benefits
- Agencies deferred enforcement until standards for data transfer could be established and infrastructure developed
- On September 16, agencies published request for information regarding AEOB requirements; responses due November 15
  - Technical challenges
  - Economic impact

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## 2. Compliance and Enforcement

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## Semi-Annual Hospital Price Transparency Compliance Report

Report Date	Hospitals Reviewed	Compliant Hospitals	Percentage Compliant
<b>August 2022</b>	<b>2,000</b>	<b>319</b>	<b>16.0%</b>
February 2022	1,000	143	14.3%
July 2021	500	28	5.6%

- 95% of hospitals posted some pricing information
- Hospital non-compliant if failed to meet any specific regulatory requirement

### Examples of non-compliance

- Incomplete pricing information (use of price ranges, formulas, blank fields, N/A)
- Discrepancies between machine-readable files and shoppable services
- Failure to include negotiated rates for specific plans
- Barriers to access
  - PRA: “We were also blocked by barriers such as the collection of personal information and specific plan identification needed for input to receive an estimate. The rule, however, mandates that hospitals enable access to prices without having to submit personally identifiable information.”
  - CMS: “In the Hospital Price Transparency Final Rule, we specifically did not include a requirement that no PII be collected because we recognize that insurance information may be necessary to provide patients with real-time personalized OOP price estimates.”

# Turquoise Health Price Transparency Impact Report – Q3 2022



## TURQUOISE TRANSPARENCY SCORECARD

*\*short-term acute hospitals only*

Bed Quantity	★★ "Partially Incomplete"	★★★ "Partially Complete"	★★★★ "Mostly Complete"	★★★★★ "Complete"
0–25 Beds	161	68	261	573
26–99 Beds	122	80	221	482
100–249 Beds	135	59	198	670
250+ Beds	126	102	290	539
<b>TOTAL</b>	<b>544</b>	<b>309</b>	<b>970</b>	<b>2264</b>
<b>% of Total</b>	<b>13%</b>	<b>8%</b>	<b>24%</b>	<b>55%</b>

Available at [https://s3.us-west-1.amazonaws.com/assets.turquoise.health/impact\\_reports/TQ\\_Price-Transparency-Impact-Report\\_2022\\_Q3.pdf](https://s3.us-west-1.amazonaws.com/assets.turquoise.health/impact_reports/TQ_Price-Transparency-Impact-Report_2022_Q3.pdf)

# Federal Enforcement Activity



- CMS monitors compliance by reviewing complaints and auditing hospital websites
  - Provide written warning notice specifying violation
  - Request Corrective Action Plan if noncompliance constitutes material violation of one or more requirements
  - Impose a civil monetary penalty - \$300/day for  $\leq 30$  beds; \$10 x # of beds/day for 31-550 beds; \$5,500/day for 551+ beds
- Action to date
  - In June 2022, imposed ~ \$1 million in CMPs against Atlanta's Northside Hospital
- OIG Work Plan (September 2022)
  - “we will ...statistically sample hospitals to determine whether CMS's controls are sufficient to ensure that hospital pricing information is readily available ... .”
  - if hospitals are not in compliance ... we will contact the hospitals to determine the reason for noncompliance and determine whether CMS identified the noncompliance and imposed consequences on the hospitals.”

# State Enforcement Activity



- Texas Health & Human Services Commission (guidance issued 09/22/22)
  - Per SB 1137, Commission will monitor hospitals' compliance with transparency rules and impose penalties on those that fail to implement corrective action plans
    - \$10/day for hospitals with gross revenue < \$10 M; \$100/day if gross revenue between \$10M and \$100M; \$1,000/day if gross revenue more than \$100M
- Colorado
  - Effective 08/10/22 (02/15/23 for CAHs), hospital cannot use debt collectors, file negative credit reports against patients, or obtain state court judgments for outstanding debts if hospital not compliant with all federal price transparency laws
  - Patient can sue hospital if hospital pursues collection action against patient and patient believes hospital not in material compliance with price transparency laws on date of service
    - Penalty equal to amount of total debt + attorneys' fees and costs; remove information impacting patient's credit report

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## **3. Pressures on Hospital Charges**

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“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 2022 Report to Congress available at <https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>

# RAND Report on Hospital Prices



*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.*

RAND Corporation, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative (May 2022), available at [https://www.rand.org/pubs/research\\_reports/RR1144-1.html](https://www.rand.org/pubs/research_reports/RR1144-1.html)

# National Alliance for Healthcare Purchaser Coalitions



*Getting to Fair Price: A Playbook for Employers/Purchasers and Regional Business Coalitions on Health (September 2022)*

As plan sponsor fiduciaries, employers must demand fair prices

National Academy for State Health Policy found hospitals' commercial breakeven averaged 127% nationally (accounting for any subsidies required for Medicare, Medicaid, and uncompensated care and expenses not recognized as eligible under Medicare)

“Employers must expect health plans and hospitals to shift from the current hospital payment system to one that is based on a reasonable multiple of Medicare or another similar benchmark.”

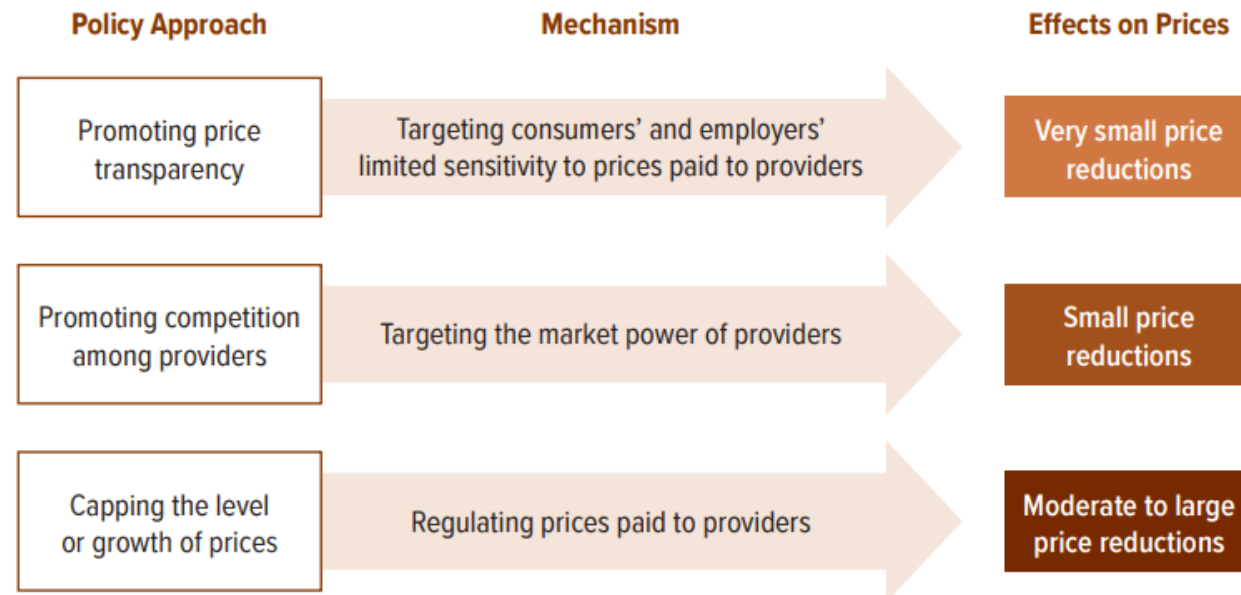
“If market pressures cannot bring this in line, then policy-based corrections (regulations) should be considered. This is especially the case in which monopolies or providers with market power have raised prices above a reasonable level.”

Available at <https://connect.nationalalliancehealth.org/viewdocument/beyond-hospital-transparency-getti>

# Congressional Budget Office



## *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services (September 2022)*



Available at <https://www.cbo.gov/publication/58222>

NC hospitals claimed \$3.1B shortfall on Medicare patients but cost report data shows they “actually reaped a total of \$87 million in Medicare profits”

**OVERCHARGED**  
NORTH CAROLINA HOSPITALS  
PROFIT ON MEDICARE

NORTH CAROLINA STATE HEALTH  
PLAN FOR TEACHERS AND STATE  
EMPLOYEES

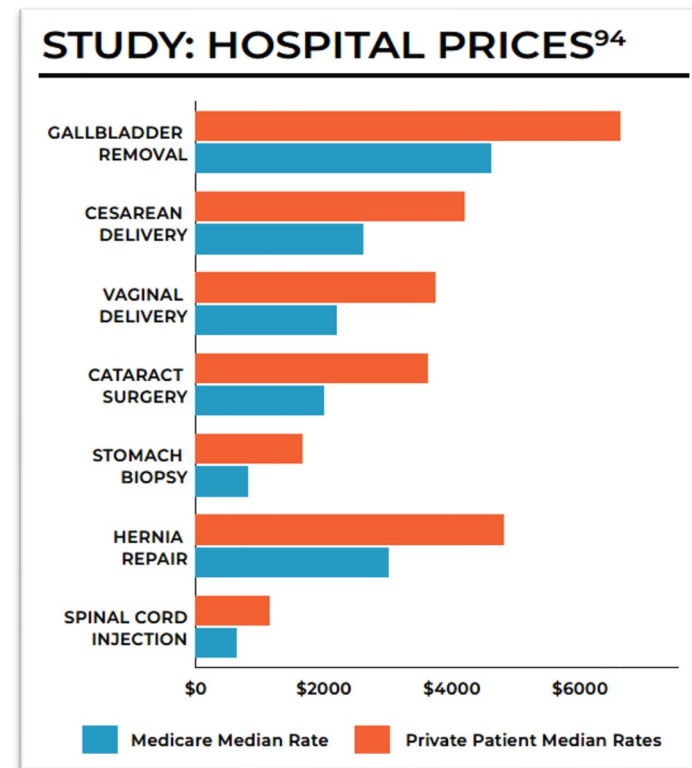
RICE UNIVERSITY'S BAKER INSTITUTE  
FOR PUBLIC POLICY

UNIVERSITY OF SOUTHERN  
CALIFORNIA'S SOL PRICE SCHOOL OF  
PUBLIC POLICY

North Carolina  
State Health Plan  
FOR TEACHERS AND STATE EMPLOYEES  
A Division of the Department of State Treasurer

John A. Fowell, CPA  
DALE R. FOWELL, CPA

RICE UNIVERSITY'S  
BAKER INSTITUTE  
FOR PUBLIC POLICY



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# 4. Using the Data – Price and Rate Analyses

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# Reporting Improvements – EKG 12-Lead Comparison

## EKG 12-lead (93005)

	A	B	C = A - B
	Max Charge		
State	June 2022	September 2022	Difference
CA	\$5,402	\$1,089	\$4,313
SC	\$4,722	\$1,048	\$3,674
TX	\$3,174	\$1,126	\$2,048
OK	\$2,879	\$931	\$1,948
MN	\$1,529	\$611	\$918
TN	\$1,917	\$1,103	\$814
NV	\$1,366	\$1,132	\$234

Data source: Turquoise Health Co.

# Price Analysis – CT Scan

CT Scan of the Head/Brain without Contrast (70450)

State	Low	High	Median	Average
NJ	\$471	\$4,623	\$3,023	\$2,843
TX	\$446	\$7,898	\$3,049	\$2,770
NV	\$727	\$5,659	\$2,000	\$2,492
CA	\$487	\$7,450	\$2,211	\$2,417
OK	\$576	\$4,303	\$2,276	\$2,302
TN	\$688	\$5,334	\$2,437	\$2,282
IL	\$568	\$5,566	\$2,073	\$2,101
SC	\$450	\$6,534	\$2,210	\$2,070
VA	\$631	\$4,781	\$2,010	\$2,030
NY	\$339	\$4,426	\$1,869	\$1,888
AR	\$429	\$4,327	\$1,516	\$1,878
WA	\$569	\$4,309	\$1,620	\$1,720
HI	\$95	\$3,050	\$1,726	\$1,676
LA	\$511	\$4,324	\$1,503	\$1,552
OH	\$648	\$2,968	\$1,250	\$1,492
IN	\$312	\$3,397	\$1,112	\$1,287
MI	\$469	\$2,943	\$909	\$1,111
MN	\$329	\$2,302	\$873	\$1,089

Data source: Turquoise Health Co.

\*As of September 2022



# Price Analysis – EKG 12-Lead

## EKG 12-lead (93005)

State	Low	High	Median	Average
NV	\$154	\$1,132	\$384	\$550
TX	\$95	\$1,126	\$458	\$447
CA	\$93	\$1,089	\$407	\$424
NJ	\$161	\$1,032	\$561	\$421
TN	\$112	\$1,103	\$429	\$372
SC	\$98	\$1,048	\$366	\$369
HI	\$140	\$575	\$325	\$348
IL	\$96	\$949	\$349	\$340
VA	\$89	\$1,184	\$299	\$304
NY	\$56	\$926	\$276	\$301
IN	\$93	\$529	\$251	\$280
AR	\$63	\$966	\$188	\$256
OK	\$87	\$931	\$145	\$244
OH	\$97	\$567	\$213	\$226
LA	\$55	\$872	\$200	\$214
WA	\$64	\$658	\$169	\$197
MN	\$29	\$611	\$143	\$159
MI	\$45	\$393	\$94	\$129

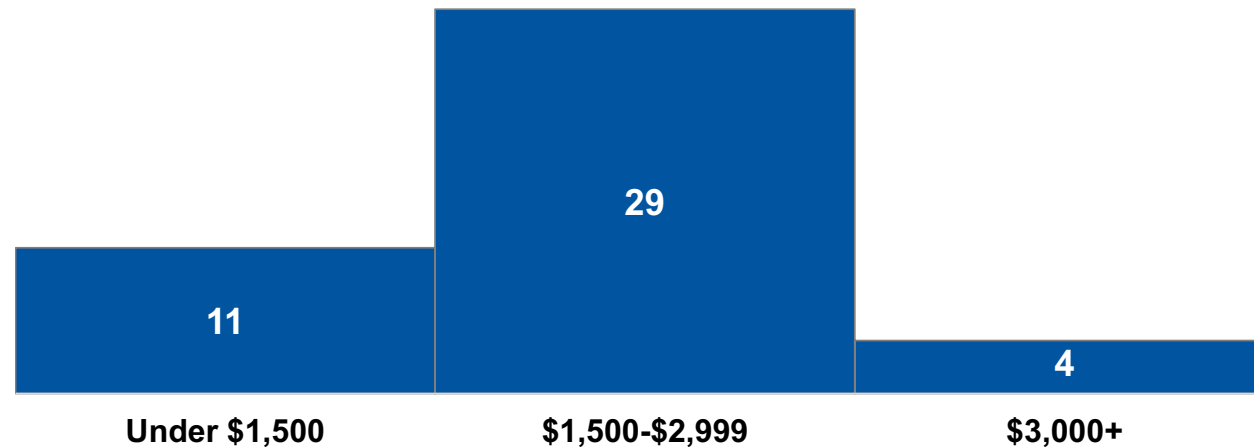
# Price Analysis – CT Scan

Consumer identification of value-priced providers

- Good faith estimate for self-pay “shoppers”
- How far will patients travel for lower prices?

## Hospital Billed Charges – Chicago CBSA

### CT Scan of the Head/Brain without Contrast (70450)



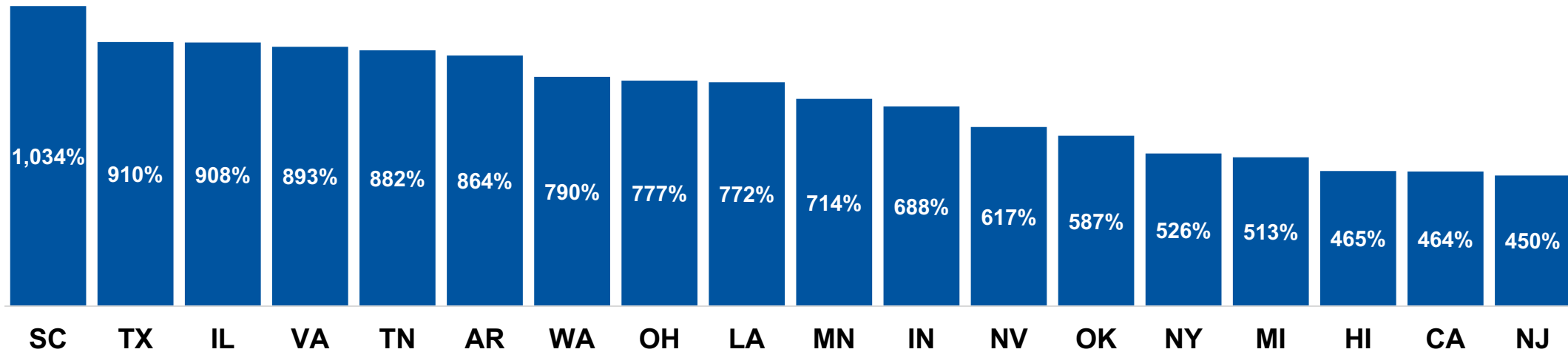
Data source: Turquoise Health Co.

\*As of September 2022

# Rate Analysis



Average Negotiated Commercial Rate as a % of Medicare  
CT Scan of the Head/Brain without Contrast (70450)



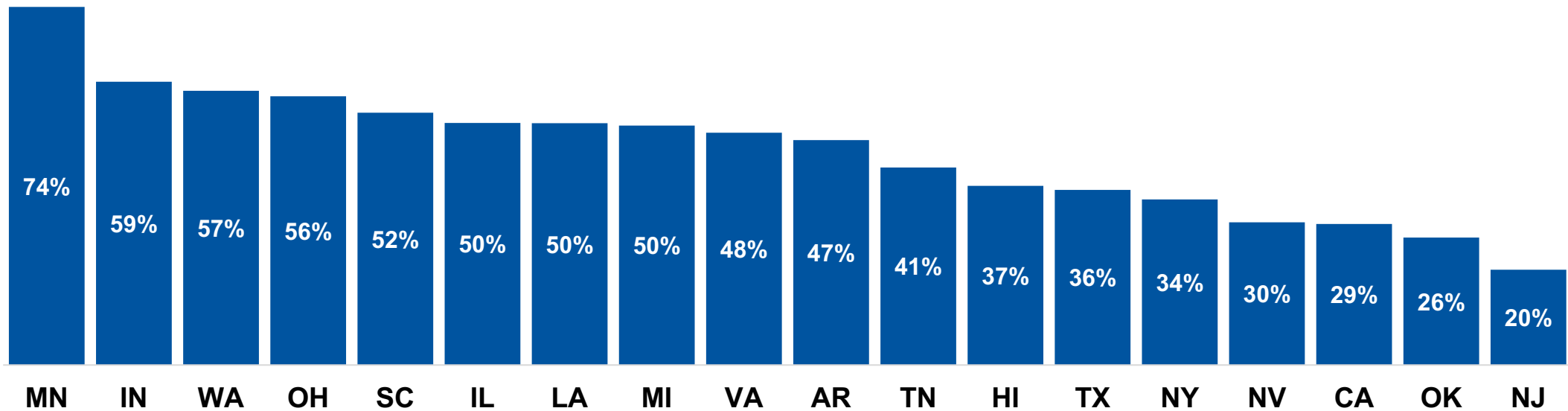
Data source: Turquoise Health Co.

\*As of September 2022

# Rate Analysis



Average Negotiated Commercial Rate as a % of Billed Charges  
CT Scan of the Head/Brain without Contrast (70450)



Data source: Turquoise Health Co.

\*As of September 2022

# Rate Analysis



Significant variation in commercial payer rates across markets

- Use in future payer negotiations

Commercial payer rates by state for Pneumonia (DRG 195)<sup>1</sup>

State	Minimum	Maximum	Average
HI	\$5,063	\$17,680	\$12,924
CA	\$4,800	\$17,778	\$11,588
SC	\$4,014	\$17,753	\$10,926
WA	\$4,809	\$17,105	\$10,533
NY	\$4,046	\$17,312	\$10,054
VA	\$3,980	\$17,863	\$9,609
IN	\$4,066	\$17,529	\$9,446
TN	\$3,969	\$17,810	\$9,356
NV	\$5,303	\$17,762	\$9,328
MN	\$3,962	\$17,330	\$8,798
LA	\$3,995	\$17,670	\$8,701
MI	\$3,987	\$17,805	\$8,279
NJ	\$3,965	\$17,544	\$8,238
TX	\$4,016	\$17,795	\$8,195
OH	\$3,956	\$14,700	\$8,014
OK	\$3,964	\$17,825	\$7,856
IL	\$3,995	\$17,841	\$7,584
AR	\$4,118	\$17,245	\$7,100

Data source: Turquoise Health Co.

\*As of September 2022

<sup>1</sup> Filtered for commercial payers (exclude MA and Managed Medicaid)

# Rate Analysis – Urban vs. Rural



Compare average and median negotiated commercial rates for urban vs. rural hospitals

Average reported negotiated rates for DRG 195 (pneumonia)

State	Average		
	Urban	Rural	Rural/Urban
LA	\$8,363	\$5,998	72%
NY	\$11,682	\$8,717	75%
TX	\$9,163	\$7,273	79%
HI	\$13,262	\$10,900	82%
SC	\$11,334	\$9,774	86%
TN	\$9,853	\$8,764	89%
OH	\$8,195	\$7,608	93%
OK	\$10,723	\$10,335	96%
VA	\$9,852	\$9,721	99%
WA	\$16,105	\$16,510	103%
CA	\$12,564	\$13,449	107%
MN	\$9,277	\$10,145	109%
AR	\$6,842	\$7,485	109%
MI	\$7,674	\$8,895	116%
IN	\$9,204	\$11,203	122%
NV	\$11,196	\$13,855	124%
IL	\$7,540	\$9,618	128%

State	Median		
	Urban	Rural	Rural/Urban
LA	\$8,307	\$4,576	55%
TX	\$8,183	\$6,122	75%
SC	\$10,776	\$8,848	82%
TN	\$8,730	\$7,350	84%
VA	\$9,767	\$8,730	89%
OH	\$8,519	\$8,078	95%
NY	\$8,548	\$8,774	103%
OK	\$7,097	\$7,777	110%
MN	\$8,443	\$9,344	111%
MI	\$7,491	\$8,583	115%
IL	\$6,912	\$8,144	118%
AR	\$5,647	\$6,964	123%
IN	\$8,843	\$11,221	127%
CA	\$8,105	\$10,314	127%
HI	\$10,573	\$13,768	130%
WA	\$11,389	\$19,756	173%
NV	\$7,951	\$16,339	205%

Data source: Turquoise Health Co.

\*As of September 2022

# Rate Analysis – California



## Shoppable Service

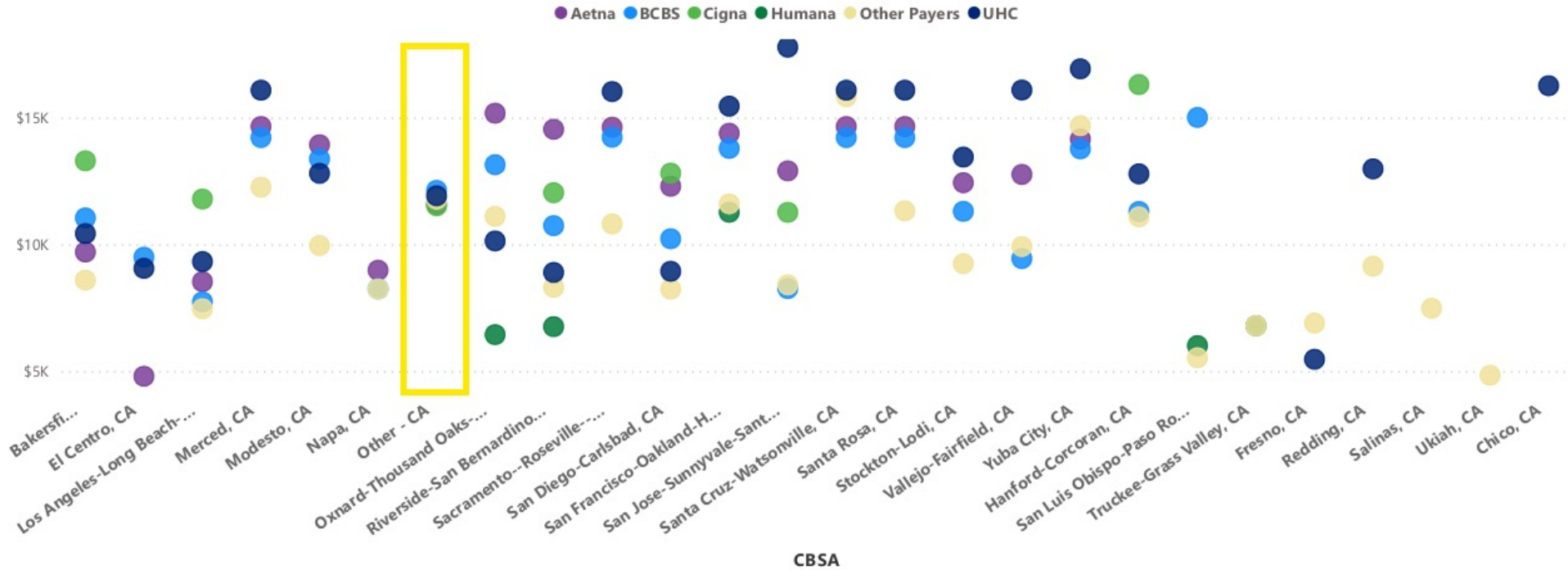
195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

### Negotiated Rate:

Minimum	Maximum	Average
\$4,800	\$17,778	\$11,588

Provider State: CA  
 Payer Name: All  
 Code Type: All  
 Service: SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC  
 Confidence Interval: 0 to 85

### Shoppable Service Summary (Negotiated Rate)



CBSA

Data source: Turquoise Health Co.

\*As of September 2022

# Rate Analysis – Texas



## Shoppable Service

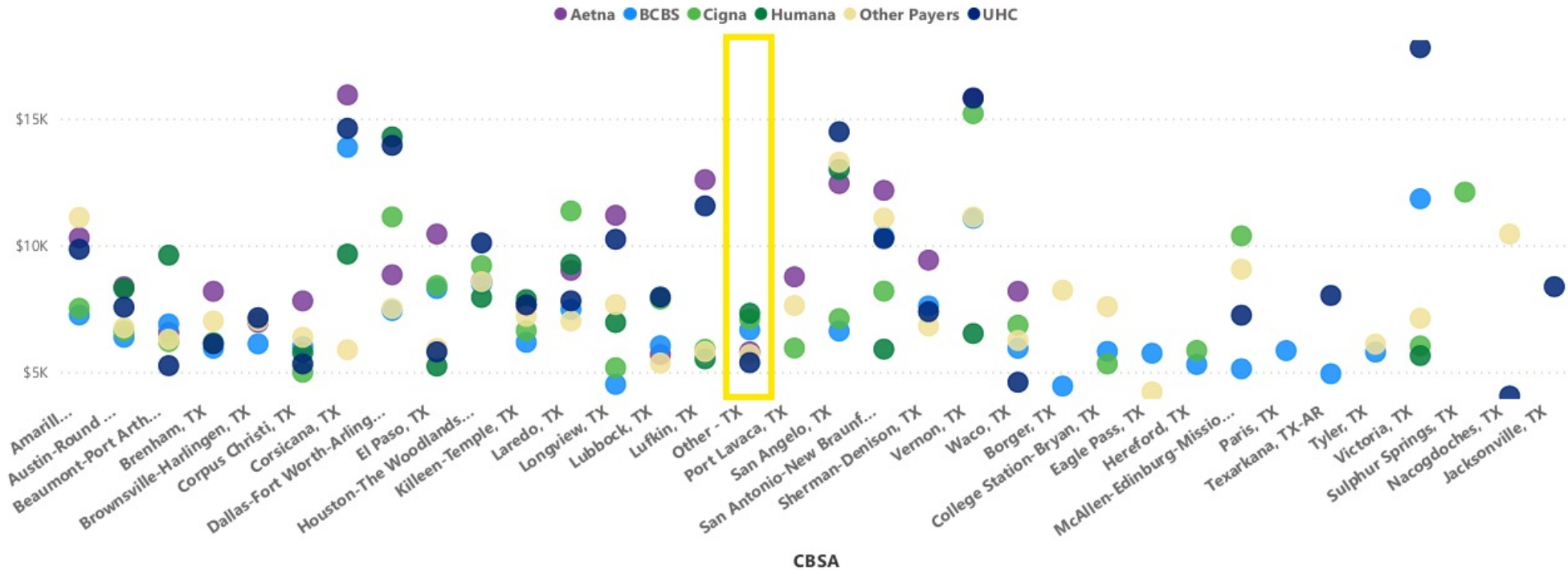
195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

### Negotiated Rate:

Minimum	Maximum	Average
\$4,016	\$17,795	\$8,195

Provider State: TX  
 Payer Name: All  
 Code Type: All  
 Service: SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC  
 Confidence Interval: 0 to 85

Shoppable Service Summary (Negotiated Rate)



Data source: Turquoise Health Co.

\*As of September 2022



# Rate Analysis – Indiana



## Shoppable Service

195 - SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC

### Negotiated Rate:

Minimum	Maximum	Average
\$4,066	\$17,529	\$9,446

Provider State: 
 Payer Name: 
 Code Type:

Service: 
 Confidence Interval:  -

Shoppable Service Summary (Negotiated Rate)



Data source: Turquoise Health Co.

\*As of September 2022

# Peer Analysis



Payer Pricing Detail

### Shoppable Service

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

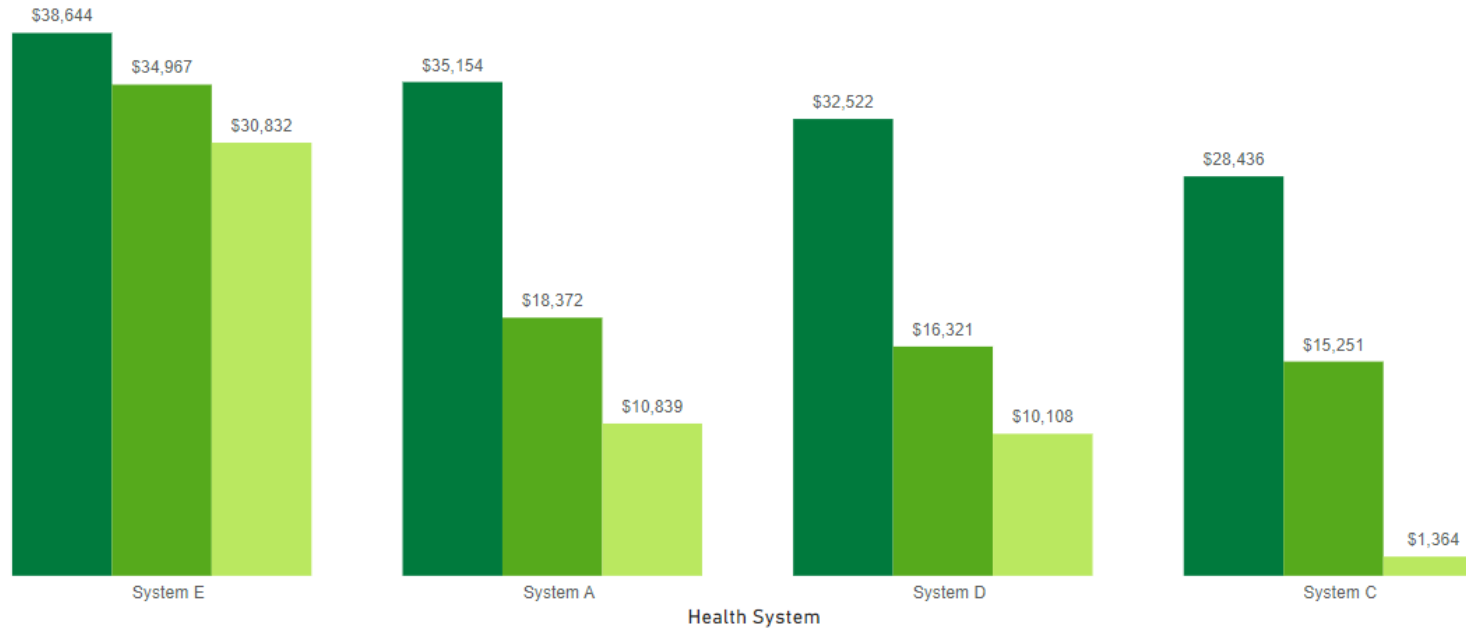
Health System: All | Facility: All | Payer Class: Commercial | Payer Group: All

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

### System Pricing Summary (Negotiated Rates)



● Maximum ● Average ● Minimum



Data source: Turquoise Health Co.

# Final Thoughts

- Review completeness and accuracy of posted price transparency data
  - MRFs consistent with shoppable services; shoppable services consistent with GFEs; consistent with payers' TiC MRFs
  - Use of current contracted rates (vs. historical payments)
- Evaluate and, if appropriate, revise CDM prices given they are now publicly available
  - \$1,528 for an EKG? \$3,561 for a CT scan?
- Consider use of reported price transparency data in payer contract negotiations, IDR process
- Be prepared to respond to public criticism of hospital prices and rates