Hospital Price Transparency – Are You Ready for July 1? – Webinar Transcript

SPEAKERS
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Presented April 24, 2024

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PYA Moderator 00:00
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Kathy Reep 01:08
Thanks, Caitlin. I appreciate that introduction. I'm Kathy Reep with PYA. And my cohort here is Marty Ross and the Kansas City office a little bit about why we're doing this presentation today on something that we're going to be very much emphasizing the requirements for you to be compliant as of July one and also some things that you needed to be compliant with as of January of this year. With top price transparency over and over again, we have always raise that issue. We've done numerous webinars. But in the outpatient rule of 2024 420 24, they are totally going in and revising some of the requirements for hospitals posting, making it much more streamlined standardizing the file format and information, I want to say making it more user friendly, but it's never been intended to be a consumer tool. When we talk about the machine readable file, I'm gonna give you a little bit of background, then we're going to be talking about what the changes are under this new rule, and the enforcement. And then what I'm excited to hear as Marty is going to address the issues of compliance and complaints about non compliance and some of the discussions that have been going on there. So let's start with the new regulatory requirements. But before I can do that, I gotta remind us of where we're supposed to be going the original rules. The original compliance was January 2021. This was as the result of an executive order under the Trump administration that came out in June of 2019. And then the rules themselves were published in the Federal Register for the outpatient proposed rule for calendar year 2020. With an effective date of 2021. When that rule came out, CMS was not prescriptive in terms of

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how we established the file format. They really just said a single machine-readable file, many providers used an Excel Excel type XML spreadsheet to post their information, others used other formats, but there was no prescribed you will use this format. So if you go out and you look at various providers, their data, it's kind of across the board in terms of what the files look like. There was the in the original rules, there were two types of files that needed to be posted the machine readable file, and that included five types of standard charges, charges in quotes, because I know that you don't negotiate charges, you negotiate rates, but in the both the executive order and in the regulations, we're looking at the requirement to post your gross charge, your payer specific negotiated charge, after you go through all of your payers and plans, then you identify your you identify your minimum and your maximum, you post those although they are de identified. You don't say it was this payer, but if you're looking at a spreadsheet, you can probably figure it out. And then also if you have a discounted cash price, you would include that in the file. Those were the requirements that we knew as of January 2021, the other for the machine readable file. We also have and it continues to be in play is a requirement to post up to 300 shoppable services 70 of them identified by CMS. And then additional 300 shoppable services, a total of 300 shoppable services, as long as you provide 300, unique shoppable services, this isn't going to be what is it going to cost me to fix a fracture, it is going to be things that people shop for more in terms of clinic visits, lab test, MRIs, things like that. The both the shoppable services and the machine readable file needed to be updated at least annually. And to identify the date of the last update from now on everything I'm going to talk about addresses only the machine readable file. Yes, well, I want to

Martie Ross 05:57
stop you there. Because just in your experience, this alternative, you had to posting the consumer friendly list of shoppable services was the price estimator tool right? At both whichever hospitals con one way or the other in terms of their preference, it'd be I think,

Kathy Reep 06:12
most hospitals have gone with a price estimator. Because they had a price estimator prior to these rules even coming into place. A price estimator is going to be something that would actually be very useful to the patient, because they're going to go in, they're actually going to put in their insurance information, more identifying information that you would ever require for the machine readable file, or the shoppable services. And then it actually queries their insurance to come back with this is how much you're going to have as an out of pocket liability. Make sense that that is what the consumer is really looking for. I don't know that the machine readable file is in any way ever going to be consumer friendly. And that list of standard charges, again, how consumer friendly, is it? Do I look up a gauze bandage and terms? I mean, do we shop for that? No. Okay, do I look up an MRI? Or do I look up magnetic resonance imaging, how user friendly are those files really, versus if I go in and I access my insurance company, this is my out of pocket liability.

Martie Ross 07:26
And we'll come back to this when we talk about compliance as well as some future legislative changes we may be looking

Kathy Reep 07:32

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absolutely. So again, this new rule is not going to do anything to address the standard, the shoppable services or the price estimator, we are really going to focus now on the machine readable file and the changes that are required to the machine readable file. So with that moving on, there have been a number of new requirements, you can either go into the Federal Register, which is very detailed, or I have to direct you to the git hub site. I have actually started playing around on this and have subscribe to the discussions on GitHub, I'm going to share some of those with you today to actually show you the kinds of things people are asking as they work to become compliant with this, and some of the responses that are being posted in it as well. So if you go out to the data dictionary, GitHub repository, I've given you the link, it's actually going to walk you through all of the requirements to post your transparency information on your website. It's very extensive. We will work on this today as we kind of go through what are they looking for. So most of the requirements are effective July one of 2024. But we did have a couple of requirements that were effective January one, and I urge you to go out and find out if your facility is compliant with those requirements. Today, because again, it's April, and they were effect they were effective January one. So the first is very simple. It's that you make a good faith effort to ensure that the information in your machine readable file is truly accurate as of the date of the file that you've posted. So number one, have you made a good faith effort. This is not any sort of attestation they just want you to make a good faith effort to be compliant. Second, is that you on the footer of your homepage, your website, you include the words price transparency, and that if you click on price transparency, it is going to take you to your machine readable file. I am sure that it's also going to take you to your shoppable service CES or your price estimator, but you must use the words price transparency, it must be on your homepage, you could have it elsewhere. You could, you could have it on a page that says financial assistance. But it's got to also be on the footer of your homepage. The other requirement as of January one, and a lot of hospitals are compliant with this. But every once in a while we find some that are not, you need to have a t x t file, a text file that is located on your website. And that txt file identifies where is the website that hosts your machine readable file, the format for this txt file is what I've given you on this slide, w w w, your hospital's domain name, slash CMS dash H PT dot txt. It doesn't have to be a.com, it could be a.net.org, whatever your domain name is, for your hospital, www dot domain name slash CMS dash H PT dot txt. If you are, if you try that with your domain name, you should get something well hold on. This is actually where you go in and you create your txt file, you're going to put in your location name, it could be that you have multiple campuses. And if you have different contracted rates, different machine readable files for different locations, you are going to indicate all of that information, you are going to indicate the URL for your file. Who is your point of contact? If there are questions about your machine readable file? And what is their email address? When you complete that on this txt file generator, you're going to get something that looks like this General Hospital, the source page, the actual machine readable file, URL, and the entire name of that file, who is my contact? And then what is their email address? This is one thing that I urge you to make a note that somebody has been listed here as your point of contact, make sure that if that person leaves, that this information is updated, because this will be a contact for I have a question about your website. So please make sure that you, you know you if you do this and you monitor it to make sure that it is correct. We have heard that there are some web vendors who cannot post a txt file. There were some complaints or some questions raised with CMS on the GitHub site about what do we do. And CMS has actually said, we're looking at it, we're going to see what we can do. We know it'd be very expensive for hospitals to recreate their websites. So they're going to see what they can do for a workaround for those providers, which again, gets into having that discussion with CMS if there are

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issues. So that is number one requirement. January one of this year, good faith effort, price transparency in the footer and the txt file.

Martie Ross 13:44
Now, just to be clear, that means every hospital should have gone out to that txt generator and completed that for

Kathy Reep 13:52
Absolutely, absolutely. If you put your hospital information in. And, well, I'm going to go this way. If you do this format, and you get paged not found somebody in your organization needs to be looking at getting this information correct. And getting it up very quickly. Again, January one was the requirement for this. All right, now let's talk about what we have to do by July a lot of requirements for July one of this year. All of the information that you have in your machine readable file is going to be encoded it rather than having a loose format with all of your various columns and headers that are kind of loosely aligned as you do on an Excel spreadsheet. What you're going to be do you're going to be doing is using a specific Epic defined format from CMS, they have is essentially device, I approved three formats. One is a comma separated value, CSV wide format, where everything goes wide versus a CSV tall format where things go up and down. Those are your two options for CSV. And then the other would be to use a JSON schema. We actually had some people post questions recently about using a JSON I schema, CMS has come back and has said that is not an appropriate format. So it will not the system will not accept anything other than the CSV wide tall and the JSON schema. Within these formats, you're going to be encoding your hospital name, your license number, the various locations, if you have east, west, north, south, whatever it might be, and the addresses of those locations, you are also going to be encoding your standard charge information this is going to be let's go back to all of those items that you have in your charge master all of your DRGs all of your APCs any way that you bundle services, that someone might look for information at the APC level DRG level. In some states, you're using APJs for Medicaid. So you would also be grouping that way. If you have negotiated contracts at that level. For each of the items and services that you have posted, you're going to identify the location, is this an inpatient service is this an outpatient Is it both think about room and board charges, those are going to be inpatient, you're going to have observation is an outpatient charge. So you're clearly going to go for each of the items in your charge master identifying location, you are also going to have to include all kinds of codes that are used to identify these various services. And before you identify, well, actually after I'll show you the format, after you identify, here's my service, let's say observation and observation has a revenue code, then I'm going to have to put a case RC behind that indicate that that was an RS a revenue code. And then I'm going to also include my CPT code. And behind that, I'm going to have to say that CPT so a lot of information before you ever get to rates. But identifying all of your various codes that you might use that could appear on a claim. For all of your payers and plans. We had a lot of providers originally who just posted, let's say, Humana, and not all the various products that you have contracted with Humana for. So they are making it very clear that for this new format, the required July one format, you have to include the individual payers, and the plans. Each one are separate data elements. The only option around that is if you have a particular payer that has a number of PPO contract products, and you have contracted the same rates for each one, you can then just lump those together and say, All PPO plans, all HMO plans, whatever it might be, if you actually have that scenario within your organization, you are then going to have to once I've got my

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rate, eventually I'm over here and with my rate that I have negotiated with that payer, I am going to have to identify is that a flat rate? Is it a fee schedule amount? Is it a per diem? Is it a percentage was is some type of a formula or algorithm that needs to be identified? So I'm going to give an example of from the previous files, where a particular payer would negotiate a percentage off of the charge. You you're going to have to say charge, percentage, what is my percentage 80. What is the math? So you're going to have to go through the entire calculation of identifying the way they are calculating as well as the outcome of that calculation. Very detailed in terms of what you're going to have to do for it. The algorithms, this is where there is going to be a stoploss, some type of an outlier threshold, something like that, as of in the future, you're going to have to give more detail on that. I'll explain that momentarily. But right now, you're merely identifying that they are going to pay this amount, and it is based upon an algorithm.

Martie Ross 20:22
So before we go on, Kathy has a question for you about coverage. So I I'm the hospital I operate under one NPI. But the hospital then has subsidiaries that are separate NPIs. Are the transparency requirements just applicable at the hospital? Or would it also be applicable to those subsidiaries? For example, if the physician practices were owned under a separate legal entity,

Kathy Reep 20:49
if the hospital bill owns the physician, then they have to be included in your file

Martie Ross 20:56
and the physician practice, right because they can practice or

Kathy Reep 20:59
the individual Yes,

Martie Ross 21:00
but it's a hospital, for example, how to JV for an ambulatory surgery center, what it is, was that

Kathy Reep 21:06
elderly physicians is the way it has been identified.

Martie Ross 21:11
So if you're in an imaging centers separate, for example,

Kathy Reep 21:13
I have, well, if it is under a different license number and provider number, then it would not be included. Okay. Thanks. Yeah, but you might get to that when we talk about what the future holds. Last, but not least for the requirements for July 120 24 is the requirement for you to click a button. And that button is going to be following a compliance statement, that compliance statement reads to the best of its knowledge and belief. This hospital has included all applicable standard charge information in accordance with the requirements of 40 to 45 CFR one 80.5. And the information encoded in this machineable machine readable file is true, accurate and complete as of the date indicated in this file. If

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you click faults, you're not going anywhere, the file is going to go back and say, Please redo until you can hit true, this isn't going anywhere in terms of accepting your file. So recognize you have now attested to the completeness and accuracy of the information you have posted.

Martie Ross 22:27
And you see that Sour Lemon face for me. Because anytime we attest to something, I'm always worried about potential False Claims Act liability, because you are attesting that these are our charges. This is how we performed provide business. And then is there a potential claim down the line when it is determined that your files are not accurate. And

Kathy Reep 22:49
that's why it is so important that remember, one of the first things that you include on this is the you're updating annually, the date that this was updated, please make sure that you really change that date, make sure that you keep that file current on an annual basis. Because again, you are always going to be attesting true to the completeness and accuracy of the file, you've got to make sure that you have updated appropriately that those truly are your rates and your contract rates.

Martie Ross 23:25
And to the extent that you've identified any ambiguity in the process of developing these files, and you've had to make a yes, a decision, we're going to do it this way, as opposed to that way, maintain the documentation of why we did it this way, as opposed to that way, which of course will then give you a defense, if you're ever challenged that the information was inaccurate, you can explain your reasoning for having done it in a certain way, having encountered this ambiguity and reporting.

Kathy Reep 23:52
And also, again, we're gonna get to the Git GitHub discussions in a minute, if you are running into a major issue. You might want to post it out there, not only will you hear from CMS, they respond every day to questions that are posted. But you are also going to get your peers who are working on posting the same information saying this is how I did it. So it's great to see that oops, okay. Oh, it okay, then we have some requirements as of January 120 25, that you need to be aware of a little bit of time allowed on this one. First of all, for those algorithms that you were dealing with, where it's that formula that gets into a stop loss cost, outlier threshold, something like that. You are going to be required to go back and actually put in under the negotiated rate, an estimated allowed amount. So this is where you're actually going to be going back to your remittances and calculating for that particular service. What was Is the allowed amount from that individual payer for that particular service. This is going to be a little bit difficult when you're actually looking at services that you build the entire claim, they didn't pay you on individual items. So hopefully you're the only time you've done a contract that gets into a calculation is when you're at, you're going to be looking at a DRG or an APC or something like that, where you're getting into a cost outlier. So but again, you're going to have to go back and calculate your estimated allowed amount is the average reimbursement in dollars that has been received from that payer in the past for that particular item or service. As of January, you're also for all of your pharmaceutical items going to have to identify the drug unit, and the type of measurement that is being used. So you're going to have to include that on your machine readable file, to clearly delineate different dosages, things like that different ways of providing that medication. And if you have a modifier that impacts your standard

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charge, left, right doesn't tend to impact standard charges, but some other things might, you are going to have to include modifiers, including a description of the modifier, and how it does impact your standard charge. The next couple of slides really walk through all of the bits of information that you are going to have to clearly delineate in your machine readable file, I have given you the name of the the of the item, I have given you the implementation date. But what you see in that middle column is detail if you want to go into 45 CFR one 80.5. And look at each one of these and the exact descriptor of each of the items that that is required. And it's carried over to the next page, because there are so many so many data elements, that you are going to be required to do that affirmation of the machine readable file, that true false is a July 2024 requirement. So this is from a webinar that CMS did in January, I have given you given you in the footer, the link if you want to look at all the slides or replay the webinar. But essentially, this is a shortened version of a CSV comma separated value file, giving you an idea of what it looks like. And then once you do this, what your spreadsheet view of this particular file is going to come up looking like let's take it a step further and show what they have posted on the GitHub site. This is an individual provider. I know this is hard to read, but it's a screenshot from the GitHub web page where you have indicated okay, you see across all of your all of this, all of your headings, but your hospital name, West Mercy Hospital, the last updated date 2020 40701 In this particular format, what is the version you should be using version 2.0 point oh, because this is where we are with CMS in terms of the new versions that we're dealing with. What is the hospital location name? It is West Mercy Hospital West mercy surgical center 12 Main Street Fullerton, California and the zip code everything it being required here. And then is this true and accurate? Yes, it's true. Getting into all of these various formulas and calculations etc. Going through the various items and services hip replacements with behavioral health. Here is the example of treatment or observation room. It is revenue code 762. clearly identifying fine that is revenue code. The location is outpatient Here are the various codes that are associated with that and the rates, they are case rates. They are individual line item rates, etc. There is a negotiated standard charge without surgery without rule out myocardial cardial infarction that is how that case rate was identified, etc. So a lot of information that you are coding now that you were not coding before because all you put before was Aetna. $5,000 Now we're getting into a lot more detail. This is how it's going to come out and look, once you actually do the spreadsheet view, again, West Mercy Hospital, the date of the last update the version, the various addresses, etc. Now we're getting into the various codes, major hip and knee joint replacement or reattachment, D DRG, 470 is 478. That is an MS DRG. Here's the hospital location information, etc. Lots of information that you are going to be posting in a lot more detail than where we are now. I mentioned the GitHub site. And I just want to share with you some of the things that have been posted recently. This particular I noticed that says answered they will tell you what the answer was in a minute. This particular individual raised the question, I have a payer contract that identifies some services, such as PTCA, and coronary surgery by a list of ICD 10 codes, coronary surgeries list is almost 4000 codes long. None of these will have a standard gross charge amount in the reimbursement as a case rates. I'm curious, how should they be handled on the report? It seems excessive to list all 4000 lines individually on the report when the only difference would be the code and it doesn't seem appropriate to list 4000 code types on one lot. CMS, their response I just want you to know was please send us some examples. So they aren't they haven't really gotten to it completely yet that I have seen. But just recognize that we've got this level of detail that are looking that people are looking at, if I have to identify all of the ICD 10 codes associated with this service, how in the world do I do that? And another discussion that was out there was an individual who said a question for clarification, when multiple codes are listed on the same line, does it mean and

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or or it sounds like you want n or the same case rate charge applies to a large set of ICD 10s. etc. And so we get into a discussion of using and versus or, and we actually have an individual come up here, as one of the many consumers of these files, it is very important to be able to reliably interpret the data, clear semantics, if the multiple codes on a row can be interpreted as an or, or then how do we know which one to use. This is getting into the fact that the people who are actually looking at these files are researchers, your competition, etc, other payers. So recognize that even when we get into the GitHub discussions, users of the file, not consumers, but users of the file are coming in and they are identifying this is why I need this to be very, very clear. So recognize that, I urge you to start following the GitHub dialogue. The last thing I wanted to share related to the files is that about two weeks ago, CMS posted an online validator where you can take your CSV tall or wide or your JSON schema, have it all completed, put run it through the validator, and it's going to tell you whether or not that information meets their requirements. That will come back I will tell you this and tell you that you have an error, tell you what it is a lot of people have identified errors with dates and things like that. But it will also come back with warnings. Warnings Don't mean that your file won't be accepted. It merely means like for instance, I have not put in drug units, units of drugs dosages is not required until January of 2025. I haven't put it in it's going to come back and give me a warning that it's missing. You need to you need to fix your errors. You don't have to fix your warnings as of right now. From an enforcement perspective, I think just a reminder, as of right now, what we are looking at from the new enforcement provisions, a couple of things I want to really stress. You're going to have to acknowledge receipt of warning notices a lot of people said under the previous rules, I did not get a notice therefore, but one that I think is very concerning. It requires it could require the hospital to submit additional information, including your contracts. In order to assist in assessing compliance. CMS could actually come to you or a contractor working for CMS could come to you and ask to see your contracts to go in and validate that the information that you have posted is true and accurate. Be prepared that I mean, if they have questions about what you've posted, they could actually want to validate based upon your individual Hospital and the contracts that you have. They will work at a systems level, if there are multiple hospitals within a system, some compliance, some not, they will actually work this more on a system level. And they are going to be very clear about publicizing their enforcement activities, how clear are they going to be? Well, I will show you a slide they have not changed the penalties. As of yet, this could come up this fall when we get the outpatient rule. But in terms of sharing the information, this is a new screen that CMS has now made available, I've given you the link there, you can go through and you can look at the individual hospitals, their locations, and it's going to tell you the results of their review. This is only going to be those hospitals that they have reviewed so far. But as you can see, this particular facility in Phoenix met the requirements when they reviewed that hospital, this particular hospital received a warning notice, so that they have actually move forward with posting the results of their reviews and actions,

Martie Ross 36:36
and calories that's on the CMS data website, which means all of that is downloadable into Excel file so you can manipulate it and have fun with it. For

Kathy Reep 36:45
those who are perhaps listening from a hospital association, you can actually go in and target those hospitals within your state Marty enforcement.

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Martie Ross 36:55
Well, in fact, that's what we did is we downloaded the file and attempted to rationalize the numbers. Although as you see, these don't add up. There's it's not a very clear process of possibly being reviewed action taken by CMS, the end result of that analysis is because it's a snapshot in time. And what is currently posted to the CMS data website is dated through the end of 2023. So we still are data blind as to the first quarter of 2024. But we know that CMS has published 913 warning notices have been sent to the listed contact from the hospital. And we have seen issues with hospitals that did not update the contact information when that role changed in the organization, which created issues with CMS. But at least 930 times CMS saw something in its review of files that it's determined was non compliant and required further action to be taken by the organization. CMS has been separately issued 478 requests for corrective action plan. So yes, there's a warning notice. But when it's a more serious violation, that there's actually a request made for a corrective action plan. So this is going to get into more of a systemic issue that they've identified in their review of files. And this maybe you haven't posted any files, you've only posted your duck posted in the cash rates, for example. So larger systemic issues, 963 closure notices have been issued following the correction of deficiency. So again, you can have a warning notice, and then you can have a corrective action plan. There's two different levels of CMS engagement in the enforcement process. But generally speaking, CMS has close these out, following the resolution of the deficiencies. Then in other reviews, CMS has identified 473 cases that the hospital met compliance. Again, this is not you know, there's over 6000 hospitals. Clearly CMS is working its way through the system to review compliance at this point in time. And it's curious whether, again, are they aggressively pursuing enforcement currently, given the significant change we're gonna see in July as to how these files are organized. And in fact, this process of actually sending your file through a review form, right, so to get to get it validated, that's also going to have an impact on other compliance issues going forward. Now, there Yeah. Next one, we always wonder who's who has reached the point of non compliance, it's resulted in a civil money penalty. And these are already by regulation required to be posted on the CMS website. So you'll see down there the link you can follow to get to these enforcement activity, these enforcement actions to the point that you click the link and it actually gives you the letter imposing the civil money penalty and the payment requirements. The first of these was June of 22. The most recent was issued in September of 23. of the 14 that have been imposed seven remain under review. So when a civil money penalty is imposed by CMS, there is a review process that kicks in automatically. Of the 14 hospitals where action has been taken seven have initiated that review process challenging that decision, or the imposition of the penalty by CMS, these amounts of the CMPs are running from about $57,000 up to $979,000. So significant range in the amount of penalties imposed. And that's because it's significant range of the type of hospital against which these have been imposed. And it is all the way from our small critical access hospitals. That low end penalty, for example, was imposed on a critical access hospital all the way up to academic medical centers. That's where you'd see that nearly million dollar fines being imposed. But the message here is no one is safe from being placed under the microscope. They are reviewing all hospital types that are subject to these rules next slide. comprehensively back in 22, CMS did an assessment of hospital compliance, they did a random selection of 600 selected hospitals to give statistically significant so different types of hospitals included in that sample. They completed their review between September and November. And you see there on the left hand side of your screen the criteria CMS applied in doing its review, they determined 82% of the hospitals they reviewed, had their consumer friendly

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display requirements. So either their shoppable services or their price estimator was in place 82% had met the substance of the machine readable file requirements. And we had 70% of the hospitals that met both requirements. So relatively positive results of this compliance review by CMS, especially given that timeframe, just about a year and a half into the requirement being in place, we find that reported by CMS next slide. Turquoise health has for the last several quarters, I believe Cafe reported on a state of price transparency. So turquoise health is a data analytics firm. They are taking data from hospital websites, their machine readable files, they are evaluating compliance with the rules based on the data that they have downloaded from these hospitals. And then they also are using that data to generate business intelligence. And so through different firms like turquoise health, one can take the reported data on price transparency, and begin using it as a sword to start impacting either negotiations with payers in terms of reviewing of what's going on in your market. And the like is very interesting change in the dynamic. As a result of these price transparency requirements have been for years of years, we've never had conversations about rates between hospitals. In fact, many of hospital association meeting I've been to we'll start with the reading of the disclaimer statement where they talk about we are not talking about price, we are not attempting to collude on price or race or the like. But now, I mean through state action, the federal government requiring us to post this information. It is becoming transparent and can in fact be utilized by hospitals, and payers and third other third parties to begin understanding these different mike mike, mike market dynamics, turquoise health at the beginning of this year, posted sort of their where are things now for beginning to be three years in to these regulatory requirements. And they are comprehensive in their review, since they're looking at effectively all hospitals in the United States. So 600 They have their database at the end of 2023 included 6357 hospitals, I love this 1 billion negotiated rates posted by hospitals. And you see their their report in terms of who has reported machine readable files, how many have reported negotiated rates and the doubt the categories. Obviously, as you get more complex, and the level of reporting they're tracking, and you'll see lower levels compliance by hospitals again, still trying to figure this out was required. Again, as Kathy noted at the beginning of this presentation, we started with these rules in 2020 The 2019 2020 into 2020. The rules are vague. And so it was sort of a feeling your way through the process. There was no GitHub back in 2021, where you could pose these types of questions. And so understandably, there's, when there's subjectivity, there are going to be more issues around compliance. Excellent.

Kathy Reep 45:19
Before you go on, let me just say a couple of things about this. First of all, if you want to go to the turquoise Health website, you can look at their evaluation of your individual hospital, they will give you stars, okay. And the if you then go and you know, you can take a look at it. They will rate your hospital, you can look at the details, what do they think I don't have? All right, what's missing? And if you're concerned that if they say to you don't have this, but you really do, if you just let them know, they'll reevaluate you This is at no charge. So it you know, it's a good public website to look up individual hospitals and their compliance. So if you are concerned with what they're showing for you, I urge you to take a look. The other I wanted to clarify that Buka B U C. H is a Blue Cross united, Cigna, Aetna and Humana, the major payers, so have you reached out reported rates for those organizations? The one that I want to call your attention to right below that is DRG rates. Because let's talk about a critical access hospital who has not negotiated anything at a DRG level? You might have, but if you haven't, would you be posting DRG rates. So that perhaps is one one thing to take a look at when they're saying

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65% compliance, because would critical access hospitals actually be included in that calculation, if they have not negotiated at a DRG basis,

Martie Ross 46:59
and there are 1200 of them. So as a significant impact on that percentage, just to know, Kathy, most recently, turquoise, reported 50% of hospitals receive a five star rating, that's in their view, substantial compliance. And remember, turquoise has an interest in these files being complete, because they want to use this data to influence the market. So the more complete, the more accurate that information, they know, their outputs won't be better. So it's not like they're giving folks an easy pass as they do their evaluation. And you said it's a public website, it's a publicly available website posted by a private company, just to be hired was definitely a for profit, definitely using this data.

Kathy Reep 47:40
But if they if you're a call, and they've given me a four star is because you don't have DRG rates, you might want to contact them and say Hey, okay, might be a good way to make get the numbers up a little bit. But Marty, I don't understand what you're you just shared good news. It's gonna mess his evaluation turquoises evaluation. Then

Martie Ross 48:02
comes patient rights advocate, or pra. Pra has been in this business since the very beginning. This is a public advocacy organization supported by private donations, they have issued a report on a semi annual basis as to the status of hospital compliance. Their most recent report came out in February of 2024. They also like CMS have done sampling. So they're not looking at all 6300 hospitals, they've done a sample of 2000. And they concluded that only about 34.5% of hospitals are fully compliant with the rules. And the reason we've included that map of the United States is because when you go to pra 's website, in their compliance report, you can actually click by state and get the compliance rate by state. So that information is at a more granular level. But and as you see pra has observed actually, I thought this was interesting between July and February, July of 2023 and February 2024, the compliance rate actually went down. That may be a factor of which 2000 hospitals they were looking at during that particular period of time. But you know, the next slide, certainly pra always gets a lot of attention when it publishes this report. They have an excellent media machine. And the healthcare finance management association HFMA has really kind of led the charge and pushing back on pra certainly American Hospital Association is in this mix as well. But they challenge pra primarily saying this is all or nothing compliance versus substantive compliance. And so you're only giving people a comply sticker. Well They've met every single requirement and even CMS as its evaluation has focused on some substantial compliance, primarily appreciating the subjectivity that's still available in the rules. The other criticism leveled against pra is that they will consider a plan non compliant, excuse me a hospital noncompliant if they do not list plan specific rates. As Kathy noted previously, yes, starting on July 1 2024, it is unambiguously clear in the regulations that its payer plan. And of course, you can, again, categorize plans within that payer. But up to this point, I think there's sufficient ambiguity in the rules that really only payers specific rates were required. And again, pra has taken that as Yes, you had to post it the plan specific level, and that's why they're seeing such a higher level of non compliance. There is also conversation in pra A's report on what they call human readable access, versus again, what the actual requirement is machine readable files. And as you look at the PRA report, it's difficult to

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distinguish whether they're talking about the price estimator tool slash shop bubble services, or the MRF and as Cathy noted, the MRF is not intended for human consumption. CMS has said that in their rule, very clearly it is. That's why we have that shoppable file shoppable services as an price estimator option for that purpose. And finally, the last criticism that flip leveled against pra is that they are not transparent regarding their sampling their analysis or validation process. And so whereas CMS has been very, for example, back at 22, when it published this report, it was very clear as to the criteria was applying and how it validated his results. That is not as evident in the PRA criticism of price transparency, compliance. Next slide. Pra is very aggressive. And it is on his website, you will see instructions to consumers on how to shop, they encourage people to shop for services to bring prices down. Back in March, there were some folks here at our shop that were very excited about the Foo Fighters concert in supportive the power to the patients, Kathy and I were like, wait, you sure you want to go have some questions here, but they are definitely bringing in the big guns to sort of bring attention to this issue of price transparency and the importance of price transparency. So it is definitely not to be ignored, the impact they're having on the market. And next slide, please. Importantly, because I think this is the end game. In December of last year, pra took this a step further, they published a report on price variation. So like turquoise using the data to look for trends. Now you have pra taking this data and saying let's look at the variation in different rates, different charges different, you know, cash price information, and they're showing within the same hospital the variation and then even within the same state, I think you'll see more and more of this coming out of pra, because this is their attempt to influence the market by showing, you know, why does it costs so such a different price between this service and that service. And this is again, very appealing to consumers and a story we need to understand how they're telling the story and how appropriately we respond to the story. Excellent. And

Kathy Reep 53:45
on this slide, they're looking not only at your average price, but they're looking at your posted minimums and maximums. So think about that, folks, I mean, make sure that what you're posting on your mins and maxes are appropriate and accurate.

Martie Ross 53:59
And Kathy, you've talked before about the 12 lead EKG being $12,000 versus you know, $9, so the same market, so it is a important. Remember, as of July one, we had to test that the accuracy of those files. There's some work to be done behind the scenes if you've got information that's not accurately in your charges today and correcting that. Right. Let's talk about the future of price transparency in the this last summer, summer. 23 was sort of a price transparency was under the microscope in Washington. There were a number of hearings on the subject, a whole slew of legislation that had been introduced, which eventually boiled itself down to the bill though now as lower costs more Transparency Act things we like lower costs and more transparency. And this bill actually was approved by the house in December. What happened is it it Got over to the Senate. And then came the Consolidated Appropriations Act 2020, for that legislative vehicle for avoiding government shutdown. And this got left on the cutting room floor. And so where there was an opportunity, sort of that omnibus legislation that we're used to seeing, at the end of the year, there was some expectation that this will be swept into that. But in the interest of negotiation, it dropped out. And so it's still it's still alive, it still can move forward as its own standing legislation. We just don't know where it's at whether there's interest in moving forward. But some key provisions which we may again, see resurrected in later legislation, or

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importantly, what will CMS do in the 2025 opp s role? Because certainly, what CMS did in 2024, was a reaction to what it was observing going on in Congress. And so this is where Congress has ended, at least the House side of what they would like to see, beginning with providing an actual statutory basis for the regulations. This all started with an executive order. And it said, providing permanence to price transparency by actually putting into statute. They are looking to extend the requirements to clinical laboratories, imaging service providers and ambulatory surgery centers. That's why Kathy said, Wait, there's more coming. So there is interest there. And imaging service providers interesting the way it's defined in the statute, Kathy and I went back and forth on this, but it would include a physician practice that provides in house diagnostic tools. So they would be there they wouldn't have to be list all of their charges and rates in a price transparency tool, at least this component, what they charge for imaging services would be included. They have new many new pricing transparency requirements for pharmacy benefit managers, obviously, that was another hot topic this year on the hill, require reporting to plan sponsors about different pricing techniques, and also permitting plan fiduciaries to investigate the behaviors of PBMs and the administration of contracts. And then probably the provision that caused a whole lot of heartache in the hospital rule world was site neutral payments for direct administration. So similar, like we have site neutral payments for physician clinic visits, we will be extending that over to drug administration, a very, and it was a very significant financial note attached to that part of the bill. So it'd be very negatively impact hospitals their next slide, we'll finish out very quickly talking about what's going on in the States, because the states were into price transparency long before the executive order showed up with a number of legislative solutions that continues. And because this price transparency is a very popular subject, consumers and voters like to see legislatures doing something around this front to control health care costs. So you are seeing a lot of adoption requirements similar to the federal trustee pricing transparency requirements. They are labeling non compliance with the federal rules as an unfair trade practice. Remember, states are limited who they can reach in price transparency on the payer side, but not on the provider side, they licensed providers, and so they have broader authority against it to implement these types of requirements. They're going to impose additional financial penalties beyond the CMPs that are currently available. They're prohibiting non compliant hospitals from pursuing any type of collection action against a consumer. So if you're not meeting the requirements, as determined, I guess, by the state in this instance, you would not be able to initiate any type of collection action against a consumer who owed any dollars to the hospital, requiring hospitals to post their own rate comparisons, such as your rate a percentage of the applicable Medicare rate, mandating hospitals to inform them directly, if cost sharing for covered services exceeds cash pricing. I hope, Kathy that in addition to telling consumers that the covered service cost sharing is higher than the self pay prices, that when you pay out of pocket, you are not impacting your deductible absolutely in any way. And so yeah, you may want to pay $1,000 out of pocket, but appreciate if you had paid 1100 That would have been against your deductible and

Kathy Reep 59:28
detectable and just letting you know that is legislation that passed Florida this year. If you're I would think whoever is sharing that information, when they are registering or talking to the patient. It is scripted, because it needs to be not only the fact that you're going you would pay less if you paid cash and did not use your insurance. But if you have future services, you haven't done anything towards meeting your deductible or your Out of Pocket Max, it's got to be clear to the patients. And I think I'm just afraid that at some point it could get short circuited and they not get the entire message.

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Martie Ross 1:00:11
There's also state legislation that would expand transparency to additional types of providers, ambulatory surgery centers, some even some medical practices, not just the imaging services, but the entirety of the medical practice. Good. This is taken from the National Academy of state health policy. You've heard Kathy and I talked about them before. But Ashley does a very nice job of tracking state legislation you see down there, the link to their website. It's tracking legislation that impacts costs of care, use the drop down menu for transparency, if you want to access any of this type of legislation, see what's going on in your state. Please, if you have questions following this presentation, include them. When at the end of the webinar, what do you have that that short questionnaire to complete that will give you the opportunity to ask questions, Kathy and I want to address as many of those as possible. We understand. This is a these are significant new requirements. There's a lot to consume here. So please ask those questions. Next slide please. Kathy. Upcoming healthcare regulatory roundups in the future on May 8, Kathy and I will delve into the 2025 that fiscal year 2025 proposed rules which of course include the Inpatient Prospective Payment System rule on May 22. I will be joined by Laurie Foley, our MIPS expert, to do a MIPS refresher course. And then on June five, we'll be back to talk about that new Medicare reimbursement to address social determinants of health. So community health worker reimbursement from CMS and what we're seeing developed there. So, Kathy, anything to add at the end here, July stance? No,

Kathy Reep 1:01:47
I do appreciate you joining us. And thank you folks. We love bringing you the regulatory roundups. Thank you. Now back to Caitlin.

PYA Moderator 1:01:57
Thank you so much to today's presenters. Please remember to stay on the line. Once the webinar disconnects to complete a short survey and post any questions you may have. You will soon receive an email with the contact information of the presenters and a recording of the webinar. Also, the slides and recordings for every PYA webinar are available on the Insights page of PYA's website papc.com. While on our website, you may register for other py webinars and learn more about our full range of services. On behalf of PYA, thank you for joining us and have a great rest of your day.

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