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HOW TO COMPLY WITH (AND EXCEED) THE CMS HOSPITAL PRICE TRANSPARENCY RULE REQUIREMENTS

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On Nov. 15, 2019, the Centers for Medicare & Medicaid Services (CMS) issued its 2020 final rule for hospitals regarding price transparency. The good news was that, unlike the original proposal, which would have provided less than two months to prepare, hospitals were given almost 14 months instead. During that time, industry groups fought and lost court battles hoping to overturn the ruling, while many other providers simply held off on beginning the onerous data compilation process, hoping the requirements would be delayed due to the pandemic or that a successful court outcome would arise. Other hospitals elected not to comply at all, thus accepting the resultant risk of penalties (now likely to increase in 2022). It has been reported [1] that more than 50 percent of the nation's hospitals are not compliant with the machine-readable file requirement, and 40 percent are not compliant with the consumer display requirements.

Providers must take heed before CMS, and a legislative gauntlet arrives at their front door. While it is difficult for many financial managers to accept their negotiated rates being made public, transparency is here to stay in our world and in healthcare. It would be more productive to focus first on complying with the rule, and then on how having access to that information can be used to one's advantage – and how, in this new paradigm, hospitals can find creative new ways to leverage existing and new public data. We believe that for those hospitals willing to lead the industry in the world of price transparency, there will be both immediate increased patient satisfaction and imminent future competitive advantages.

BROADLY, THERE ARE TWO REQUIREMENTS:

1. Annually provide a **machine-readable file** containing gross charge and negotiated charges (rates) for all items and services.

2. For 300 shoppable items and services only, including 70 defined by CMS if offered by the hospital, provide a **consumer-friendly display** of gross charge and negotiated charges (rates). This can alternatively be provided via a more costly interactive online tool that calculates the patient's estimated obligation to pay for each of the 300 items and services.

Machine-Readable File Rule Highlights

Under the final rule, hospitals are required to provide on their websites – without barriers, and for each provider within a health system – a machine-readable file containing the following data elements for all items and services:

- Description of each item or service (including both individual items, services, and service packages);
- The corresponding gross charge for each item or service, with indication of the inpatient or outpatient department setting;
- The corresponding payer-specific negotiated charge (rate) for items, services, and service packages, with indication of the inpatient or outpatient department setting and clear indication of the payer name and plan;
- De-identified minimum negotiated charge (rate) for items, services, and service packages, with indication of the inpatient or outpatient department setting;
- De-identified maximum negotiated charge (rate) for items, services, and service packages, with indication of the inpatient or outpatient department setting; and
- The corresponding discounted cash price, if any, that applies to these same services; where no discounted cash price is offered, include the gross charge.

Users must be able to search the data digitally, and the CMS-specified naming convention for the file must be used: <ein>_<hospital-name>_standard charges (.json or XML or CSV).

Additionally, the file must be updated no less than annually, with the date of the last update clearly identified. Note that providers should not feel compelled to display new rates or CDM prices going into effect Jan. 1 of each year if such rates or prices are not final (or yet available) while the file is being finalized in November or December. It is only important to disclose the date the prices and rates published went into effect ("as of" date).

Consumer-Friendly Display Highlights

When displaying gross charges, negotiated charges (rates), and discounted cash prices for the 300 shoppable items in a consumer-friendly manner, or when providing consumer estimates of their obligation to pay, the following data elements must be included:

- Plain-language description of each shoppable service;
- An indication of when one or more of the 70 CMS shoppable services are not offered by the hospital. The hospital must replace such services with other shoppable services to achieve 300, if it is feasible to do so;
- The negotiated charge (rate) for each item or service package with a third-party payer, with name and plan clearly identified;
- The discounted cash price that applies to each shoppable service (and corresponding ancillary services, if applicable). If a discounted cash price is not offered for an item, the undiscounted gross charge should be displayed;
- The de-identified minimum negotiated charge that applies to each shoppable service (and corresponding ancillary services, if applicable);
- The de-identified maximum negotiated charge that applies to each shoppable service (and corresponding ancillary services, if applicable);
- Indication of inpatient or outpatient setting of shoppable service; and
- Any primary code used by the hospital for purposes of accounting or billing for the shoppable services, including, as applicable, the CPT codes, the HCPCS codes, the DRGs, or other common service billing codes. For the five CMS shoppable MS-DRG codes (216, 460, 470, 473, and 743), hospitals may also use an APR-DRG code.

GETTING STARTED

Consumer-Friendly Display

For those hospitals just getting started, identifying your hospital's "shoppable" services and service packages can be accomplished rather swiftly by leveraging historical claims data and incorporating clinical coding intelligence into the analytics process.

It's important to remember that providers can go beyond the minimum required by CMS. If additional information will be helpful to consumers (or to your team, when they are trying to determine which items and services will be easiest to display to the consumer), consider collecting and providing more information than required.

For example, in your analysis and selection process, isolate first the items and services that are most often directly related to a simple and single fee schedule rate, DRG rate, or other case rates, without multiple contract provisions and calculations such as carve-outs, additional per diems for excess days, etc. Gathering additional information for the consumer, even when not required by CMS, such as showing the average range of charges and payments and disclosing related items and service categories that they may fall into, would also be useful. For example, you could show selections with CCs, with CCs and MCCs, and without CC or MCC rates – or show average length of stay (LOS) for per diem-based items and services. You can even calculate the average negotiated reimbursement for per diem-based items and services to provide a better estimate for the consumer display, even though this exceeds CMS requirements. While analyzing the historical claims data, it would also be useful to identify other related procedures or services typically provided in conjunction with the primary shoppable code, so that this information could also be proactively disclosed to the consumer. Also, in providing estimates for consumers beyond what the CMS rule requires for complex contract terms and procedures, calculating inlier averages and outlier average negotiated payments may prove to be particularly useful and meaningful to a consumer.

Panacea is one of the few vendors to have successfully helped small and large health systems nationwide comply with and exceed the CMS final rule requirements by Jan. 1, 2021. The following program is offered to provide hospitals and health systems with the consulting and technology support needed to assist with compliance under the CMS price transparency rules.

PANACEA'S SHOPPABLE SERVICES DISAGGREGATION ALGORITHM AND REPORT SET

The CMS final rule requires that each provider within a health system determine its own unique list of non-urgent shoppable items and services – and consider volume and/or revenue in the process.

Accordingly, Panacea has developed an algorithm and software program that examines up to 12 months of claims and payment data, representing 100 percent of the patient population, to ensure that cases classified as non-urgent and as potential shoppable items and services are valid.

The software does this by disaggregating the data through a hierarchical process that removes non-urgent cases based on a myriad of criterion. This includes a proprietary list of elective service codes as well as the use of bill type codes, revenue codes, admission status, and other criterion. The methodology goes far beyond that to provide:

1. A unique report for each hospital within a health system to help clients select their 300 shoppable items and services and comply with CMS transparency requirements. This report utilizes an algorithm and process that removes non-urgent cases and services from the analysis;

2. Insights within the report to shed light on which items and services might be easiest to present to the consumer, in terms of the least complex contract terms;

3. Sufficient detail in the report to take revenue and/or volume into account, as per CMS requirements;

4. Additional low-, average-, and high-gross charge and payment profiles, sorted by items and services, with average LOS and volume data broken out at the patient type, in-network and out-of-network, and payer level (useful for out-of-network estimates), calculating estimated self-pay discount amounts and more;

5. Flags on items and services typically provided in conjunction with other services, and disclosure of what those services are;

6. Inclusion of related items and services to those meeting shoppable criterion, such as CCs and MCCs, with contrast and with and without contrast, etc.; and

7. Flags on items found on the required CMS shoppable list, and identification of those of the 70 not available or applicable, based on the provider case mix. This assists hospitals in selecting additional items, as required by CMS, to ensure that 300 are selected.

Note: Panacea offers the data processing and report for one fee per provider, with an optional full day of consulting to assist with the use of the report in selecting your final shoppable list of 300 items and services. Some clients that have already developed their shoppable list in-house have utilized Panacea's report to validate or reassess their internally developed list. Those clients using CLAIMSauditor on a full or limited license basis already, or utilizing Panacea's popular Hospital Zero-Base Pricing system, will receive discounts off the standard report fee.

HOSPITAL ZERO-BASE PRICING® WITH SHOPPABLE ITEMS AND SERVICES INTEGRATION

Hospitals should continue to update their chargemasters in a rational and defensible manner, with gross and net revenue modeling considered – but with new consideration given to the selected and complete list of shoppable items.

The final rule still requires that hospitals display the gross charge(s) for the shoppable items and services. Our preliminary use and testing of the new disaggregation algorithm and report set reveals (as does the list of 70 shoppable items required by CMS) that many items will be single chargemaster-level items utilized by private outpatients. Moreover, as a result of this new rule, providers are beginning to realize that chargemaster and pharmacy prices do matter, not only because they will now be scrutinized by being made public, but also because many items and services continue to be paid on a percentage-of-charge basis – and more than 90 percent of Panacea's clients offer self-pay discounts off the chargemaster price. CMS requires the discounted price be disclosed, and where no policy exists, the gross charge must be disclosed.

Accordingly, hospitals should continue to update their chargemasters in a rational and defensible manner, with gross and net revenue modeling considered – but with new consideration given to the selected and complete list of shoppable items. Many hospitals will have 50 percent or more of their 300 items listed in their CDM, with sometimes 200 percent or more items being related (e.g., with contrast, without contrast, with and without contrast). This makes rational pricing scrutiny and modeling on more than the 300 items required to be listed by CMS critical.

Our popular Hospital Zero-Base Pricing® system has recently been enhanced to facilitate the integration and tagging of those items on client-specific -shoppable lists. There is also a new "what-if" modeling feature that determines the extent that such prices can be further decreased with little or no impact on net revenue.

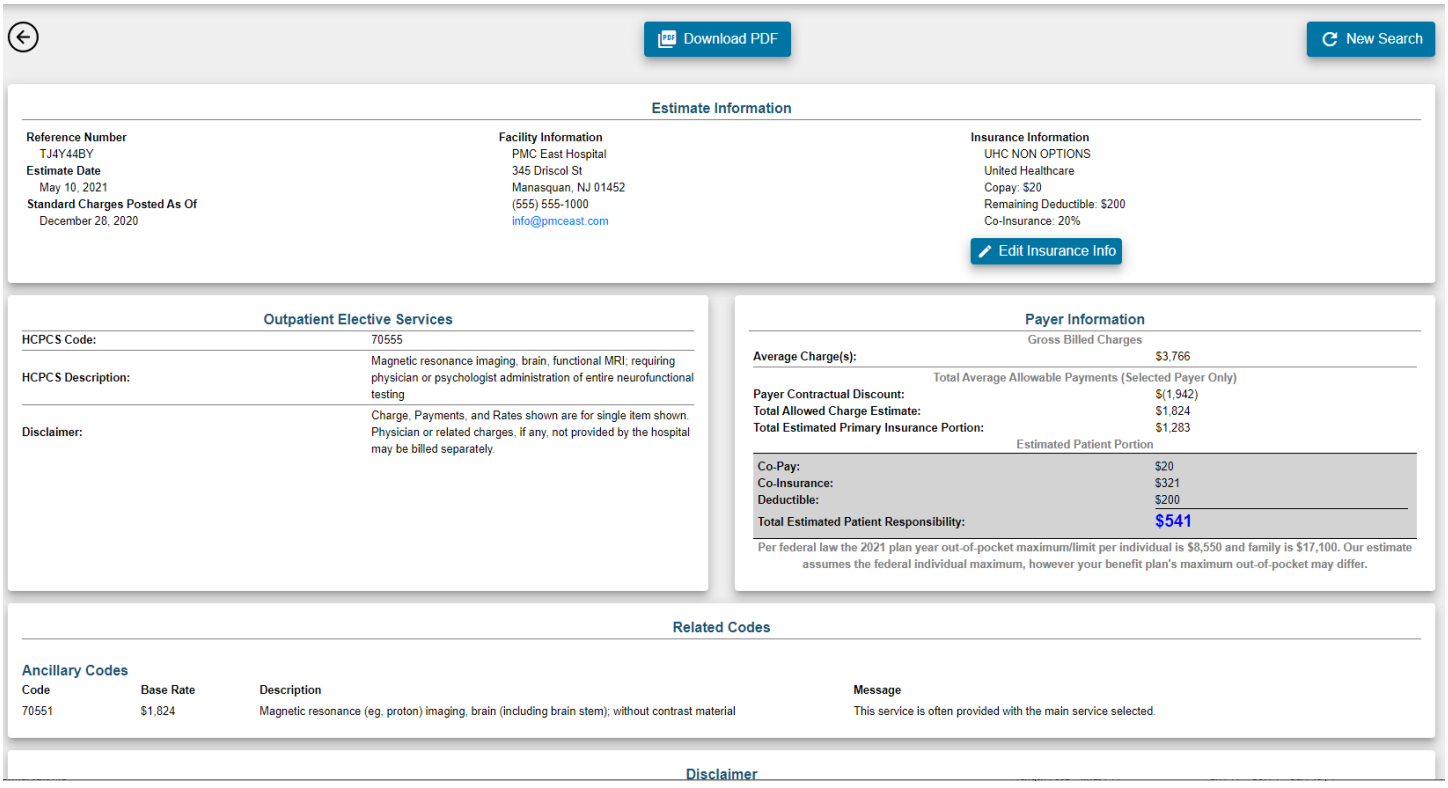
Hospitals already licensing the Hospital Zero-Base Pricing® system and/or service, or renewing in the current year, will receive access to these new pricing system enhancements at no additional cost.

PANACEA'S CONSUMER DISPLAY/ PATIENT ESTIMATION SYSTEM SOLUTION

Panacea offers three display levels:

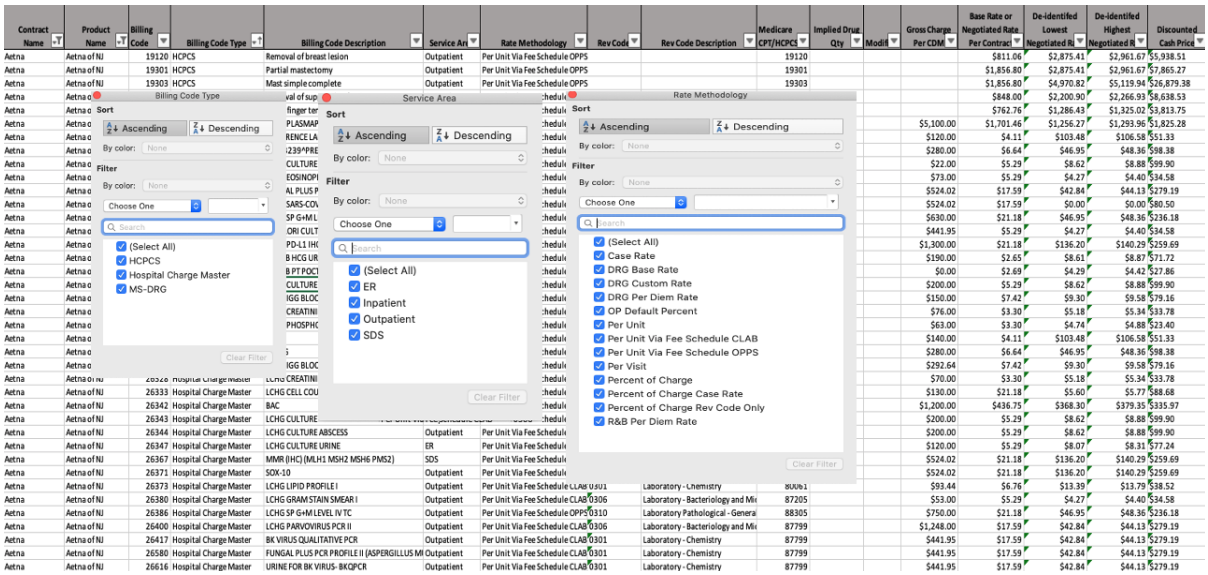
- **Level One** displays gross negotiated charges, and is designed to simply comply with the minimum requirements of the CMS final rule. This option is not consumer-friendly, and requires full disclosure to the consumer of the minimum and maximum negotiated rates, alongside that of their insurer.
- **Level Two** allows consumers to enter co-pay, coinsurance, and deductible to estimate out-of-pocket amounts.
- **Level Three** is the most consumer-friendly, as it integrates with an eligibility system to import the co-pay, coinsurance, and deductible amounts to provide more accurate patient responsibility calculations.

> **Note:** all three levels, hosted in Panacea's secure cloud environment, are web-friendly and operate excellently on mobile devices. Panacea is currently working with providers to further exceed requirements by integrating, where feasible, quality and safety score information, and other comparative data.



Panacea's Machine-Readable File Program and CLAIMS Level Analytics

Panacea's Managed Care Module within its CLAIMSauditor® system facilitates the following:



- Annual or interim year update production of the CMS required machine-readable file;
- Ability to enter simple or complex negotiated terms;
- On-screen and Excel output for contract and rate validation, and Panacea-hosted links to CSV or JSON formats for compliance;
- Automatic system calculation of Medicare reimbursement amounts, with ability to customize for third-party payer (e.g., Medicare Advantage) plans;
- Optional managed care under payment analytics that identifies actual versus expected payment from in-network payers;
- Modeling of stop-loss and lesser-of-charge and case rate net revenue impacts by simulating the proposed rational chargemaster prices with 12 months of itemized bill claims;
- Central repository of all managed care contract terms in a single database with data entry screens and fee schedule upload capabilities;
- Links within system to PDF versions of contracts for fast retrieval and viewing;
- Email alerts when contract renewal dates are approaching or past; and
- Use by our team of managed care experts, your team, or both.

Note: Those hospitals already utilizing our CLAIMSauditor system under a limited license in conjunction with our Hospital Zero-Base Pricing® system will receive a 50-percent discount off our standard annual fee for the Managed Care Under Payment Analytics and Machine-Readable File Production Service. Those hospitals utilizing only Hospital Zero-Base Pricing® wishing to upgrade to include any or all of these new services will receive a 25-percent discount off the standard fee.

In summary, implementing the CMS Price Transparency Rule requires more to do than meets the eye. Panacea provides the industry's most comprehensive applicable suite of services – to ensure that your prices are compliant, competitive, and easily accessible by consumers.

The suite includes the following:

- **Disaggregation Algorithm & Report Set:** This module processes thousands of claims and pieces of payment data against proprietary coding tables and algorithms to identify top shoppable items and create valuable charge, payment, and allowable reimbursement profiles for all items and services.

- **Machine-Readable File Validation Reports and Production:** This module produces a machine-readable file containing gross charges and negotiated managed care rates for all items and services that hospitals can post on their websites.

- **Hospital Zero-Base Pricing®:** Using Panacea's HFMA Peer Review-designated Hospital Zero-Base Pricing software, data is processed to create defensible chargemaster prices, with special analytics utilizing the developed "shoppable list."

- **Consumer Display:** There are three display levels: one displays gross negotiated charges; another allows consumers to enter co-pays and deductibles to estimate out-of-pocket amounts; and a third integrates with an eligibility system to import the co-pay and deductible amounts. All are web- and mobile-friendly.

Note: Panacea also provides best-practice pharmacy and physician pricing services and software.

[1] Per Guidehouse study published Feb. 9, 2021

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*HFMA staff and volunteers determined that CDMauditor® – Hospital Zero-Base Pricing® and related modules have met certain criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this service