

# Competitive Advantages of Price Transparency

May 5, 2022

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IBM Watson Health®

# Today's Speakers

**James G. Haulihan**

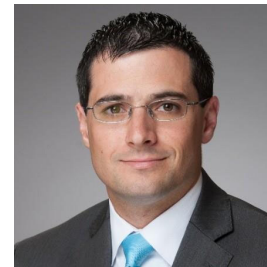
Associate Partner, Provider Consulting  
& Analytics



IBM **Watson Health**<sup>®</sup>

**Robert M. Gilbert, FHFMA, COC**

Senior Manager, Healthcare Advisory



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# Agenda

- Price Transparency – Current State of Affairs
- Current CMS Compliance Focus Areas
- Competitive Advantages of Price Transparency Case Studies

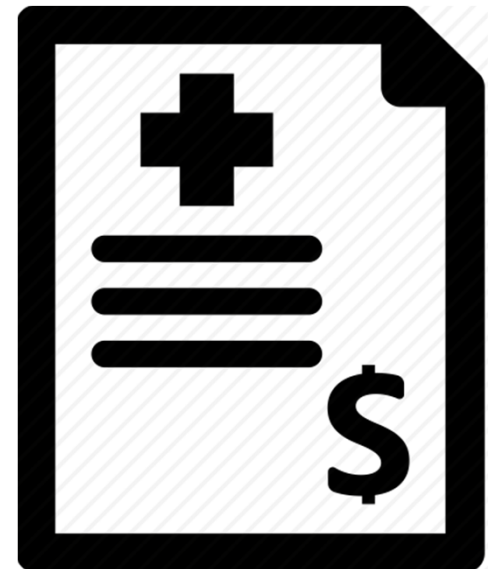
# Price Transparency – Current State of Affairs

# Price Transparency Rules

- Is the Machine Readable File Compliant?
  - Required elements
  - Naming convention
  - Clearly and easily posted on website
- Are the shoppable services listed, or is an embedded tool being used?
  - Clearly and easily posted on website
  - If software solution, does not require registration and is easy to use

# Price Transparency Final Rule

- The Machine Readable File and 300 Shoppable Services need to include the following:
  - Billing identifier (CPT/HCPCS/DRG)
  - Service description
  - Gross charge of service
  - Payer-negotiated rates
  - De-identified minimum and maximum payer-negotiated rates
  - Self-pay cash rate



# Machine Readable File

- The Machine Readable File is NOT a CDM only file
  - CDM with applicable contract rates
  - Fee Schedules
  - OP Case Rates
  - IP DRG Rates



# Current CMS Compliance Focus Areas



# Interpretation and Intent of Current Rules

- The intent of the final rule was for hospitals to have a Machine Readable File available to download
- Some organizations have elected to interpret “digital representation” language to have an embedded look-up tool

charge technology.

*Final Action:* We are finalizing as proposed the requirement that hospitals post their standard charge information in a single digital file in a machine-readable format. We are finalizing our definition of machine-readable format as a digital representation of data **or** information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and

# 2022 OPPS Final Rule Penalties

**TABLE 76: Application of CMP Daily Amounts for Hospital Noncompliance for  
CMPs Assessed in CY 2022 and Subsequent Years.**

<b>Number of Beds</b>	<b>Penalty Applied Per Day</b>	<b>Total Penalty Amount for full Calendar Year of Noncompliance</b>
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).

# Hospital's Perception of the Final Rule

- The VP of one large health system said that their organization has worked for months, and had numerous conversations with legal experts in attempts to comply with the final rule, yet is still unsure if their implementation will be accepted by CMS
- The executive noted that everyone has a different interpretation: Some are saying to simply publish their rate schedule, others are saying to summarize the CMS packages and negotiated charges by package



# What's Next After Compliance?

- Unsolicited Pricing Estimates
- Analyzing Pricing
  - Internal Pricing
  - Market Pricing
  - Strategic Pricing
- Contract Negotiation Knowledge

# Use of Unsolicited Price Estimates

- Informing patients of the cost upfront can be a difficult conversation
- Patients will appreciate understanding what their responsibility will be
  - Avoids surprise billing
  - Allows for better collections
  - Reduces bad debt



Description	Code	Amount
ision charge	851000095	87.00
urg Private room	172001525	174.00
C-Ray	225647700	37.60
cy	751004102	9.10
ry	225000641	18.12
Private room	919566450	174.00

# Use of Unsolicited Price Estimates (Continued)

- Opportunity for upfront POS collections
- Upfront collections could reduce third party early out expense
- Unsolicited cost estimates also increase patient satisfaction



# Competitive Advantages of Price Transparency Case Studies

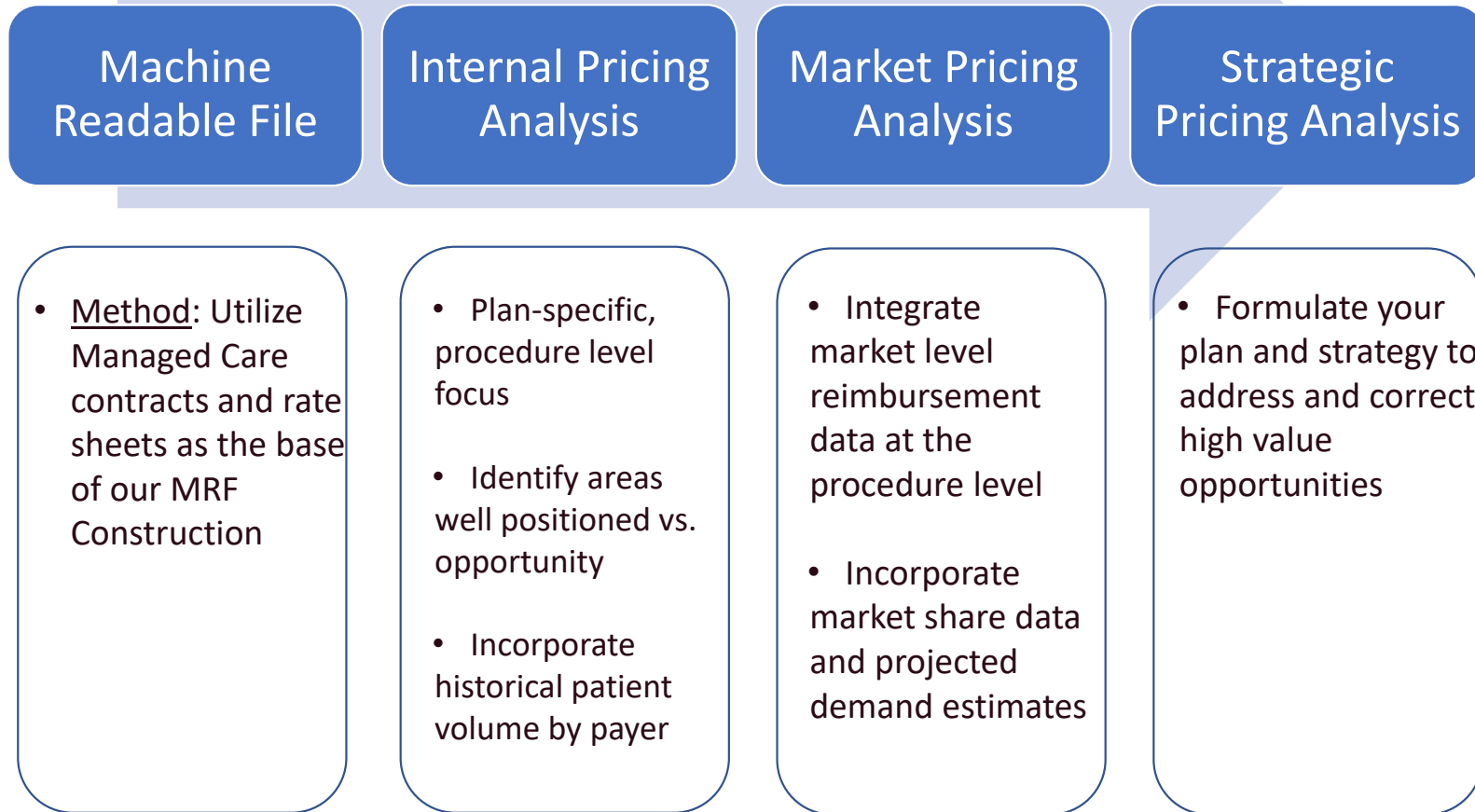
# Pricing Studies

- Ability for the organization to understand internal and external pressures
- Payers are more than likely already doing this





# Case Study #1 - Path to Strategic Pricing Analysis



# Internal Pricing Analysis

- Internal Pricing Analysis: Utilizing the MRF as the foundation for negotiated rate comparison across payers for IP and OP items and services
- Clearly identify payers (and specific plans) which are contributing to your “De-identified Minimum”
- See opportunities for contract renegotiation in key service areas at the level of the procedure or service code
- Incorporate historical volumes by payer to clarify the order of magnitude

DRG	APC	item_description	item_se	1199 SEIU	Aetna Com	Aetna Com	Aetna Man	Affinit	Affinity Ess	De Id M	De ID Max
457		SPINAL FUSION EXCEPT CEF I		\$159,779.65	\$148,288.41	\$159,779.65	\$65,211.68	\$0.00	\$92,218.54	\$0.00	\$403,947.54
458		SPINAL FUSION EXCEPT CEF I		\$123,171.94	\$114,313.49	\$123,171.94	\$50,419.99	\$0.00	\$71,301.00	\$0.00	\$311,397.61
459		SPINAL FUSION EXCEPT CEF I		\$165,623.90	\$153,712.34	\$165,623.90	\$67,573.11	\$0.00	\$95,557.93	\$0.00	\$418,722.70
460		SPINAL FUSION EXCEPT CEF I		\$96,683.43	\$89,730.02	\$96,683.43	\$39,717.06	\$0.00	\$56,165.55	\$0.00	\$244,430.58
461		BILATERAL OR MULTIPLE M I		\$149,591.57	\$138,833.05	\$149,591.57	\$61,095.10	\$0.00	\$86,397.11	\$0.00	\$378,190.51
462		BILATERAL OR MULTIPLE M I		\$77,269.02	\$71,711.88	\$77,269.02	\$31,872.49	\$0.00	\$45,072.21	\$0.00	\$195,347.96
463		WOUND DEBRIDEMENT AN I		\$132,093.27	\$122,593.21	\$132,093.27	\$54,024.74	\$0.00	\$76,398.63	\$0.00	\$333,952.11
464		WOUND DEBRIDEMENT AN I		\$73,198.21	\$67,933.85	\$73,198.21	\$30,227.64	\$0.00	\$42,746.16	\$0.00	\$185,056.34
465		WOUND DEBRIDEMENT AN I		\$45,359.33	\$42,097.11	\$45,359.33	\$18,979.08	\$0.00	\$26,839.11	\$0.00	\$114,675.36
466		REVISION OF HIP OR KNEE I		\$131,488.18	\$122,031.64	\$131,488.18	\$53,780.25	\$0.00	\$76,052.88	\$0.00	\$332,422.35
467		REVISION OF HIP OR KNEE I		\$87,995.77	\$81,667.17	\$87,995.77	\$36,206.73	\$0.00	\$51,201.44	\$0.00	\$222,466.84
468		REVISION OF HIP OR KNEE I		\$68,930.63	\$63,973.19	\$68,930.63	\$28,503.29	\$0.00	\$40,307.68	\$0.00	\$174,267.24
469		MAJOR HIP AND KNEE JOIN I		\$75,903.88	\$70,444.93	\$75,903.88	\$31,320.90	\$0.00	\$44,292.17	\$0.00	\$191,896.69
470		MAJOR HIP AND KNEE JOIN I		\$46,741.68	\$43,380.05	\$46,741.68	\$19,537.63	\$0.00	\$27,628.98	\$0.00	\$118,170.16
471		CERVICAL SPINAL FUSION VI		\$123,469.56	\$114,589.71	\$123,469.56	\$50,540.25	\$0.00	\$71,471.06	\$0.00	\$312,150.04
472		CERVICAL SPINAL FUSION VI		\$75,111.86	\$69,709.86	\$75,111.86	\$31,000.87	\$0.00	\$43,839.62	\$0.00	\$189,894.33
473		CERVICAL SPINAL FUSION VI		\$62,451.78	\$57,960.29	\$62,451.78	\$25,885.45	\$0.00	\$36,605.69	\$0.00	\$157,887.71

# Market Pricing Analysis

- Market Pricing Analysis: Comparison of negotiated rates using Machine-Readable File to Market specific reimbursement
- Requires need for external data set on Market Reimbursement
- Integrate and compare Market level reimbursement at the procedure level for all IP and OP services provided
- Incorporate market share data and projected demand estimates
- In some cases, Competitors' Machine-Readable File can provide alternative for Market specific reimbursement



# Market Pricing Analysis - IP

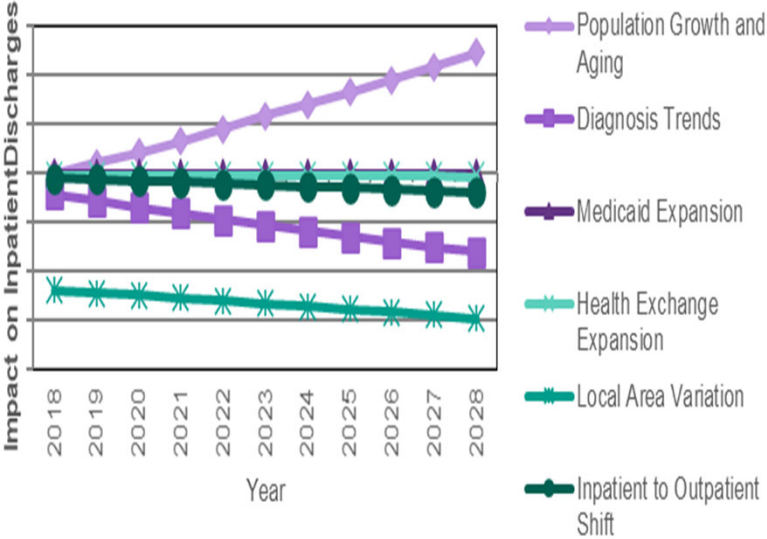
cpt	cpt_modifier	hcpcs	hcpcs_modifier	DRG	item_description	item_setting	medicare	Aetna	Blue Cross	Cigna	UHC
				470	MAJOR HIP AND KNEE JOINT I		\$19,043.92	\$24,907.11	\$29,916.67	\$27,916.67	\$22,043.92
				469	MAJOR HIP AND KNEE JOINT I		\$25,201.49	\$29,139.16	\$34,284.31	\$34,284.31	\$27,201.49

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MARKET Geography	Reported by	MS-DRG	MS-DRG Description	Allowable Payment					
				Average	10th Percentile	25th Percentile	Median	75th Percentile	90th Percentile
ohio	Per Case	469	Major joint replacement or reattachmer	30,881.77		23,836.40	28,358.38	38,476.54	
ohio	Per Case	470	Major joint replacement or reattachmer	25,392.39	15,320.65	19,320.59	26,076.47	29,991.00	34,711.42

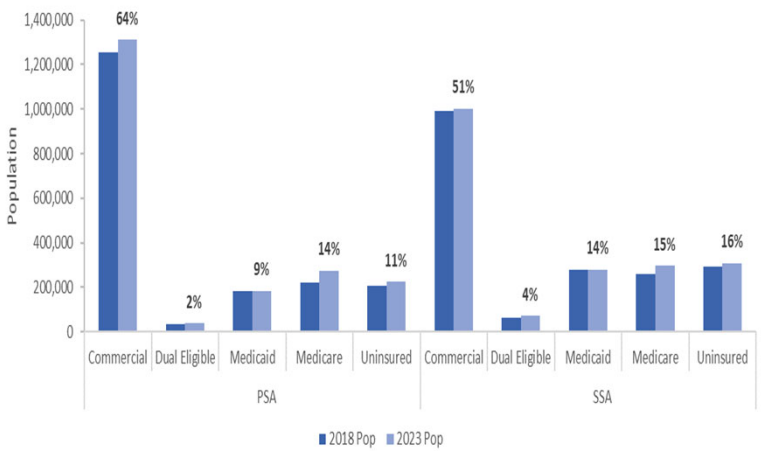
- Key Question – Which percentile (or range) does my hospital target in negotiations?
- How are the demographics and/or IP Discharges projected to change in my market?

IP Discharges Effect by Impact Component



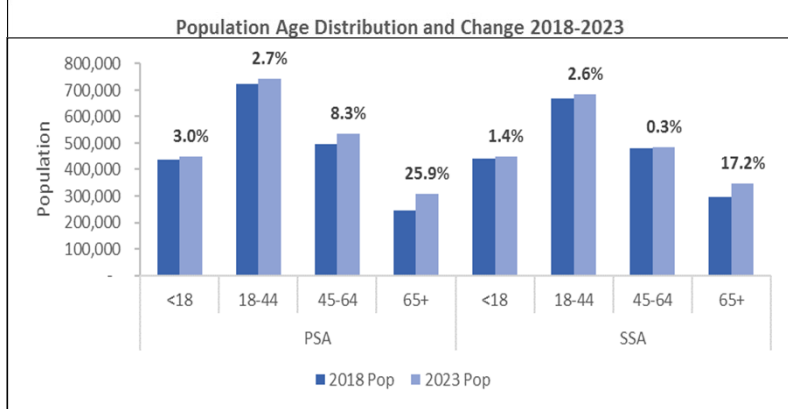
# Market Pricing Analysis- OP

cpt	cpt_modifier	hcpcs	hcpcs_modifier	DRG	item_description	item_setting	medicare	Aetna	Blue Cross	Cigna	UHC
27447					TOTAL KNEE ARTHROPLASTY	O	\$14,546.98	\$18,768.59	\$19,324.51	\$21,389.54	\$15,311.24



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MARKET Geography	RB Type	Reported by	HCPCS	Allowable Payment					
				Average	10th Percentile	25th Percentile	Median	75th Percentile	90th Percentile
ohio	Option 1 - All CPT	Per Case	27447	17,615.91		13,051.03	15,826.10	24,793.16	
ohio	Option 2 - Primary CPT	Per Case	27447	17,691.22		13,247.75	15,826.10	26,600.00	
ohio	Option 3 - Case Rate	Per Case	27447	21,684.02		16,166.52	23,368.42	26,600.00	



- Key Question – Which percentile (or range) does my hospital target in negotiations?
- How are the demographics and/or OP procedures projected to change in my market?

# Strategic Pricing Analysis - Sample

ANNUALIZED FY18 IP Volume and Pay DRG 246 -251 PSA						
	Volume		Commerical Pay			Median Pay per D/C
	Comm	Total	25th	Median	75th	
Hospital	134	688	\$2,757,631	\$3,461,784	\$4,407,641	\$25,834
Rest of Market	3,208	9,838	\$66,307,095	\$82,263,182	\$103,462,949	\$25,643
Total	3,342	10,526	\$69,064,726	\$85,724,966	\$107,870,590	\$25,651

ANNUALIZED FY 18 OP Cardiac Catheterization, Left & Intracoronary Stent, Placement - PSA						
	Volume		Commerical Pay			Median Pay per D/C
	Comm	Total	25th	Median	75th	
Hospital	90	426	\$390,383	\$578,685	\$867,155	\$6,430
Rest of Market	868	2,392	\$3,921,332	\$5,408,218	\$7,739,019	\$6,231
Total	958	2,818	\$4,311,715	\$5,986,903	\$8,606,174	\$6,249

10% Shift from IP to OP ANNUALIZED FY 18 Combined Commerical Payments PSA						
	Original Commercial Pay			Commercial Pay After Change - PSA		
	25th	Median	75th	25th	Median	75th
Hospital	\$3,148,014	\$4,040,469	\$5,274,796	\$2,930,374	\$3,780,450	\$4,963,141
Rest of Market	\$70,228,427	\$87,671,400	\$111,201,968	\$65,107,521	\$81,527,371	\$103,835,373
Total	\$73,376,441	\$91,711,869	\$116,476,763	\$68,037,895	\$85,307,821	\$108,798,515

- Hospital's median IP revenue per case for MS-DRGs 246-251 (drug eluting and non-drug eluting stents) is \$25,834 compared to OP revenue of \$6,430
- Reduction in payment of \$19,404 for each case that shifts from IP to OP care setting

## Case Study #2

- BNN partnered with a New England Hospital who was interested in understanding what their market
- Challenge: All files were in different formats. The first step was to normalize the data first



# Approach and Methodology

- Selection of the hospitals they considered to be part of their market
- Selection of which payers they wanted to compare
- Detailed analysis of the hospitals contracts
- Normalization of public data



# Outcome

- Understanding of where their contracts were favorable vs. unfavorable
- Detailed file that can be sorted by payer. Can used as tool preparing for managed care contracting
- Overall summary of results

# Result Summary

	Evaluation & Management	Radiology	Medicine	Surgery	Pathology & Laboratory
Payer 1	Green	Red	Yellow	Green	Yellow
Payer 2	Green	Red	Yellow	Green	Yellow
Payer 3	Yellow	Yellow	Green	Green	Green
Payer 4	Green	Red	Yellow	Green	Yellow
Payer 5	Green	Red	Yellow	Green	Yellow
Payer 6	Yellow	Red	Yellow	Green	Yellow
Payer 7	Green	Red	Yellow	Green	Green
Payer 8	Green	Red	Yellow	Green	Red

# Payer 1 – Hospital 1

	CPT Count	
Total CPT Count	4,219	
Total CPT Matched	2,239	53%
Unfavorable > 25% variance	648	29%
Neutral Variance	451	20%
Favorable > -25% variance	1,140	51%

CPT Category	Favorable		Unfavorable	
	CPT Count	Average \$ Difference Favorable	CPT Count	Average \$ Difference Unfavorable
Pathology and Laboratory	584	\$ (65)	21	\$ 111
Surgery	465	\$ (3,262)	466	\$ 1,513
Medicine	103	\$ (760)	159	\$ 6,227
Radiology	60	\$ (599)	336	\$ 237
Evaluation & Management	5	\$ (308)	9	\$ 2,551
HCPCS & Other	15	\$ (1,728)	16	\$ 2,943
Total	1,232		1,007	

# Payer 1 –Hospital 2

	CPT Count	
Total CPT Count	4,219	
Total Matched	3,119	74%
Unfavorable >25% variance	1,807	58%
Neutral Variance	366	12%
Favorable > -25% variance	946	30%

CPT Category	Favorable		Unfavorable	
	CPT Count	Average \$ Difference Favorable	CPT Count	Average \$ Difference Unfavorable
Pathology and Laboratory	64	\$ (222)	1,278	\$ 65
Surgery	828	\$ (2,396)	102	\$ 1,910
Medicine	181	\$ (1,257)	154	\$ 877
Radiology	53	\$ (469)	363	\$ 542
Evaluation & Management	16	\$ (204)	7	\$ 128
HCPCS & Other	43	\$ (717)	30	\$ 1,895
Total	1,185		1,934	

# Payer 2- Hospital 1

	CPT Count	
Total CPT Count	4,219	
Total Matched	2,239	53%
Unfavorable >25% variance	923	41%
Neutral Variance	225	10%
Favorable > -25% variance	1,091	49%

CPT Category	Favorable		Unfavorable	
	CPT Count	Average \$ Difference Favorable	CPT Count	Average \$ Difference Unfavorable
Pathology and Laboratory	225	\$ (44)	360	\$ 73
Surgery	551	\$ (2,698)	363	\$ 3,266
Medicine	146	\$ (1,899)	115	\$ 3,774
Radiology	258	\$ (629)	131	\$ 1,578
Evaluation & Management	11	\$ (913)	11	\$ 3,564
HCPCS & Other	19	\$ (363)	49	\$ 2,342
<b>Total</b>	<b>1,210</b>		<b>1,029</b>	

# Payer 2 – Hospital 2

	CPT Count	
Total CPT Count	4,219	
Total Matched	3,119	74%
Unfavorable >25% variance	1,973	63%
Neutral Variance	492	16%
Favorable > -25% variance	654	21%

CPT Category	Favorable		Unfavorable	
	CPT Count	Average \$ Difference Favorable	CPT Count	Average \$ Difference Unfavorable
Pathology and Laboratory	3	\$ (17)	1,339	\$ 346
Surgery	682	\$ (1,153)	240	\$ 587
Medicine	192	\$ (842)	143	\$ 480
Radiology	50	\$ (608)	366	\$ 661
Evaluation & Management	10	\$ (578)	13	\$ 670
HCPCS & Other	26	\$ (2,374)	55	\$ 615
Total	963		2,156	

# Payer 3 – Hospital 1

	CPT Count	
Total CPT Count	4,219	
Total Matched	2,239	53%
Unfavorable >25% variance	475	21%
Neutral Variance	374	17%
Favorable > -25% variance	1,390	62%

CPT Category	Favorable		Unfavorable	
	CPT Count	Average \$ Difference Favorable	CPT Count	Average \$ Difference Unfavorable
Pathology and Laboratory	552	\$ (30)	53	\$ 25
Surgery	748	\$ (4,215)	175	\$ 2,711
Medicine	110	\$ (2,592)	152	\$ 2,633
Radiology	211	\$ (414)	185	\$ 737
Evaluation & Management	6	\$ (1,862)	8	\$ 1,712
HCPCS & Other	23	\$ (3,354)	16	\$ 3,188
Total	1,650		589	

# Payer 3 –Hospital 2

	CPT Count	
Total CPT Count	4,219	
Total Matched	3,119	74%
Unfavorable >25% variance	1,901	61%
Neutral Variance	440	14%
Favorable > -25% variance	778	25%

CPT Category	Favorable		Unfavorable	
	CPT Count	Average \$ Difference Favorable	CPT Count	Average \$ Difference Unfavorable
Pathology and Laboratory	27	\$ (254)	1,315	\$ 94
Surgery	696	\$ (3,199)	226	\$ 861
Medicine	140	\$ (1,584)	195	\$ 582
Radiology	57	\$ (398)	359	\$ 347
Evaluation & Management	15	\$ (79)	8	\$ 154
HCPCS & Other	32	\$ (2,089)	49	\$ 1,101
Total	967		2,152	



# Pricing Transparency Checklist

- Pricing transparency rule requirements met.....
  - Machine readable file
  - Shoppable services listed or approved price estimation tool?
- Patient perception and contract maximization.....
  - Rate Rationalization study
  - Cost comparison study
- Market Comparison.....
  - Contractual and market study



# Patient perception and contract maximization

- Rate Rationalization study

- Understand where charges compare to case rates/fee schedules
- Is money being left on the table
- Are other charges over inflated and rates can come down?
  - If charges are over contracted rates, increase contractual and bad debt
  - Great opportunity to lower gross charges for transparency perception

- Cost Comparison Study

- Are charges related to cost?
- Utilize the Medicare Cost Report
  - Medicare paper based manual section 2202.4: Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.

# Market Comparison

- Contractual Market study
  - Understand how the hospital compares to local market
  - Understand areas to promote (i.e. radiology in case study)
  - Prepare for managed care contracting conversations
- Strategic decisions pricing of service lines and site of service
  - Radiology
  - Physical Therapy
  - Lab
  - Surgery



# Any Questions???

## **James G. Haulihan**

Associate Partner, Provider Consulting  
& Analytics

IBM Watson Health

267-449-3093

[James.Haulihan@ibm.com](mailto:James.Haulihan@ibm.com)

IBM **Watson Health**<sup>®</sup>

## **Robert M. Gilbert, FHFMA, COC**

Senior Manager, Healthcare  
Consulting

Baker Newman Noyes

603-812-2415

[rgilbert@bnn CPA.com](mailto:rgilbert@bnn CPA.com)

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# Appendix

Actual CMS Citation Letter

# CMS Citation Example

1. Failure to make public a machine-readable file containing a list of all standard charges for all items and services as required at 45 CFR §180.40(a). Specifically, items and services as defined at 45 CFR §180.20 such room and board, were not found in the online machine-readable file. If your hospital does not provide one or more of these types of items and services, please respond and provide supporting documentation.
2. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all gross charges were posted in the online machine-readable file as required at 45 CFR §180.50(b)(2). If your hospital does not have established gross charges for certain items and services, please respond with an explanation.
3. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all payer specific negotiated rates were posted in the online machine-readable file as required at 45 CFR §180.50(b)(3). If your hospital does not have established payer specific negotiated rates for certain items and services, please respond with an explanation.
4. Failure to make public a machine-readable file containing a list of all standard charges for all items and services as provided in 45 CFR §180.50. Specifically, not all discounted cash prices were posted in the online machine-readable file as required at 45 CFR §180.50(b)(6). If your hospital does not have established discounted cash prices for certain items and services, please respond with an explanation.

## CMS Citation Example (Continued)

5. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all de-identified minimum negotiated charges were posted in the online machine-readable file as required at 45 CFR §180.50(b)(4). If your hospital does not have established de-identified minimum negotiated charges for certain items and services, please respond with an explanation.
6. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all de-identified maximum negotiated charges were posted in the online machine-readable file as required at 45 CFR §180.50(b)(5). If your hospital does not have established de-identified maximum negotiated charges for certain items and services, please respond with an explanation.
7. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, the file did not contain all codes used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifiers as required at 45 CFR §180.50(b)(7). If your hospital does not have established codes for certain items or services, please respond with an explanation.
8. Failure to clearly indicate the date that the standard charge data described in 45 CFR §180.50(b) was most recently updated, either within the file itself or otherwise clearly associated with the file as required at 45 CFR §180.50(e).

# CMS Actions Required From the Hospital



- *“XYZ Hospital must take action to correct the deficiency or deficiencies identified by CMS within 90 days of the date of this notice. Failure to comply with the hospital price transparency requirements may result in further compliance actions as specified in 45 CFR 180 subpart C”*