MILLIMAN BRIEF

Hospital Price Transparency: June 2021 Update

Early implementation trends for new regulations

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Regulations that took effect January 1, 2021 introduced a new level of price transparency in the U.S. healthcare system. For the first time, hospitals and health systems are required to publish price data. To help stakeholders better understand how the industry is responding to these new regulations, Milliman is tracking this price information. This brief—which provides observations from the first five months—is the second in a series of reports Milliman will publish on this topic. The first brief[1] was published on April 5, 2021.

Introduction

On November 27, 2019, CMS published a Final Rule[2] detailing requirements for hospitals to publish a machine-readable file of their payment rates and a consumer-friendly website for 300 "shoppable" services.

The data elements required on the machine-readable file include: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for all items and services (both individual and packaged) provided by the hospital to a patient in connection with an inpatient admission or an outpatient department visit.

The consumer-friendly website should contain standard charges for at least 300 "shoppable" services that are grouped with charges for ancillary services customarily provided by the hospital: discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges. Note that shoppable services are typically provided on hospital-specific websites intended primarily for patient-level access and browsing. The machine-readable files provide a more comprehensive reimbursement view for the hospital and are the focus on this brief.

As part of our data collection efforts, we reviewed postings from 1,410 hospitals within the top 100 health systems (based on the number of beds in short-term, children's, and critical access hospitals) across the United States. Our review was focused on determining:

- Whether the hospital or health system had file(s) containing negotiated rates
- The file formats, structures of the files, and ease of retrieving data
- Whether the published files contained the fields required by the regulation

Findings

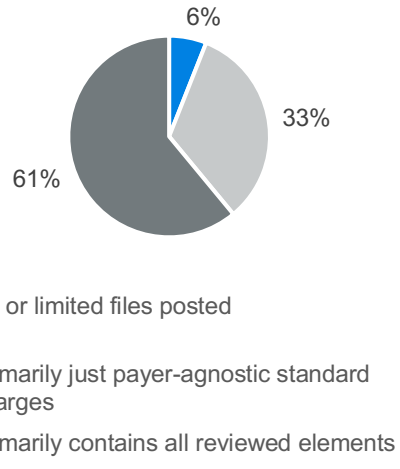
Of the health systems Milliman reviewed between January 1, 2021 and June 3, 2021, 61% have posted a machine-readable file containing gross charges, discounted cash prices, payer-specific negotiated rates, and de-identified minimum and maximum charges by item/service for most of their hospitals.

It is notable that even among organizations that posted files there was variation among the scope of the postings. We segmented this variation among three categories:

- No or limited files posted – Either no information was posted by the hospital, or the files that were posted did not have useful charge or payment information.
- Primarily just payer-agnostic standard charges – Contained charge information, but insufficient data on payment levels to support a payer-specific analysis.
- Contained most key items of gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges – Sufficient data elements appeared present to support a payment analysis, although the quality of the content was not assessed.

At the end of the five-month period, only a small fraction (6%) of health systems had posted no or limited files. Figure 1 shows the distribution of postings among these categories.

FIGURE 1: FINDINGS BY HEALTH SYSTEM REVIEWED



As shown in Figure 1, 61% of health systems reviewed had posted a file containing the elements we reviewed. About one in three had posted payer-agnostic standard charges only, and a small fraction (6%) had either not posted any files or had posted a limited number of files.

CHALLENGES WITH POSTED FILES

Several challenges exist with the subset of published data Milliman is collecting, cleansing, standardizing, and analyzing:

- The payer name and line of business are often difficult to decipher and do not always appear identically across a hospital's file.
- The granularity of the data varies widely from hospital to hospital with some files incorporating an internal coding system as a level of detail in addition to common healthcare coding schemes.
- Some files contain what appear to be duplicate records, but have differing negotiated rates between the records, which could be due to missing attributes (such as procedure code modifiers) not published by the hospital.
- The level of detail in the files is not necessarily specific to how the negotiated charges are imposed for each payer: case rate, per diem, discount off of billed charges, etc. Additionally, there is no manner in which to distinguish a value derived from the hospital's experience data from one sourced directly from a contract.

Because of these challenges, it can be difficult to ascertain comparable information across hospitals and payers from a simple review of the files. In order to extract maximum value from the posted information, users will need to develop a methodology to convert the raw data into useful information. Milliman is developing a process for this that will be covered in future whitepapers and briefs.

Potential uses

The data being published opens up both opportunities and competitive threats for industry stakeholders including providers, payers, and technology vendors including:

- Collecting, transforming, and automating the collection of current and historical payer rates to determine trends
- Analyzing market position relative to competing providers and payers
- Comparing hospitals' weighted average reimbursement based on utilization distribution and payer mix[3]
- Developing direct-to-provider contracts for employers
- Identifying the financial impact of network types and supporting negotiations
- Assisting consumers to better understand the cost of healthcare services and episodes along with the impact of out-of-pocket costs

Conclusion

The hospital price transparency rule introduces new opportunities and competitive threats. The landscape continues to evolve rapidly as hospitals and health systems work to meet the regulation. Milliman is closely monitoring the situation, and working to develop new tools for analyzing and enriching these new data assets. Even when working with files that contain all the elements required by the rule, there are challenges in using and comparing data as-is. Milliman provides the expertise and knowledge to better interpret hospital price data.

Limitations & caveats

- Each health system website was manually searched for price file data and some health systems post files that apply to multiple hospitals. In many cases, we only reviewed a sample of hospitals within a health system to ensure consistency of the posted data across the system. The three categories of findings (no or limited files posted, primarily just payer-agnostic standard charges, and primarily contains all reviewed elements) are assigned to a health system based on our observations that held true across a majority of the hospital files we reviewed within that health system and could be subject to sampling bias.
- The top 100 health systems were based on the total bed count in short-term, children's, or critical access hospitals. Our selections may not be representative of regional or nationwide averages.
- The categorizations in this brief reflect a point-in-time conclusion. Files may have been updated since retrieval and the categorization may not be complete.
- Reviewed elements include gross charges, discounted cash prices, payer-specific negotiated rates, and de-identified minimum and maximum charges by item/service.
- No audit of the values in the files was performed.
- There are over 6,000 total hospitals[4] in the United States and results are subject to change as more data is collected and analyzed. We are analyzing files for short-term, critical access, and children's hospitals in this brief.
- The CMS Final Rule contains a standard file naming convention, but we did not analyze this as part of the current brief.

Endnotes

1. Barrington, A., Boschert, J., Gaal, M., & Lewis, D. (April 2021). Hospital price transparency: March 2021 update. Retrieved on May 25, 2021, https://us.milliman.com/-/media/milliman/pdfs/2021-articles/4-5-21-hospital_price_transparency.ashx.
2. Federal Register, Vol. 84, No. 229 (November 27, 2019). Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public. Final Rule. Retrieved on March 8, 2021, from https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf.
3. Pickering, J., Lewis, D., Hamacheck M., & Barrington, A. (December 2020). Hospital price transparency – Now what? Retrieved on March 8, 2021, from https://us.milliman.com/en/insight/hospital-price-transparency-now-what.
4. Fast Facts on U.S. Hospitals, 2021. Retrieved on March 8, 2021, from https://www.aha.org/statistics/fast-facts-us-hospitals.

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