MILLIMAN BRIEF

Hospital price transparency: March 2021 update

Early implementation trends for new regulations

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Regulations that took effect January 1, 2021, are set to introduce 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 60 days—is the first in a series of reports Milliman will publish on this topic.

Introduction

On November 27, 2019, CMS published a Final Rule[1] 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 that are 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 55 health systems (representing more than 600 hospitals) across 42 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 March 3, 2021, 68% have posted at least one machine-readable file containing gross charges, discounted cash prices, payer-specific negotiated rates, and de-identified minimum and maximum charges by item/service.

In the first month after the Final Rule effective date, few of the health systems we researched had posted any files containing payer-specific negotiated rates. Starting in February we observed an increase in the number of organizations with posted files.

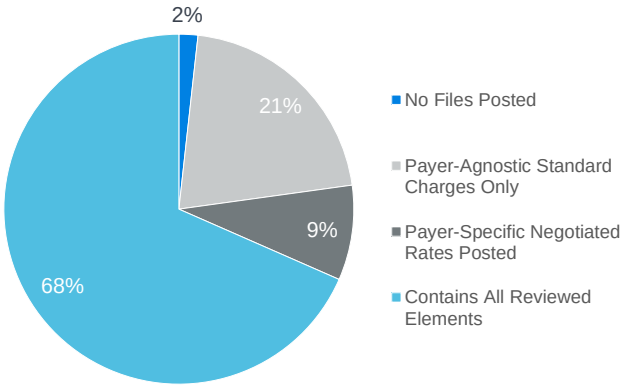
It is notable that even among organizations that posted files, there was variation among the scope of the postings. We segmented this variation among three categories:

- Payer-agnostic standard charges only
- Payer-specific negotiated rates
- Gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges

At the end of the 60-day period, only a small fraction (2%) of health systems had not posted any files. Figure 1 shows the distribution of postings among these categories.

As shown in Figure 1, 68% of health systems reviewed had posted a file containing all the elements we reviewed. Just over one in five had posted payer-agnostic standard charges only, and just shy of 10% had posted a file containing payer-specific negotiated rates. A very small fraction (2%) had not posted any files.

FIGURE 1: FINDINGS BY HEALTH SYSTEM REVIEWED



CHALLENGES WITH POSTED FILES

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

- The regulation requires that files be posted in machine-readable file formats (e.g., JSON, CSV, and XML). Some of the posted files do not meet this requirement (e.g., PDFs).
- There is a high degree of diversity in the file layouts, with everything from very "wide" flat files to very complex hierarchical structures.
- The schemas used across the posted files are not standardized. Although the posted files tend to be consistent for all/most hospitals within each health system's posting, this is not always the case within a single health system and seldom the case among health systems.
- Hospitals often do not provide supplemental documentation regarding the layout or content of the files. All assessment of the information is based on the data itself without guidance from the hospital that posted the files.
- The composition of the information is diverse, with most files having at least Current Procedural Terminology (CPT) codes. Several files include rates using classification schemes such as Diagnosis-Related Groups (DRG) or Ambulatory Patient Groups (APG).

Although not reflected in the early postings, we expect there will be some variation resulting from changes in the schemas.

Potential uses

The data being published opens up both opportunities and competitive threats for industry stakeholders such as 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[2]
- 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 is working to develop new tools for analyzing and enriching these new data assets.

Limitations and caveats

- Each health system website was searched for price file data and some health systems post files that apply to multiple hospitals. Note that our sample 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[3] in the United States, and results are subject to change as more data is collected and analyzed.
- The CMS Final Rule contains a standard file naming convention, but we did not analyze this as part of the current brief.

ENDNOTES

[1] 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

[2] 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.

[3] 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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