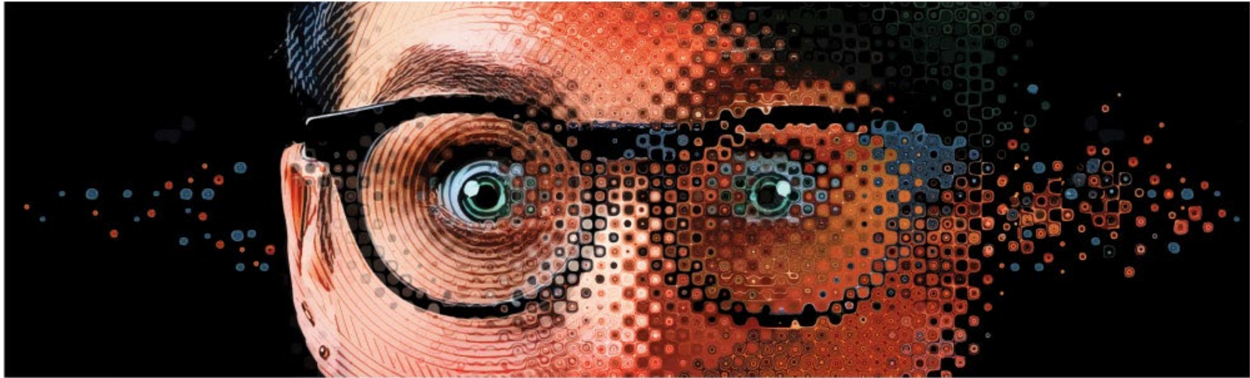
AMS
INTELLIGENT ANALYTICS



The Hospital Price Transparency Paradox

Chargemaster Confusion

It was meant to be easy. In the mid-1950s public reporting requirements necessitated hospitals begin to publicly set their rates based on billed charges for individual "shoppable" items and services they provided. The Chargemaster.

It didn't take long, however, for Chargemaster prices to become useless. Why? Because while hospitals moved to payments based on (lower) health insurance industry negotiated rates, the prices listed in the Chargemaster remained the same. In essence, the "shoppable" rates in the Chargemaster continue as an artifact of those public reporting requirements, reflecting what uninsured, cash customers have to pay (i.e., highly inflated prices several times that of actual costs to the hospital).

To be fair, at the highest, broadest level, CPT codes (a medical code set used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations) are uniform throughout healthcare. Find a code for, say, a 1st degree burn (CPT 15000) at Hospitals A, B, and C and their respective charges (prices) are readily apparent.

But what about the myriad of items or services that do not have CPT codes? Take, for instance, supplies such as screws. There is no required consistency with an item from one provider to the next. Hospital A may list a "Screw Spinal" whereas Hospital B might just list "screw" and Hospital C "TI screw." Other descriptions vary just as much, from simplistic to extreme detail. A real-world example:

- Hospital A: "Cervical plate"
- Hospital B: "Spinal plate", "plate spinal cervical nonsterile"
- Hospital C: "PLATE SPINAL L52XW18MM L43MM THK2.5MM CSLP TITANIUM CERVICAL 2 LEVEL VARIABLE ANGLE LOCKING IMPLANTABLE NONSTERILE"

Then there's the terminology. A "Charge" is not the same as a "Billed Charge."

A Charge is the full price of a single service or supply before an insurance rate, or a negotiated discount is applied. A Billed Charge totals the units of services or supplies. A claim may have 2 units. Therefore, if a procedure Charge is listed as $10 per unit on a Chargemaster the Billed Charge is the total, in this case $20.

Simple? Well, keep in mind that although hospitals charge the same amount to all payers, regardless of negotiated rates, what they will accept as reimbursement is altogether different. Payers call this the Allowed Amount. Payers allow a different amount vs. the Billed Charge in accordance with their specific negotiated

contract discount, DRG Rate, case rate, per diem or fee schedule—which may also be different by insurance product.

To be sure, language consistency was hardly the only issue causing confusion. Over time there grew a whole host of Chargemaster pricing disparities across provider platforms. Below are a few graphics illustrating the variations, using Remicade as an example throughout. All are based on the only dosage available for the drug: a 100 mg single dose vial.

Table #1 shows the Unit Price for Remicade for different hospitals across the US. In Washington state alone the prices run the gamut from $2379 all the way up to $6355.

State	Hospital Name	Unit Price
Alaska	Central Peninsula General Hospital	$1,420
Alaska	The Children's Hospital at Providence	$5,612
California	Redlands Community Hospital	$4,794
California	Barton Memorial Hospital	$5,409
Montana	Community Hospital of Anaconda	$1,863
Montana	Providence Saint Patrick Hospital	$2,721
Nebraska	Mary Lanning Memorial Hospital	$2,828
North Carolina	WakeMed Raleigh Campus	$4,625
Oregon	Providence Medford Medical Center	$3,807
Oregon	Providence Portland Medical Center	$3,807
Oregon	Providence Saint Vincent Medical Center	$3,807
South Carolina	AnMed Health Women's and Children's Hospital	$5,095
Washington	Kadlec Regional Medical Center	$2,379
Washington	Providence Sacred Heart Medical Center and Children's Hospital	$2,469
Washington	Swedish First Hill Campus	$4,804
Washington	Providence Saint Peter Hospital	$5,188
Washington	Providence Regional Medical Center Everett Pacific Campus	$6,355
Wyoming	Cheyenne Regional Medical Center	$4,223

Table #1: Remicade Unit Price by Hospital

Table #2 reveals the wide array of average charges for Remicade in different US states, ranging from $76 in New York to $2522 in Montana.

State	Hospital Name	Average Charge
California	Henry Mayo Newhall Memorial Hospital	$119
Georgia	Fannin Regional Hospital	$383
Indiana	Indiana University Health Bloomington Hospital	$324
Indiana	Indiana University Health Methodist Hospital	$324
Michigan	C.S. Mott Children's Hospital	$2,233
Michigan	Metro Health Hospital	$2,233
Montana	Livingston HealthCare	$2,522
New Mexico	Lea Regional Medical Center	$641
New York	Jamaica Hospital Medical Center	$76
New York	White Plains Hospital	$167
New York	UHS Delaware Valley	$189
New York	UHS Binghamton Hospital	$201
New York	UHS Wilson Medical Center	$201
New York	UHS Chenango Medical Center	$205

Table #2: Remicade Average Charge by Hospital

Let's pause here a moment to address what some eagle-eyed readers may have spotted in the first two tables, namely a conspicuously wide span of charges. This has to do with units. Often, units aren't properly attributed to a price nor billed correctly.

As an example, Remicade could be (incorrectly) billed as: a) 1 unit, which could represent 1/100 of a 100 mg vial or a single 100 mg vial; b) 10, which would represent the correct amount but must be billed in units of 10; or c) 100, which would be 1-100 mg vial. So, in the first row of Table #2 where you see the average charge of $119, it's very probable that figure represents 10 units, hence the vial would be $1190. (This is why it's useless to simply republish—as many vendors are doing and touting as "solutions"—the 300 shoppable services that are in various Chargemasters.)

Price variation also occurs within the same network for different hospitals. That variance is depicted in Table #3, listing the Average Negotiated Payment Rates.

State	Hospital Name	Network Name	Average Negotiated Payment Rate
Alabama	Baptist Medical Center South	BLUE ADVANTAGE	$42
Alabama	Prattville Baptist Hospital	BLUE ADVANTAGE	$42
Alabama	Baptist Medical Center South	BLUE CROSS	$48
Alabama	Medical West	BLUEADVANTAGE_OPPS	$48
Alabama	Prattville Baptist Hospital	BLUE CROSS	$48
Alabama	DCH Regional Medical Center	BLUE CROSS	$3,087
Alabama	Fayette Medical Center	BLUE CROSS	$3,087
Alabama	Northport Medical Center	BLUE CROSS	$3,087
Minnesota	Park Nicollet Methodist Hospital	Blue Cross Blue Shield of Minnesota	$57
Mississippi	Saint Dominic Hospital	Blue Cross of Mississippi FMP OP Rate	$114
Nebraska	Kearney Regional Medical Center	Blue Cross Inpatient Allowable Rate	$2,204
Nebraska	Kearney Regional Medical Center	Blue Cross Outpatient Allowable Rate	$2,204
New Mexico	UNM Sandoval Regional Medical Center	Blue Cross Blue Shield Medicare	$47
New Mexico	UNM Sandoval Regional Medical Center	BLUE CROSS BLUE SHIELD	$222
New York	Elizabethtown Community Hospital	Blue Cross Blue Shield of NY Empire	$1,654
New York	The University of Vermont Health Network Ticonderoga Campus	Blue Cross Blue Shield of NY Empire	$1,654
New York	Nicholas H Noyes Memorial Hospital	Blue Choice OPT	$1,980
Wisconsin	ProHealth Waukesha Memorial Hospital	Anthem Blue Priority	$2,304

Table #3: Same Network, Different Hospitals

Note that the same issues pertaining to units in the first two tables apply here as well. Yet again, confusion reigns supreme.

Lastly in Table #4, we see the Average Negotiated Payment Rates for the same hospital, but different networks. For just one Alabama hospital, Remicade pricing runs from $42 to $181.

State	Hospital Name	Network Name	Average Negotiated Payment Rate
Alabama	Baptist Medical Center South	BLUE ADVANTAGE	$42
Alabama	Baptist Medical Center South	PHYSICIAN MUTUAL	$42
Alabama	Baptist Medical Center South	HUMANA MEDICARE	$44
Alabama	Baptist Medical Center South	VIVA MEDICARE	$45
Alabama	Baptist Medical Center South	UHC Medicare	$46
Alabama	Baptist Medical Center South	HUMANA PEEHIP MEDICARE	$47
Alabama	Baptist Medical Center South	BLUE CROSS	$48
Alabama	Baptist Medical Center South	VIVA HEALTH	$87
Alabama	Baptist Medical Center South	FIRST HEALTH	$135
Alabama	Baptist Medical Center South	UNITED HEALTHCARE	$136
Alabama	Baptist Medical Center South	BEECHSTREET	$145
Alabama	Baptist Medical Center South	HEALTH CHOICE	$145
Alabama	Baptist Medical Center South	HUMANA	$145
Alabama	Baptist Medical Center South	Multiplan	$145
Alabama	Baptist Medical Center South	Cigna	$158
Alabama	Baptist Medical Center South	Aetna	$181

Table #4: Same Hospital, Different Networks

It's no wonder that the terminology gymnastics coupled by out of proportion Chargemaster pricing became a running joke in the healthcare business sector. And it probably would have stayed the industry's open secret if drug pricing didn't keep ballooning over the years.

Payers Perplexed

Fast forward to 2021. Congress can no longer ignore the outrageous spread imbalance between Chargemaster rates, and the real prices insurers negotiated to pay, finally stepping in to do something.

Effective January 1, the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) released the Hospital Price Transparency Rule. It requires hospitals to make their prices available online in two forms and update this information annually. Let's dig a bit deeper into the two specific rule requirements before we address some of the ambiguity in the final rule that is causing so much confusion among payers.

1. **The first requirement was to be a comprehensive, machine-readable file including "all items and services" provided by the hospital.**

This requirement impels hospitals to provide a billing code and description for all services and procedures provided during outpatient or inpatient care, including supplies, procedures, room and board, facility fees, and professional charges. For each procedure, item or service, the hospital must provide:

- The standard charge or gross charge as listed on their Chargemaster
- The discounted cash charge billed to individuals who pay cash for services
- The payer-specific negotiated charge for each contracted payer
- The de-identified minimum and maximum negotiated charge for each item or service
- For multi-hospital systems, each individual hospital with different charges must post this information separately for each location

2. **The second requirement was intended to provide the public with "consumer-friendly shoppable services" for 300 shoppable services provided by the hospital**.

The requirement requires a hospital to provide a listing of 70 CMS-specified shoppable services and 230 hospital-selected shoppable services that are commonly provided by the hospital for procedures that can be scheduled by a patient in advance. For each shoppable service, the hospital must provide:

- Ancillary services provided by the hospital that are billed by the hospital in conjunction with the primary shoppable procedure
- The hospital must also indicate the location where the service is provided
- The hospital must indicate whether the charge is for the inpatient or outpatient setting, or both
- In lieu of listing, the hospital may provide an internet-based price estimator tool, allowing consumers to estimate out-of-pocket amounts

With hospitals complying with the rule requirements consumers could now compare prices across hospitals and estimate the cost of care beforehand. Couldn't be simpler, right? So why is there so much confusion and non-compliance?

Delving into the requirement details above, there is a multitude of nuances and ambiguity on a variety of levels. As we've seen in the tables above, payers have multiple Payer-Negotiated Payment Rates based on the different Lines of Business or insurance products that they have (i.e., Traditional PPO, HMO, Medicare Advantage, etc.). In an industry already notorious for eschewing transparency wherever possible, it's not surprising in the least that they are loathe to reveal these. But the CMS is presently requiring hospitals to disclose "standard charges" for all items and services, which include gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.

Confusion abounds in what exactly those "standard charges" are. Apparently, the rule is so poorly written that providers have no clarity as to which will be acceptable to the CMS. This leads to the inevitable: Providers are submitting a vast array of different price points for the same things.

This, of course, means that those items and services supposedly meant to be easily equated have essentially become apples and oranges. The rule was to be "shoppable," but now with discounted rates, averaged rates, and single and multiple rates for each Line of Business …it has come to be categorically dissimilar and disjointed, and thus the intent of the rule is defeated. This is the transparency paradox. Information is being reported, but what good is all that data if you can't make sense of it?

Sensible Solutions

But what if there was a way to make sense of it all, even as jumbled and complex as it is? Is it possible to take that morass of information and transform it into clean data with meaningful insights as it was originally intended? Perhaps an engine could amass all the disparate rates and funnel them into one cohesive software solution. The dashboard would be able to search across multiple platforms (by provider, network, CPT code, zip code, keyword, etc.) to pinpoint the exact charges (by hospital, Medicare, network) and billed amounts the user was looking for. Wouldn't that be something?

A healthcare leader with a data-driven analytics powerhouse focused on providing clients with payment intelligence could do that. And probably is. Stay tuned…