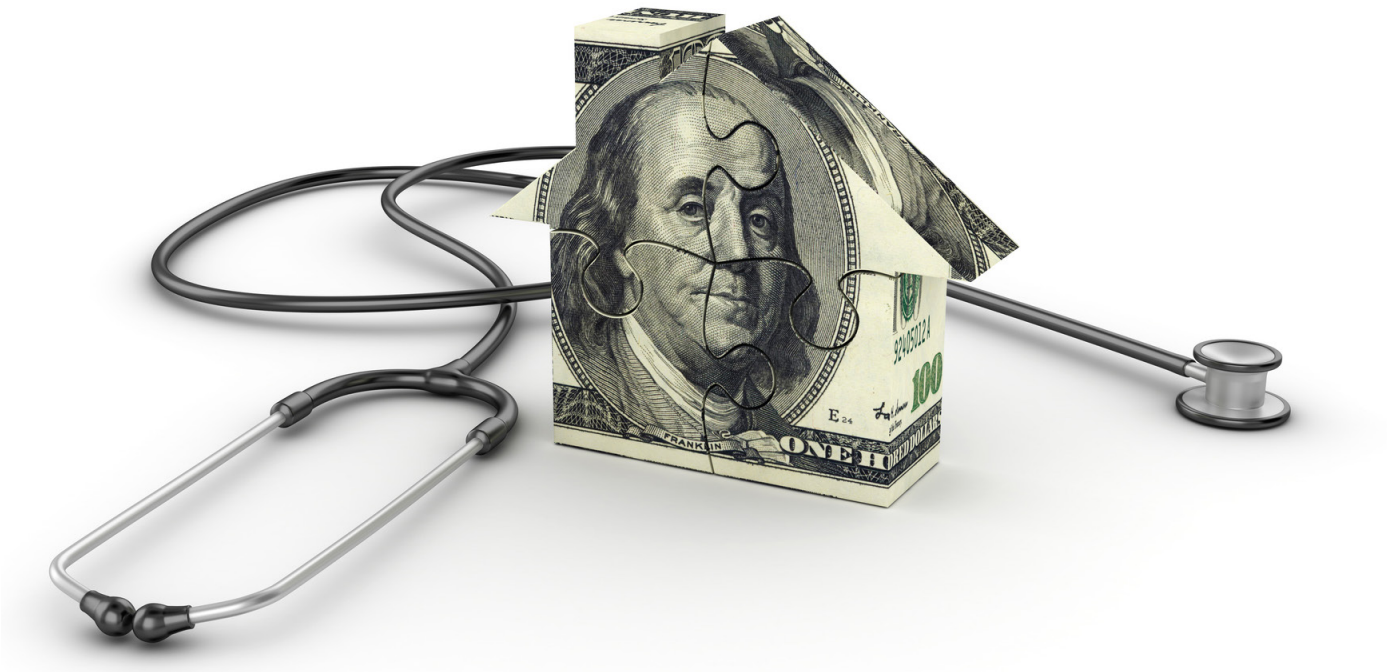
The Hospital Price Transparency Rule

DRIVING IMPROVED PAYMENT ACCURACY

David Cardelle, R.PH, Chief Strategy Officer, AMS



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If you happen to be interested enough to be reading this, you are likely aware of The CMS Hospital Price Transparency Final Rule that went into effect January 1, 2021. You may also be aware that while some hospitals have been compliant in publishing chargemaster rates, negotiated rates and cash discount prices, many hospitals have not been fully compliant. Under the new hospital transparency final rule, most hospitals in the United States must post their standard charges (chargemaster rates), certain other negotiated rates and specific shoppable rates including cash discounted rates. This data needs to be published in a prominent way, accessible on a publicly available website, in machine readable format. Sounds pretty straight forward, right? Well, there is more to the story as nothing in healthcare is ever that simple.

CMS required hospitals to be compliant with this final rule almost 2 years ago. So how can so many hospitals still be classified as non-compliant? Taking a closer look at the "non-compliant" hospitals, many have reported partial data, leaving gaps around important information. For instance, the published chargemaster data may be accurate but they may not have reported negotiated rates or disounted cash prices. Some hospitals published excessive amounts of data, even more than required. However, in doing so, the data is published in a way that is extremely difficult to parse out the important required information. Still others have submitted data that is lacking integrity throughout, or the data is formatted in an unstructured way. All of these issues in aggregate renders a significant portion of the data published by hospitals as "unusable." This becomes concerning, especially for those facilities that may be doing this intentionally.

To be fair, there are plenty of good reasons for hospitals to be partially compliant, just based on the final rule itself and the lack of standardized requirements. Likewise, there are plenty of good reasons for non-hospital stakeholders to be frustrated with the level of hospital partial compliance, this far after January 1, 2021. Your opinion will depend on where you sit in this equation.

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Rather than further that controversial debate, it is more interesting and more meaningful to think about innovative use cases for the “useable” subset of data that does exist today. Also, the volume of useable data continues to improve as fines are imposed, and hospitals are starting to refine what they are publishing on their websites. Focusing on the useable data, my payment integrity background leads me to think about the importance of this newfound data through that lens versus the intended “rate shopping” use case. Specifically, there are a few exciting use cases that can now leverage this new important data to drive improved payment accuracy and do so at scale. While these use cases may not be completely new to the payment integrity domain, these use cases can now be deployed at scale. The lack of accessible pricing data in the past, significantly limited the ability for health plans to verify list prices or billed amounts. Specifically, “Chargemaster Reconciliation,” “Chargemaster Validation” and other payment integrity use cases and solutions can now be deployed in a much more efficient, pervasive, and meaningful way. Before getting into these use cases, it makes sense to provide a brief summary of the hospital price transparency final rule. Then we can look closer at how the final rule enables chargemaster list prices and the discounted cash prices to drive incremental payment integrity and payment accuracy opportunities.

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What is The CMS Hospital Price Transparency Final Rule?

To be compliant with the new hospital transparency final rule, most hospitals in the United States must post their standard charges prominently on a publicly available website and do so in two ways.

1. **Machine Readable File**[2]
   Single machine-readable digital file containing the following standard charges for all items and services provided by the hospital: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.

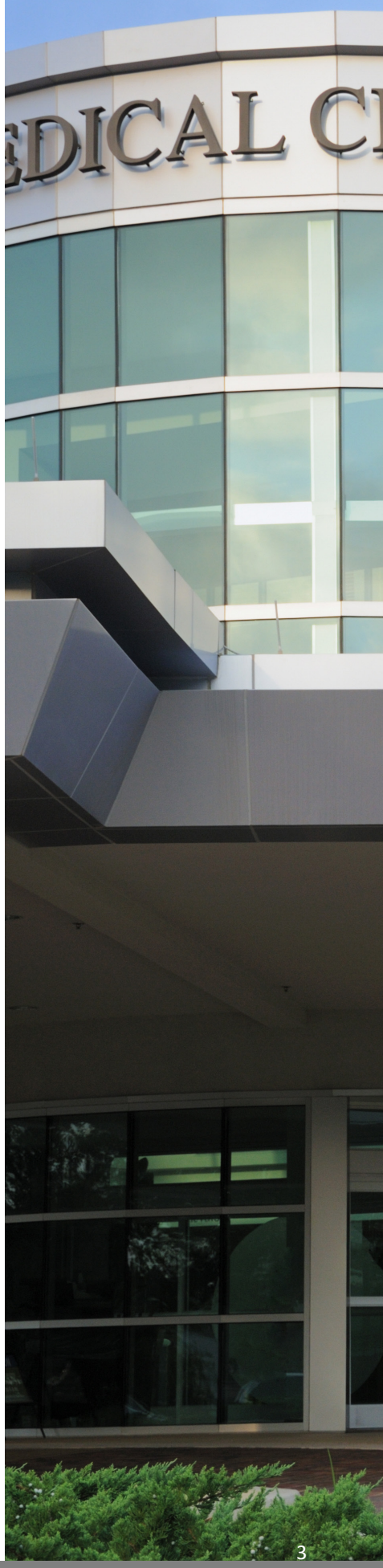
   More on Machine Readable File Requirements
   https://www.federalregister.gov/d/2019-24931/p-1010

2. **Consumer-friendly Display of Shoppable Services**[2]
   Display of at least 300 "shoppable services" (or as many as the hospital provides if less than 300) that a health care consumer can schedule in advance. Must contain plain lanuage descriptions of the services and group them with ancillary services, and provide the discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.

   More on Shoppable Services Requirements
   https://www.federalregister.gov/d/2019-24931/p-1030

What is The Discounted Cash Price?

Embedded in the hospital price transparency rule is the "discounted cash price" reporting requirement. This is the cornerstone of a unique and practical use case. The discounted cash price is a publicly published price of what the hospital accepts as reimbursement, from an uninsured patient, for a specific service provided to them from the hospital.



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Price Transparency Stakeholders

Hospitals and the Hospital Price Transparency Final Rule Impact

For most hospitals, the requirement to publish volumes of pricing data can be contentious. This pricing data has been previously viewed as proprietary information vs. public information. Most hospitals would only release a standard chargemaster report, if a contract allowed a Payer to access this information. Payers can utilize a chargemaster to verify year over year rate increases. The problem is, some contracts did not allow this information to be easily obtained and some hospitals simply did not provide this information, even if requested. Now, hospitals are being required to publicly publish and make available in electronic readable format, not just chargemaster data but negotiated rate information, and some discounted cash prices. All this has become a new burden on hospitals.

To gain a better perspective of the enormity and complexity of the data lift involved, we should look at the number of community hospitals in the United States that this rule impacts.

U.S. Community Hospitals 2020 Data (AHA Survey published 2022)[1]	
Total Community Hospitals	5,139
Total Community Staffed Beds	789,354
Total Community Admissions	31,393,318
Total Community hospital Expense	$1,102,282,383,000

Chargemaster systems in total serve many purposes in a hospital, from inventory control to financial functions across the facility and the “chargemaster report” is just one key report within the overall system. The chargemaster report is a comprehensive list of items and pricing. The specific descriptions of items and values of the data in those fields, is unique to each facility. Because each different chargemaster contains tens of thousands of unique items or services, the number of variables becomes exponential, and you can easily see how massive the chargemaster data is in its entirety.

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In addition, when the final rule went into effect, it did not require hospitals to publish their data in a standard format. This lack of standardization led to confusion and partial compliance. This oversight opened the door for a hospital to publish data in a variety of different formats, rendering some of this data as unusable. After reviewing thousands of chargemaster files, from thousands of hospitals, there are plenty of organizations that did a decent job. However, there are many others that put a lot of work into making these files extremely complex, massive in size and difficult to interpret or use. As example, some of the published pricing data does not line up with the procedure or service unit description, providing a package size price instead of the price for a single unit of an item or drug. It may land as a bit ironic that with "interoperability" becoming one of the biggest buzz words over the last few years, you would assume that something as simple as requiring a standardized format for hospitals to publish data, would be of upmost priority.

Consumers and the Hospital Price Transparency Final Rule Impact

For consumers, the intended benefactor of the final rule, there seems to be limited immediate value. Unless consumers gain access to this data through a third-party vendor, capable of aggregating and parsing out the unusable data and curating the useable data, it is exceedingly difficult and time consuming for a lay person to use what is published. The value and intention of the hospital transparency rule was for a patient to be able to compare prices across various hospitals for the same procedure. I know how difficult this actually is because I tried. I conducted three individual searches of three local hospital websites for the same procedure. Each data file was published differently. They all had different information and price points listed in different formats, and it became a time-consuming challenge of comparing apples to oranges. Also, it created more questions than it answered. I felt the next step would have to be a phone call to the hospital to try and validate and gain clarification. I encourage everyone to try it themselves to see firsthand, just how complicated this process can become. Third-party analytics organizations can help sort out the massive amount of data and disparities across the thousands of published files.

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Third-Party Analytics Organizations and the Hospital Price Transparency Final Rule Impact

The technical lift to obtain all the chargemaster prices, negotiated rates, shoppable rates and discounted cash prices, from all the hospitals is a massive undertaking. To curate this data and make it useable, is yet another enormous undertaking. There are several third-party software and analytics-based organizations currently pulling all this disparate data together and curating what is useable for the intended use case, shopping for comparative rates for common procedures. Some are ahead of others, some are more accurate than others, some offer more functionality and features than others and some are doing this at no cost to the consumer. As hospitals become more compliant and the aggregate data becomes more complete, these analytics and tools will become more meaningful. Being able to comparison price shop, helps further the commoditization of healthcare services.

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What Exactly is a Hospital Chargemaster?

Hospitals use the Chargemaster or more specifically the Chargemaster Report to create a comprehensive list of charges for all procedures, services, supplies, devices, products and drugs for those services and items. The chargemaster is also used to track and report on volumes of items and service, costs, and revenue. **Consider the chargemaster a comprehensive menu of every item and service that can be billed by the hospital.** For each item or service, the chargemaster should include at least the following:

Department Number
Hospital specific numeric designation for department, not universal or standardized.

Charge Code or Item Number
Hospital specific code assigned by the facility and unique to one service line item. This is not a universal or standardized code.

Revenue Code
Universal code used by all hospitals Established by the NUBC (National Uniform Billing Committee).

Procedure Code
Current Procedural Terminology (CPT) code created and maintained by the AMA. Healthcare Common Procedure Coding System (HCPCS) code created and maintained by the CMS.

Modifiers
Modifiers are specific to particular codes to add more detail to the item or service. Some modifiers may impact reimbursement.

Item Description
Translates the CPT or HCPCS into a brief description created by the hospital and these are not universal or standardized.

Charge Amount
Fee assigned to the service line item. This is the price charged to the Payer and does not represent hospital cost.

What is a Basic Chargemaster Report?

A typical and basic hospital chargemaster report does not contain contracted rates, discounted cash prices or other monetary values, other than the gross list pricing for services and items. While these other monetary data points are maintained within the same chargemaster system, they are not considered part of the basic chargemaster report. Now, with the new hospital price transparency rule, some of these negotiated rates and discounted cash prices are required to be published, where they had not been public information in the past. This is important as these new data points open up some very new and meaningful use cases relative to payment accuracy objectives. The mere fact that hospitals are now required to publish rate information also opens the door for added accountability and responsibility from a consumer protection perspective, which requires the publishing of price information to be accurate. We are all familiar with examples of deceptive, predatory, and other unlawful pricing strategies in the retail and service industries, and those same laws would apply to shoppable healthcare procedures with publicly published rates.

Hospital Name: General Hospital NPI: 0987654321

Dept. #	Charge Code	Rev Code	Proc Code	Mod	Item Description	Charge Amount
1234	123456	123	A1234	AB	Item Description	$1,234
4321	654321	123	98765		Item Description	$5,321

Table 1 | Basic Chargemaster Report

Furthermore, hospitals create their own chargemaster information and assign their own pricing. If an item or service is not included in the hospital chargemaster, it should not be billed by the hospital and it should not be reimbursed by the Payer. Some items that are listed on the chargemaster are also considered “Not Separately Billable (NSB), “Not Separately Reimbursed” (NSR) and are often billed but should not be reimbursed by the Payer. These items represent mostly unbundled items that are included in base reimbursement rates, or the item is simply a non-covered service or item. Regardless, for billable items, the chargemaster list price should match the billed charges on a submitted claim. The hospitals published discounted cash rate should reflect what the hospital is willing to accept as reimbursement. More on this later.

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Is Chargemaster Data Even Useful for Payment Integrity Reviews?

Over the past several years I have read various articles, blogs, and posts on how "Chargemaster" information is meaningless, because "no one really pays at the chargemaster list price." In fact, chargemaster data is extremely valuable information for a variety of reasons. While it is true that no one should have to pay the full chargemaster list price, knowing this upper limit published price is especially important. Hospital chargemaster list prices provide information necessary to validate the accurate starting point before contractual discounts are applied on fee-for-service claims.

What is Chargemaster Reconciliation?

Chargemasters are dynamic and can change at any time based on new or expired regulations, products, services, codes, departments, and costs. Many Payer contracts impose a limit on how much list charges can increase annually from contract year to contract year, so Payer audits or "reconciliation" of chargemaster rate increases is important. One problem with Payer reconciliation of chargemasters is that these audits are done on an item-by-item comparison of just one unit and do not consider the utilization or volume of the items being billed. This linear audit methodology masks the overall aggregate price increase and hides what is most important, the financial impact that rate increases have on a Payer.

For example, an item has a list charge of $1,000 and that service has low utilization and is only billed 100 times a year, but analysis shows that this same item has a chargemaster list price reduction of -18.96% per unit. However, a different item has high utilization and is billed 1,000 times a year and has a chargemaster price increase of 8.06% per unit. The total new chargemaster pricing, in aggregate shows a net reduction in chargemaster rates of -10.96% on a one unit to one unit comparison and falls well below the contracted price inflation cap with the Payer. This is extremely misleading because it is unit to unit comparison for each item and does not incorporate actual utilization volume and extended total price. The full financial impact of these 2 price changes is masked. When adding in the total volume utilization of the two items, the financial impact to the Payer is +7.45%, above the contracted annual price inflation cap and more important, has a net $429,000 cost increase to the Payer for just two items in this example below.

Per Unit Chargemaster Price Increase/Decrease						Actual Net Annual Chargemaster Price Increase/Decrease			
Proc Code	Per Unit	Charge Amount	New Charge	% Change	Price Increase/ Decrease	Annual Unit Utilization	Original Charge Amount	New Charge Amount	Net Change $
A1234	1	$1,234	$1,000	81.04%	-18.96%	100	$123,400	$100,000	($23,400)
98765	1	$5,321,000	$5,750	108.06%	8.06%	1,000	$5,321,000	$5,750,000	$429,000
					-10.90%				**7.45%**

Table 2 | Year-Over-Year Chargemaster Reconciliation

For decades, Payers have asked for chargemaster information in order to perform reconciliation audits to verify contractual rate increases. This has been a difficult task to perform for a variety of reasons. Mostly, there was a lack of hospital cooperation, standardization of data, contractual language and/or technology limitations, preventing chargemaster reconciliation audits to be done in scale. Chargemaster reconciliation was mostly limited to performing on a one-off basis. Some contracts had rate increase caps outlined in the contracts, but they did not have specific audit rights to include receiving chargemaster data from the hospital in order to validate the year-over-year variance.

That in a nutshell is mostly what chargemaster reconciliation was then. Today, things became instantly different with the enactment of the hospital price transparency rule. One of the best by-products of this new requirement is that chargemaster reconciliation is now possible, and it can be done efficiently and in scale. More importantly, the data now opens up additional, and more meaningful use cases of chargemaster reconciliation than just year-over-year rate comparison. There are now additional opportunities to perform overall chargemaster validation that allows Payers to verify that the correct discount is applied to the correct charge to begin with and do so across all hospitals.

What is Chargemaster Validation?

Chargemaster Validation is the verification of a hospital's published chargemaster report or list price for an item or service, directly compared to the actual billed charges on a submitted claim. To perform true validation of accurate reimbursement on fee-for-service claims, one needs to verify that the billed charge submitted on a claim is in fact the correct starting point before applying a contractual discount (xx% off billed charge). The easiest example of this, outside of healthcare but where consumer protection and other laws are specific, is with retail sales. The price tag on an article of clothing is $50 and the sign advertising a sale states, "50% off" the price tag.

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The correct starting point is $50 x 50% discount = $25, about as simple as it gets. The chargemaster list price is the hospital "Price Tag" of retail, or the starting point, before negotiated discount. Previously, without access to the chargemaster list price on every transaction, there is no way to validate that the billed charge on a submitted claim, was in fact what the hospital had documented as their list price for that service on their chargemaster. Due to timely payment penalties and turn-around requirements, Payers traditionally apply discounts to whatever billed charges were submitted, in good faith, with few options to validate the accuracy of the billed charge at the time of payment and even post payment.

When you get the bill at a restaurant, did the restaurant charge you exactly the amount on the menu for that glass of wine? Would you pay more than the price on the menu without questioning the discrepancy if it more than the menu price, even 2, 3, 4 or more times? Just like in retail or any other consumer protected transaction, the billed charge submitted on a healthcare claim should match the chargemaster list price on the date the service was provided. Can this newfound data be used to identify and avoid these billing and reimbursement discrepancies? What type of supporting rationale to enforce this, is there beyond practical common sense? First, CMS actually requires that even on DRG reimbursed claims under the inpatient prospective payment system (IPPS), hospitals charge accurate billed charges for each item. This is because accurate billed charges are just one data point (but an extremely important one) of many that is required to be reported to CMS in the annual hospital reporting requirement. CMS uses this and other data points to understand resources used to treat patients at that hospital and determine the appropriate weighting in that complex calculation.

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.[3]

This indirectly is part of the hospital annual cost reporting requirements that CMS uses to determine cost to charge ratio information, which ultimately determines appropriate DRG reimbursement rates.

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Medicare-certified institutional providers are required to submit an annual cost report to a Medicare Administrative Contractor (MAC). The cost report contains provider information such as facility characteristics, utilization data, cost, and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). HCRIS includes data for the Hospital Cost Report (CMS-2552-96 and CMS-2552-10), Skilled Nursing Facility Cost Report (CMS-2540-96 and CMS-2540-10), Home Health Agency Cost Report (CMS-1728-94 and CMS-1728-94), Renal Facility Cost Report (CMS-265-94 and CMS-265-11), Health Clinic Cost Report (CMS-222-92), Hospice Cost Report (CMS-1984-99 and CMS-1984-14), Federally Qualified Health Clinic Cost Report (CMS-224-14), Rural Health Center Cost Report (CMS-222-17), Community Mental Health Center Cost Report (CMS-2088-92 and CMS-2088-17) and Organ Procurement Organizations(CMS-216-94).[4]

So, skewing the billed charges, skews the hospital annual cost report and that skews the Medicare prospective payment rates for DRG on future claims to that hospital. While this a significant reason that underscores the importance of billing claim amounts that align with the chargemaster list price, it is also common sense that these two should always align. Billed charges on a claim need to match a chargemaster list price because the intent of consumer protection laws and regulations are more than enough to justify why this is essential. Furthermore, the same applies to publicly published discounted cash prices. These should also be viewed as the maximum anyone, especially without coverage, should ever pay, when those prices are made publicly available.

Validating the correct starting point, before discount is applied, is exactly where billing errors and incremental savings can now be documented. It's a simple, straight forward, and obvious use case that can now be performed in scale, using the newly published chargemaster list price data and discounted cash prices. After retrospectively reviewing thousands of hospital chargemasters against millions of records of actual claims data, the vast majority of hospitals are in fact billing the exact amount for each listed procedure, service, item, or drug, in alignment with their published chargemaster list price, specific to the date the service was provided. This is exactly as you would expect it should be. While this is the majority of healthcare transactions, there are other facilities that are in fact, submitting billed charges that far exceed their own published chargemaster pricing and sometimes this variance is multiples of the correct chargemaster price. It does not make sense to take a 20% discount off a billed charge that is 500% higher than the hospital's own published chargemaster price for that service or item. Additionally, there are many facilities billing claims and being reimbursed exponential to their own published discounted cash price for services rendered to patients that are out of network or where no insurance coverage exists.

Hospitals still have a long way to go in reporting accurate data to get to 100% useable data. Regardless, AMS has been actively marshalling this enormous amount of data over the past 3 years to help deliver a solution that can provide this essential information in an accurate and seamless way, wherever possible.

Current AMS Curated Data Chargemaster, Negotiated & Discounted Cash Price Data (All "useable" data is increasing with improved hospital reporting compliance)	
Hospitals with Chargemaster Data	5,606
Files Downloaded	6,214
Unique Codes	5,090,617
Line Items Downloaded	4,884,990,301
Total Billed Dollars per Unique Line Item	$261,074,278,198
Unique Negotiated Networks	121,670
Negotiated Prices	11,178,586
Hospitals with Useable Cash Price Reported	1,933

The 3 Most Practical Questions Now Become:

1. **Participating Provider, In-Network Claims**
   Why would any Payer negotiate and reimburse a hospital more than their own published discounted cash price, which is based on 1 patient and 1 unit of care?

2. **Participating Provider, In-Network Claims**
   Why would any Payer base reimbursement on a billed charge that is higher than the hospitals own publicly reported Chargemaster Price?

3. **Non-Participating, Out-of-Network Claims**
   Why would any Payer reimburse a hospital more than an uninsured individuals discounted cash price?

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Use Cases | Chargemaster and Discounted Cash Price

1 Why would any Payer negotiate and reimburse a hospital more than their own published discounted cash price, which is based on 1 patient and 1 unit of care?

Leveraging large membership in a geographic location, professional contract negotiators at Payer organizations drive lower pricing based on volume discounts. While this may be the case most of the time, there is a large volume of claims reimbursed at Payer negotiated rates which are surprisingly several times the uninsured cash customer discounted price, so this is something to identify, quantify and improve, using this new data as powerful business intelligence. However, there are some contracts that are negotiated with a ***"lowest price guarantee"*** documented in the contract, so this becomes something else to verify, audit and reconcile. Now that hospitals are required to make these discounted cash prices available to the public, Payers can make a compelling argument that for contracted or participating providers, the lowest price guarantee includes comparing to a hospital discounted cash price. If they do not have this lowest price guarantee documented in their contracts today, Payers should at the very least, negotiate upon renewal for this guarantee or introduce ***"lesser of" language.*** It is hard to imagine how a hospital can rationalize charging an insured patient more money than an uninsured patient, just because they have insurance. If anything, Payers should negotiate below a hospital's discounted cash price. The only argument that has been made, is that the hospital may charge more for some items and less for others, so the aggregate basket pricing approach should yield lower net pricing for contracted Payers. Without empirical data, this claim is usually unsupported. Below in Table 3 is an actual example of one facility where the discounted cash price for procedures for one uninsured patient is lower than an In-Network negotiated reimbursement from a major Payer that drives volumes of patients to that provider.

NPI	Hospital Name	Claim ID	Claim Line Item	Date of Service	Proc Code	Proc Code Desc	Chargemaster Uninsured Discounted Cash Price	In-Network Claim Allowed Amount	Savings
XX1	Facility 1	XX1A	9	2/7/2022	83090	Homocysteine	$168	$248	$80
XX1	Facility 1	XX1A	9	2/7/2022	83090	Homocysteine	$168	$248	$80
XX1	Facility 1	XX1A	16	2/7/2022	84443	Thyroid (TSH)	$116	$171	$55
XX1	Facility 1	XX1A	3	2/7/2022	82525	Copper	$109	$161	$52
XX1	Facility 1	XX1A	14	2/7/2022	83735	Magnesium	$63	$93	$30
XX1	Facility 1	XX1A	10	2/7/2022	83540	Iron	$53	$77	$25
							$677	**$998**	**$321**

Table 3 | In-Network "Allowed Amount" Exceeds "Uninsured Discounted Cash Price"

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2 Why would any Payer base reimbursement on a billed charge that is higher than the hospitals own publicly reported Chargemaster Price?

Identifying claims where reimbursement exceeds a chargemaster list price, allows for clear cut overpayments to be quantified and recovered. Most hospital billing systems draw from the chargemaster to create accurate billed amounts when submitting claims to Payers for reimbursement. Logically, one would assume that the billed charge per unit of any item on the chargemaster is the same amount billed per unit on the actual claim. Unfortunately, there are some hospitals filing claims where the billed amounts per unit exceed the chargemaster price. The units below have all been validated that there are no "package size" or other issues driving these excessive billed amounts.

NPI	Hospital Name	Claim ID	Claim Line Item	Date of Service	Proc Code	Proc Code Desc	Chargemaster "List Price"	Claim Billed Amount	Savings
XX1	Facility 1	XX1A	1	5/26/2022	78452	Homocysteine	$814.41	$7,895.00	$7,080.59
XX1	Facility 1	XX1A	2	5/26/2022	93306	Homocysteine	$1,848.00	$3,257.00	$1,409.00
XX1	Facility 1	XX1A	3	5/26/2022	93017	Thyroid (TSH)	$26.11	$1,384.00	$1,357.89
XX1	Facility 1	XX1A	1	1/10/2022	78452	Copper	$814.41	$7,895.00	$7,080.59
XX1	Facility 1	XX1A	2	1/10/2022	93306	Magnesium	$1,848.00	$3,257.00	$1,409.00
XX1	Facility 1	XX1A	3	1/10/2022	93017	Iron	$26.11	$1,384.00	$1,357.89
							$5,377.04	**$25,072.00**	**$19,694.96**

Table 4 | In-Network "Billed Amount" Exceeds Chargemaster "List Price"

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3 Why would any Payer reimburse a hospital more than an uninsured individuals discounted cash price for an Out-of-Network claim?

Some hospitals across the country refuse to negotiate a participating (PAR) provider or "In-Network" contract rates with Payers and therefore, renders these patients as "uninsured" at those facilities. For this specific circumstance, reimbursement should be reconciled to the hospital's own publicly published and reported, discounted cash price, whenever that price is available. Until recently, these discounted cash prices were not known, however with the new hospital price transparency final rule, this information is publicly available and every patient that has no insurance or who has insurance but there is no coverage at a specific hospital, the discounted cash price should apply. In Table 5 below, this example shows actual claims at several hospitals where the reimbursement, exceeds the published discounted cash price for out-of-network, non-par providers, where the patient is rendered "uninsured".

NPI	Hospital Name	Claim ID	Claim Line Item	Date of Service	Proc Code	Proc Code Desc	Chargemaster Uninsured Discounted Cash Price	Out-of-Network Claim Allowed Amount	Savings
XX1	Facility 1	XX1A	1	6/16/2022	70450	Diagnostic Radiology (Diagnostic imaging) Procedure of the Head and Neck	$137	$2,050	$1,913
XX2	Facility 2	XX2B	1	2/14/2022	73721	Diagnostic Radiology (Diagnostic imagaing) Procedure of the Lower Extremeties	$327	$2,096	$1,769
XX3	Facility 3	XX3C	1	7/1/2022	93306	Thransthoracic Echocardiography	$605	$3,177	$2,572
XX4	Facility 4	XX4D	1	6/22/2022	19081	Biopsy of the breast with placement of breastlocal-ization device(s)	$1,275	$8,169	$6,894
XX5	Facility 5	XX5E	1	2/10/2022	10005	Fine Needle Aspiration (FNA) Biopsy	$866	$4,686	$3,820
XX5	Facility 5	XX5E	2	2/10/2022	99173	Cytopathology, evaluation of fine needle aspirate	$69	$1,979	$1,910
XX6	Facility 6	XX6F	1	2/24/2022	74177	Computed Tomography, Abdomen and Pelvis	$742	$4,755	$4,013
XX6	Facility 6	XX6F	2	2/24/2022	71260	Diagnostic Radiology (Diagnostic imagaing) Procedures of the Chest	$371	$1,188	$817
							$4,392	**$28,100**	**$23,708**

Table 5 | Out-of-Network "Allowed Amount" Exceeds "Uninsured Discounted Cash Price"

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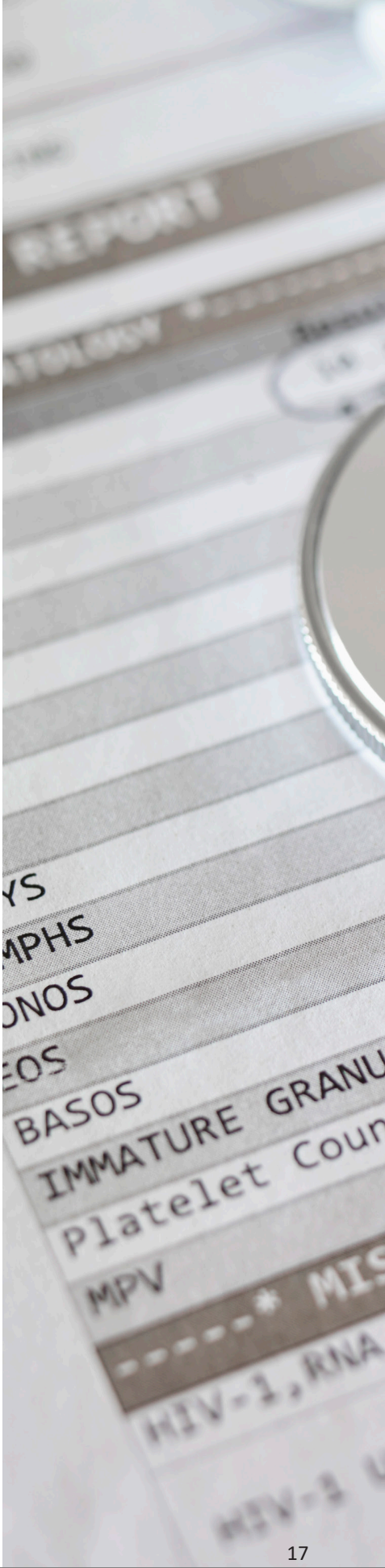
A Case for AMS Chargemaster Validation and Reconciliation Use Cases

AMS has been actively marshalling the enormous amount of chargemaster data over the past 3.5 years and more recently, integrating the shoppable rates and published discounted cash prices. The effort to curate this massive and complex aggregation of non-standardized data was a one of our main priorities, knowing how important this data would be. Payers can now perform a variety of chargemaster reconciliation and chargemaster validation use cases, at scale. Chargemaster validation use cases can also be performed at different points of deliver, either pre-submission, pre-payment, or post-payment. **AMS' affordability platform can integrate this new pricing information directly across a Payers claims data so that avoidance or recovery of millions of dollars in pricing discrepancies can be realized.** In addition to avoidance or recovery, pinpointing specific providers for specific procedures, where pricing is out-of-balance, the Payers contract negotiators can zero in on exactly what to address and how to fix it. Coming to the negotiating table, armed with empirical evidence of pricing discrepancies that exceed published rates, negotiators can work with providers to fix these inconsistencies and help drive closer to payment accuracy, lowering the cost of care.



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