

CMS / PARA Price Transparency Q&A

1. Can you comment on min and max for the 300 shoppable services when the individual is asking about his or her benefits (ex-Aetna with 200 deductible / 2,500 OOP Max)?

The PARA Price Transparency Tool will incorporate the Patient's current position on deductibles, co-insurance, co-pay and max annual out of pocket costs with a successful EDI insurance query from the PARA system. These data points are automatically incorporated in the final quote.

2. Is oral surgery included in the requirement?

Oral surgery codes, neither the surgical CPT/HCPCS codes or the dental "D" codes are contained within the CMS mandatory 70 items shoppable list, however the facility could elect them in the 230+ facility defined supplement to the shoppable list.

If they are in the CDM, they will be required to be included in the machine readable CDM Listing.

3. How do you reflect contracted rates for items that are bundled such as APC's/APG's?

The PARA contract model process will take the line items from a primary procedure and common associated ancillary charges group into an APC, APR-DRG, MS-DRG or EAPG and price to payer specific negotiated rates.

4. What about Case Rate pricing - How can you accomplish this in your organization? what about charges that are manually posted using a miscellaneous Charge Code? What is to stop a payer to compare shop and state that they will only pay what the other payers pay? What does the rule state if there is no contract with any payer?

PARA develops the "case rates" using either the actual billing transactions plus the HIM ICD10 codes, 837 claim EDI files or the CY 2019 Medicare claim files. For each primary code PARA will know the common associated ancillary charges along with the average of the miscellaneous priced transactions by line, that detail "bill" will then be priced to the payer specific negotiated rates.

There is nothing in the rule to prevent a payer from "learning" from the shoppable table and then renegotiating the managed care contract.

If the facility does not have a contract with the facility, the encounter will be "out of network" the PARA EDI insurance will bring back the co-insurance and max out of pocket limits and apply them to the quote.

5. Does this also apply to prescription benefit billing as well (such as prescription insurance) or only medical insurance and hospital billing?

Currently, it is only for hospital billing.

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6. Can a Hospital show more fields such as Medicare and Medicaid payments, not just insurance companies? Can insurance companies sue hospitals not disclose the prices because written in contract to not to disclose?

Yes, the PARA Price Transparency Tool can be easily customized.

This is a federal-required disclosure, I would think it would supersede any specific contract language, that was one of the reasons for the AHA court challenge.

7. Is the \$300 per day per facility / location or for the entire health network?

The penalty appears to be by Medicare provider number.

8. Is it your understanding that for the Machine-readable file requirement that charges and negotiated rates need to include those of any provider-based locations (Professional and Facility services)? For the Machine-Readable format requirement, if we negotiated rates by DRG for some contracts, how are we to show the gross charge? How would we calculate that as the charges would be variable by patient?

It appears that any billing which is related to the facility will be required to report the payer specific negotiated rates.

This question points out the error in the charge description master portion of the requirement of the machine-readable file. You will not be able to calculate the payer negotiated rates at the line level, you will need to go to the second requirement of the primary procedure and commonly associated ancillary procedures to price accurately.

The PARA process is to develop template claims by each type of service to value to the payer specific negotiated rates.

9. Why wouldn't a price estimator with the option to price multiple payers upon request not meet the requirement? With a separate 300 shoppable list.

Based on PARA's understanding of the rule, a price estimator will replace the "TABLE II" requirement of the machine-readable file as long as the high, low and cash payment rates are posted along with the Patients specific payer negotiated rate.

10. Does Requirement #1 also have to include service packages vs only CDM charges?

CMS requirement number 1 is only for the machine readable, priced charge master file, the service packages are in requirement number 2.

11. Is apply all the data (including payer negotiated rates) in excel spreadsheets posted on the website acceptable?

Yes, if you post both the entire charge master and the 300+ shoppable items along with the common ancillary procedures with each of the payer specific negotiated rates and the cash discount price.

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12. How much does this cost for a critical access hospital that does not have much money?

Less than CMS estimated, please connect with a PARA Account Executive for a specific quote, the last page of this document has their contact information, additionally, this would be an eligible cost to report on the Medicare Cost Report.

13. For the price estimator, how do you estimate the deductible, as each plan will have a different deductible? How do you indicate prices if a Medicare or Medicaid advantage plan pays 100% of Medicare/Medicaid and pay vs APG or APG?

The PARA system can generate an EDI query to the Patients insurance plan to collect the remaining annual deductible, co-insurance percentage, co-pay and remaining annual max out of pocket. These data points will then be incorporated in the charge quote for a final patient out of pocket quote.

14. Do you have a "stand alone" price estimator? I was under the impression that hospitals that do not employ the physician do not have to report physician charges.

PARA does have a "stand alone" price and specific payer negotiated rates quotation system. The facility is not required to report the value of the professional / physician charges, but they required to report all additional claims associated with the requirement number 2 primary procedures.

15. Sorry I was late; do you have a CDM solution?

Yes, PARA does have a charge master solution for requirement number 1 and a process to meet requirement number 2, without the intervention of the facility IT staff.

16. Does PARA have a pricing estimator that interfaces with the hospital's EHR that could be used by the facility and resemble the pricing transparency tool that customers would see. Is there verbiage indicating that the estimate is time stamped.... since a deductible could be met by another claim that may drop.

PARA can hand off to EHR systems the Patient and payer specific quote, and yes, the quotes are time stamped to lock in the deductible, co-insurance, co-pay and annual max out of pocket. The deductible, co-insurance, co-pay and remaining annual out of pocket values, are developed using the PARA EDI insurance query process.

17. If we have a web-based, public facing price estimator, what requirement(s) does this fulfill? Does this allow us to avoid providing our negotiated fees?

It appears you will meet requirement number 2, if you provide a payer specific negotiated rate quote, along with the high, low and cash negotiated rates.

You will still need to develop the payer specific rates plus the cash discounted price for the complete charge master list.

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18. Is the NDC required for Drugs?

The “primary” code for billing is required, that would be the HCPCS code for high cost drugs (revenue code 0636), the NDC code may be required for those low cost common to the primary procedure ancillary charges (revenue code 025x), the NDC code and the “unit multiplier” are displayed in an example of the Table 2 required to meet the second portion of the CMS requirement.

19. How do you suggest the hospitals post their negotiated rates for implants and other services when it is logic based? For example: 30% of the invoice cost if over certain dollar amount.

This will be an area where the facility will need to use an average to meet the requirement, PARA will assist facilities in developing the most accurate implant charge associated to the primary procedure.

20. Considering Epic is the 500lb EHR gorilla in the room (country), do you or the vendor have a take on their plan to utilize their Guest Estimates tool to meet the 300 shoppable services requirement?

I have not seen any “workable” solution to the CMS requirement from EPIC.

21. What kind of training is available for Healthcare Technology Managers to align their efforts with the new criteria? Any certification exams to reflect expertise?

Currently there are no certification processes or requirement, we are all learning this collectively.

22. How do you report MS-DRG, APR-DRG, APC and EAPGs?

The PARA process is to group the primary procedure along with the common associated ancillary services to create the code, which will then be “valued” to the payer specific regional rate using the PARA contract module.

23. Are professional billable rates (MD, NP charges) also included in the price transparency act?

The rates are not required, unless they are billed by the facility, this would be the case with Critical Access Hospital using Method II and some facility which combine their professional on to the UB04.

However, the rates may not be required, but the notification to the Patient that a separate bill will be forthcoming is required.

24. What are the requirements to provide Medicare Advantage and managed care contract specific reimbursement by DRG in the Cost Report?

In the Inpatient prospective Payment Prosed Rule, there is a requirement for facilities to assemble the average reimbursement for Medicare Advantage plans plus the contracted managed care payers for reporting to CMS and to be included in the HCRIS (Healthcare Cost Report Information System).

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25. On the listing of negotiated prices is it by Payor or by the actual payor contract? i.e. if you have three BC contracts do you have to show each contract price

We recommend you list the rates tied to each contract.

26. Are Medicare and Medicaid rates required to be disclosed alongside the managed payor negotiated rates

The Medicare and Medicaid rates are not negotiated, they do not appear to be a requirement.

27. How does PARA value the items in the Charge Master readable file for more than a single patient type (i.e. Inpatient, outpatient, emergency or ambulatory surgical)?

The Charge Master machine readable file can only be valued for single line item procedures, the file cannot be valued for inpatient, emergency, or ambulatory encounters, that will be the role of the Table II 300 plus shoppable services file. The Charge Master can only be valued for single line item procedures performed in an outpatient encounter.

28. What qualifies as a hospital? We have a rural clinic under our hospital license. Does that qualify?

Any facility which is state licensed as a hospital or registered with CMS as a hospital needs to report, PARA would recommend that you report these specific negotiated rates.

29. We have a rural health care center under our tax id number but with a separate NPI. Does this RHC need to comply with price transparency?

Any facility which is state licensed as a hospital or registered with CMS as a hospital needs to report, PARA would recommend that you report these specific negotiated rates.

30. Is it part of the requirement to check patient eligibility and quote true out of pocket such as patient copay and deductibles?

It is not required under the regulations to check the Patient's remaining annual deductible, co-insurance, co-pay or max annual out of pocket, but PARA would recommend it to reduce bad-debt and collection costs.

31. If we use a price estimator, does it need to include all contracts or just our top 5 or so?

In reviewing page 14 of the CMS PowerPoint (link pasted below), as long as you have this tool, and you have the 70 CMS required and additional 230 shoppable services you have met the requirements of regulation #2, you will still need to post the charge master with all payer specific negotiated rates to meet regulation #1 requirement.

32. If you provide a solution for online price estimator, is it for all services or only the 300 determined shoppable services?

The price estimator tool must contain the 70 CMS required services plus the 230 facility add-on services at a minimum, PARA has unlimited capability to provide additional services in the online price estimator.

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33. How does PARA value OB services since there are very few in the Medicare claims data?

PARA can develop the common associated ancillary procedures from either a roll-up of the charge transactions with HIM soft codes or 837 claim files, whichever is more convenient for the facility.

34. How does PARA value different versions of the MS-DRG or APR-DRG in the Charge Master readable file?

The Charge Master machine readable file can only be valued for single line item procedures, the file cannot be valued for inpatient, emergency or ambulatory encounters, that will be the role of the Table II 300 plus shoppable services file.

In the Table II shoppable file the payer specific contract blended rate times the MS-DRG / APR-DRG cost weight is used to calculate the inpatient reimbursement, the file is required to be updated annually, in the PARA process we update quarterly which will update the blended rate upon the beginning of the new federal fiscal year. The APC / EAPG rates will be update at the beginning of the calendar year.

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Additional Information:

[Webinar: Price Transparency-Clarifying the Unknown](#)

[List of CMS 70 Shoppable Services](#)

[PARA Price Transparency Tool](#)

[PARA Price Transparency Tool Demonstration](#)

[MLN - Hospital Price Transparency Final Rule](#)

[IPPS FY2021 Proposed Rule - Federal Register](#)

[CMS Healthcare Cost Report Information System](#)

To View a Price Transparency Demo or for more information, please contact:

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