Modern Pricing

Clarifying Hospital Charges for Consumers

A Voluntary Implementation Guide
for California Hospitals

CALIFORNIA HOSPITAL ASSOCIATION

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May 2014

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Why Modern Pricing?

Every stakeholder has a role in making meaningful price information available to patients.

OUR COMMITMENT

The need for greater transparency in health care continues to be an issue of increasing importance to the public and policy makers. In 2013, the Centers for Medicare & Medicaid Services (CMS) released hospital charges for 100 of the most common inpatient diagnostic related groups (DRGs) and later released similar information on hospital charges for services performed in the outpatient setting. CMS recently provided similar information on payments to physicians currently serving Medicare beneficiaries. The release of this information is not new for California hospitals, as state law requires the public display of the hospital charge master. California is one of 42 states that already report such information. However, there are those who would contend that hospital charges as a proxy for price are no longer meaningful and does not meet the needs of patients and communities. Public scrutiny of certain hospital charges may lessen our credibility as providers caring for patients and their families.

The CHA Board of Trustees, in collaboration with a workgroup of members with expertise in hospital finance, considered multiple options to address the current hospital billing/charging system. CHA undertook this work in an effort to proactively mitigate efforts by others to mandate unreasonable and unsustainable pricing policies on hospitals, and to improve the public's perception about hospital bills and pricing. CHA believes this is one of a number of steps that hospitals can take to make information more meaningful to patients and purchasers. At the same time, CHA recognizes that every stakeholder — providers, health plans, employers and purchasers — has a role in making meaningful price information available to patients.[1]

1 The California Hospital Association (CHA) is a membership organization that seeks to develop consensus, establish public policy priorities, and represent and advocate on behalf of the interests of hospitals and health systems. In concert with its members and member organizations, CHA is committed to establishing and maintaining a financial and regulatory environment within which hospitals can continue to provide high-quality patient care. CHA is a trusted resource, working with members to achieve legislative, regulatory, and legal accomplishments at the state and federal level.

Consistent with CHA's mission, it is the policy of CHA to comply with all applicable laws, including federal and state antitrust laws. CHA, its Board of Trustees, committees and members come together to discuss topics and issues important to the hospital industry. It is the intent of CHA to comply fully with all legal obligations when exploring issues that might provide general benefit to the industry.

CHA acknowledges and recognizes that discussing issues significant to the hospital industry could be characterized as an opportunity to exchange information that could implicate anticompetitive or otherwise unlawful conduct in violation of antitrust laws. Therefore, communications are confined to subjects directly related to regulatory activities or public policy.

OUR PRINCIPLES

The CHA workgroup developed a set of principles for a hospital charging system that guided this work. The five principles are:

- PATIENT and PURCHASER FRIENDLY — A hospital charging system should be easy for all stakeholders to understand. Information given to patients and other purchasers should be clear, concise, meaningful and timely.
- REASONABLE PAYMENT — It is reasonable for a hospital to ensure that the payment it receives covers the cost of:
  - Services provided to patients;
  - Future growth and replacement of property, plant and equipment;
  - Depreciation and financing costs;
  - Government unfunded requirements;
  - Mission-specific activities such as teaching, research and education;
  - Uncompensated care;
  - Specialty services such as trauma, burn units and intensive care; and,
  - Other unique needs of hospitals in the communities they serve.
- ADAPTABLE — A hospital charging system should be flexible and adaptable to the changing environment of health care financing and delivery. It should be nimble enough to keep pace with constantly evolving policies and practices. A charging system should not control how care is provided – it should incentivize efficient and efficacious care.
- ADMINISTRATIVE EASE — A hospital charging system should be easy to administer and simple to modify in response to changing policies and market forces.
- VALUE — It is reasonable for an efficient, effective hospital to decline to accept a payment that generates losses. Quality and price together are the determinants of value. Value means that a hospital is operating efficiently while providing high quality care. Hospitals should be rewarded for delivering optimal patient care in the most efficient way.

TAKING ACTION

In October 2013, the CHA Board of Trustees adopted "Modern Pricing," a voluntarily effort by hospitals to adjust their prices (i.e. charges) to a level that is explainable, understandable and reflects the unique cost structure of the hospital's mission and patient population. California's hospitals have been and continue to be leaders in health care — on the cutting edge of both payment reform and system redesign. The CHA Board of Trustees adopted this policy knowing that hospitals across California are already voluntarily taking steps to adopt modern pricing and, in moving this effort forward, have asked CHA to develop the resources needed for hospitals to take action.

This work is not without several legal, regulatory and operational concerns that must be carefully considered. This *Guide* was written to help hospitals understand those issues and overcome the perceived barriers that will need to be addressed. The *Guide* includes information compiled from numerous meetings with regulatory agencies and extensive legal research, and provides information for hospitals to help prioritize the issues that are specific to their unique organizations so they may be adequately addressed.

In addition, CHA is working with hospitals to develop communication strategies on how best to respond to inquiries regarding this voluntary initiative. Adjusting charges may create both positive and negative reactions, and hospitals must be prepared to respond. Information to assist in communications will be available on topics including:

- What drives hospital costs?
- How do vulnerable populations receive health care?
- How do hospital financing and the cost shift work?
- What are the differences between price, cost and charges?
- How do hospitals fund research, and train and develop tomorrow's health care professionals?

California's hospitals continue to lead the nation by taking steps that strengthen our health care system. CHA is pleased that many hospitals have voiced their commitment to this effort. We urge all hospitals to carefully consider the information provided in this *Guide* and to work with CHA and the regional associations to adopt the Modern Pricing approach. Meaningful information should be available to patients, communities and other stakeholders.

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Chief Executive Officer
University of California,
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President/CEO
California Hospital Association

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The California Hospital Association (CHA) would like to express sincere appreciation for the time, knowledge and expertise that the hospitals and health systems listed below provided to this project.

CHA would also like to thank the federal and state regulatory agencies that provided helpful guidance, including the Centers for Medicare & Medicaid Services, the Office of Inspector General and the California Department of Health Care Services.

Finally, CHA is grateful for the legal expertise provided by Hooper, Lundy & Bookman, PC.

Contributing hospitals:

Adventist Health
Arrowhead Regional Medical Center
Cedars-Sinai Medical Center
Children's Hospital Oakland
Community Hospital of the Monterey Peninsula
Community Medical Centers
Cottage Health System
Dignity Health
El Camino Hospital
Good Samaritan Hospital
Healdsburg District Hospital
Henry Mayo Newhall Memorial Hospital
Kaiser Permanente
Kaweah Delta Health Care District
Loma Linda University Medical Center
Lucile Salter Packard Children's Hospital
Marshall Medical Center
Natividad Medical Center
Oroville Hospital
Palomar Health
PIH Health
Prime Healthcare Services
Providence Health & Services
Rady Children's Hospital San Diego
San Joaquin General Hospital
Scripps Health
Sharp HealthCare
Stanford Hospital and Clinics
Sutter Health
UC Davis Medical Center
UC Irvine Health
UCSF Medical Center
Ukiah Valley Medical Center
Washington Hospital Healthcare System
Western Medical Center Santa Ana

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Introduction

Modern pricing is a voluntary effort hospitals can undertake to adjust their charges to create a user friendly billing process and achieve regulatory compliance, while sustaining revenue integrity. This initiative is critical to ensuring that hospital charges are explainable, understandable, and reflect the unique cost structure of each hospital's mission and patient population.

Embarking on this complex journey will require a diverse set of representatives from across the hospital and the health system. Medicare and Medi-Cal regulations can negatively affect these efforts and can have profound impacts on hospital revenues. Hospital charges have implications on operational considerations such as cost accounting, inventory, patient billing and contractual agreements with health insurance companies. Communication with patients, the public, and other stakeholders regarding this effort must also be considered.

Modern Pricing is designed to assist hospitals in understanding the legal, regulatory and operational issues that will need to be addressed to voluntarily adjust charges.

Developed by CHA, *Modern Pricing: Clarifying Hospital Charges for Consumers, A Voluntary Implementation Guide for California Hospitals* is designed to assist hospitals in understanding the legal, regulatory and operational issues that will need to be addressed to voluntarily adjust charges. Each of these critically important issues are discussed and serve as a guide to help hospitals achieve the goal of improved public perception of hospital billing and charges, and eliminating the need for unnecessary and unsustainable policy actions such as price controls.

The *Guide* includes information compiled from numerous meetings with regulatory agencies and extensive legal research to provide information to help hospitals prioritize the significant issues that are specific to their unique organizations.

Specifically, CHA convened several meetings with the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG) and other regulatory agencies to discuss various regulatory challenges faced by hospitals. The outcomes of these meetings were positive, and both CMS and the OIG generally shared CHA's perspective on how each of the perceived regulatory hurdles could be overcome. CHA will continue to engage CMS and other stakeholders as part of our effort to support the implementation of Modern Pricing.

Included in the *Guide* is a description of steps hospitals can take to voluntarily adjust charges, the background of each regulatory issue, and suggested actions to overcome concerns surrounding these issues.

Getting Started

Establishing an interdisciplinary team is a critically important first step. Senior leadership of the organization should be included and updated, as appropriate, to ensure the goals of the work are aligned with other organizational goals. Furthermore, the involvement of internal or external legal counsel should be strongly considered.

Hospitals have noted that team members with expertise in the following areas are essential for success in implementation.

THE CHARGE DESCRIPTION MASTER (CDM)

The hospital CDM contains a list of hospital services and their respective charges, along with a short description, unique reference number, revenue code and Healthcare Common Procedure Coding System (HCPCS) code. Such detail and coding is necessary for Medicare, Medi-Cal, and other health insurance programs to make certain that insurance claims are processed in an orderly and consistent manner. Initially, use of the codes was voluntary, but with the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), use of the HCPCS for transactions involving health care information became mandatory.

ANCILLARY CARE DEPARTMENTS

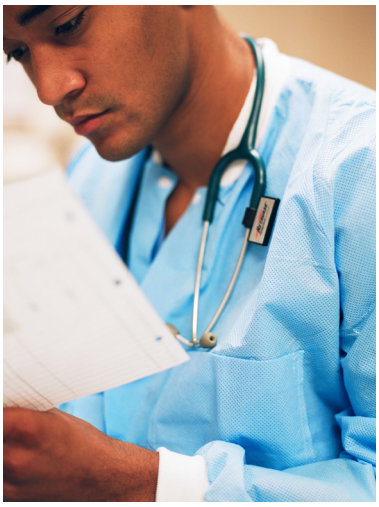
A primary source of critical operating revenues is from ancillary care departments (laboratory, radiology, pharmacy, etc.) and each department is often responsible for recommending services and charges in the CDM. Each department needs to be represented on the implementation team. In addition, representatives from patient accounting, advocacy, financial services, reimbursement and contract management must be part of a well-coordinated team effort. The CDM team leader should be a senior manager in the hospital (chief operating officer, chief financial officer, etc.). The hospital should allow for a dedicated project manager or consider using a reimbursement consultant to help manage the project and coordinate team efforts.

CHARGING METHODOLOGIES

How hospitals determine their charge structure is not only unique to each facility, but often unique to each department within the facility. Determining charges may include an analysis of the average cost, commercial contract discount considerations, payer mix, and other mission-driven activities such as research, teaching or serving vulnerable populations. Adjusting charges is also handled in diverse ways, including:

across the board increases or decreases; department level cost-to-charge-ratios; publicly available; market rate information; and price sensitivity. Regardless of the approach, hospitals must ensure that their charging strategies are aligned with the mission and goals of the organization, allow for competitiveness, and comply with legal and regulatory requirements.

Simplifying the CDM before embarking on the major effort required to voluntarily adjust prices may prove helpful.



QUICK START STRATEGIES

Hospital CDMs are very complex. Simplifying the CDM before embarking on the major effort required to voluntarily adjust prices may prove helpful.

Suggestions for streamlining the CDM include:

- Eliminating charges for low-cost items (e.g., no charges listed for items lower than a certain threshold).
- Eliminating charges for items that can be easily purchased at a local drug store (shampoo, soap, etc.).
- Eliminating obsolete or low volume items.
- Ensuring codes (procedure, revenue, HCPCS, APC, etc.) are accurate and complete.
- Ensuring compliance with CMS regulations.

State and Federal Regulatory Considerations

In thinking through the various steps toward implementation, a number of state and federal regulatory issues were identified as concerns regarding the potential for significant losses in revenue that would result from an adjustment in hospital charges. After substantial consultation with legal counsel and discussions with federal regulatory agencies, CHA has determined that, with careful planning, each of the regulatory barriers identified could likely be overcome and risks mitigated. CHA encourages member hospitals to work with their legal counsel to ensure compliance throughout each step of the process.

A summary of each issue and conclusions follow.

After substantial consultation with legal counsel and discussions with federal regulatory agencies, CHA has determined that, with careful planning, each of the regulatory barriers identified could likely be overcome and risks mitigated.

COST REPORTING

Medicare Cost Reporting

Hospitals are required to complete and annually file Medicare and Medi-Cal cost reports. The cost reports for both programs must be completed in accordance with Medicare cost reporting principles contained in 42 C.F.R. Part 413 and the Medicare Provider Reimbursement Manual (PRM).

Most hospitals are no longer reimbursed under Medicare on a reasonable cost basis. Generally, Medicare reimburses hospitals for inpatient services under the Inpatient Prospective Payment System (IPPS) and for outpatient services under the Outpatient Prospective Payment System (OPPS). Payments under IPPS and OPPS are based principally on fixed rates depending on the Medicare Severity — Diagnosis-Related Groups (MS-DRG) or Ambulatory Payment Classification (APC) to which the patient or service is assigned, and the rates do not depend on the hospital's own costs. Charges are used in the development of MS-DRG and APC weights, discussed later in this *Guide*.

Medi-Cal Cost Reporting

Until recently, most inpatient hospital services were reimbursed under Medi-Cal pursuant to fixed-rate contracts that did not vary based on hospital costs. Hospitals that did not have Medi-Cal contracts were reimbursed on a reasonable cost basis subject to California-specific limits, and the reasonable costs were determined

using hospital cost reports. However, on July 1, 2013, the Medi-Cal fee-for-service reimbursement system converted to a prospective payment system based on All Patient Refined – Diagnosis Related Groups (APR-DRGs). Although the payment system is still being implemented, an individual hospital's costs will likely have little impact on payment with the exception of outlier payments. Hospital outpatient services under Medi-Cal for most hospitals are reimbursed based on a fee schedule. Reimbursement does not depend on a hospital's own costs.

Special Circumstances

Although most Medicare and Medi-Cal hospital reimbursement is no longer based on costs and this trend is expected to continue, there are still some important remnants of cost reimbursement. Critical access hospitals, children's hospitals, certain sole community hospitals, Medicare organ acquisition services and certain non-physician teaching costs are reimbursed on the basis of costs under Medicare. Costs affect Medi-Cal reimbursement for designated public hospitals and distinct-part nursing facility (DP/NF) services; thus, while the importance of Medicare and Medi-Cal cost reports is waning, they remain significant for certain payment purposes.

While the importance of Medicare and Medi-Cal cost reports is waning, they remain significant for certain payment purposes.

Role of Charges in Cost Reports

Charges are used in cost reports to apportion ancillary costs. The costs of each ancillary department are apportioned between government program patients and other patients based on the ratio of the department's charges for program patients to the department's total charges. Charges are defined as "the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services." Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services. Charges are required to be uniformly recorded for all patients and payers in order to be acceptable for cost apportionment. The reduction of charge rates would not be problematic for cost apportionment so long as gross charges are recorded uniformly for all patients regardless of payer class. This is because a charge reduction applicable to all patients would not affect the ratio of program charges to total charges.

MEDICARE OUTLIER REIMBURSEMENT

The Medicare program provides additional reimbursement under the inpatient prospective payment system (IPPS) for outlier cases. A case qualifies as an outlier if the cost of the case exceeds the applicable outlier threshold, which is set each fiscal year. The amount of additional reimbursement for outlier cases is based on the amount of the cost for the case in excess of the applicable outlier threshold. Thus, the key element in determining outlier payments is the cost of each Medicare case. The cost of a case is determined by multiplying the hospital's charges for covered services by the Medicare operating and capital ratio of costs-to-charges (RCC). The operating and capital RCCs used to determine costs for outlier purposes are based

on either the most recently settled cost report or the most recent tentatively settled cost report at the time the claim is processed, whichever is from the latest cost reporting period.

An issue arises under the Medicare outlier payment methodology when a provider significantly reduces its charge rates. This is because the costs of each case are determined by applying a prior period's RCC to the current period charges. This would result in a large reduction to the hospital's outlier reimbursement solely because the hospital reduced its charge rates.

However, the Medicare regulations permit a hospital to request that its Medicare Administrative Contractor (MAC) use a different (higher or lower) RCC based on substantial evidence presented by the hospital. Accordingly, there is a mechanism for hospitals to have their RCCs adjusted to reflect significant reductions in charges. This process has been used successfully by hospitals around the country for a number of years.

In addition, several other Medicare prospective payment systems have cost-based outlier payments including inpatient rehabilitation facilities and long-term acute care hospitals. As hospitals look across service lines or within a health system, it is important to also consider any outlier implications associated with these payment systems.

CMS has provided guidance on how MACs should handle requests from hospitals to use a different (higher or lower) ratio of costs to charges (RCC). Hospitals should work with their MAC to demonstrate why an alternative ratio is more accurate.

The CMS Regional Office will approve requests once the MAC performs an evaluation of the information. Request forms are available at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03004.pdf and www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03058.pdf. CMS and the MAC process such requests within 90 days. Hospitals should time their requests so that a new RCC is ready to launch at the start of a cost reporting year.

Conclusion

Reducing charges could lead to reduced outlier reimbursement until the RCCs used to calculate outlier payments are based on the reduced charge levels. However, with proper planning and appropriate timing, hospitals are able to apply for and are likely to be successful in obtaining an adjustment to the RCCs used to determine outlier payments. Doing so would allow for significant reductions in charges, while maintaining revenue integrity. Information from CMS on reconciling outlier payments can be found at www.cms.hhs.gov/mlnmattersarticles/downloads/mm3966.pdf.

MEDI-CAL OUTLIER REIMBURSEMENT

The Medi-Cal APR-DRG system also makes available additional payments for high cost outlier cases. Unlike Medicare, Medi-Cal payments are reduced for low cost cases, referred to as a "low-side outlier." For some facilities, the outlier payments comprise a significant portion of their Medi-Cal fee-for-service inpatient reimbursement.

As with Medicare, the costs for a case that are compared to the outlier thresholds and serve as the basis for determining outlier payments are based on the most currently accepted RCC from a hospital's cost report multiplied by the Medi-Cal covered charges for the case. Thus, a reduction in charges could lead to a computed reduction to costs since a prior period RCC is being applied to current period charges, regardless of whether costs have actually decreased. This could lead to a significant reduction to outlier payments and an increase in payment reductions for low-side outlier cases.

There is not an express provision allowing hospitals to obtain a change to the Medi-Cal RCC to account for a reduction in charges. CHA will address this issue with the California Department of Health Care Services if necessary to develop a process for adjusting hospital RCCs.

PERMISSIVE EXCLUSION/USUAL CHARGE RULE

The Medicare program contains a permissive exclusion provision that allows the Secretary of Health and Human Services (Secretary) to exclude an individual or entity from federal health care programs that the Secretary determines:

> has submitted or caused to be submitted bills or requests for payment under Medicare or Medicaid containing charges for items or services furnished substantially in excess of such individual's or entity's costs for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs.

Exposure under the Medicare Usual Charge Rule should be limited where billed charges are not less than Medicare or Medi-Cal payment rates.

The Office of the Inspector General (OIG) within the United States Department of Health and Human Services has adopted a regulation implementing this provision. The regulation essentially repeats the language of the statute without furnishing guidance. Subsequent attempts to provide definitions through proposed rules have failed because of wide criticism by provider organizations. The OIG continues to emphasize that free or substantially reduced charge to uninsured or underinsured patients would not be taken into account in determining usual charges.

The Medicare Usual Charge Rule likely creates minimal risk for hospitals that substantially reduce charges. Exposure under this rule should be limited where billed charges are not less than Medicare or Medi-Cal payment rates for services for which payment is affected by billed charges.

MEDI-CAL OUTPATIENT CHARGE LIMITS

The Medi-Cal program limits billing and reimbursement for certain outpatient services based on usual charges. For example, a provider is prohibited from submitting a claim for reimbursement to Medi-Cal "in any amount greater or higher than the usual fee charged by the provider to the general public for the same services." Similarly, "no provider shall charge for any services or any article more than would have been charged to others for the same service or article to other purchasers of comparable services or articles under comparable circumstances."

A reduction in charge rates would likely lead to a reduction in Medi-Cal reimbursement if the reduced charge rates were less than Medi-Cal rates. Given the low Medi-Cal rates, this would not appear likely for most services.

MEDICAID CUSTOMARY CHARGE LIMIT

Federal Medicaid law provides that federal matching funds will not be made for expenditures for inpatient hospital services where such expenditures exceed a hospital's customary charges. We understand that this limit has been applied historically (to the extent it has been applied at all) on an aggregate basis for a fiscal year.

There is no clear definition of "customary charges" under the Medicaid program for purposes of applying this limit. There is a complex set of Medicare regulations and manual provisions addressing customary charges for Medicare cost reimbursement, but these provisions do not directly apply to the Medicaid program.

The reduction to a hospital's charges could lead to a reduction in federal matching funds, and potentially a reduction to payments to a hospital, under the Medicaid customary charge limit if the hospital's aggregate customary charges are less than the hospital's Medi-Cal payments for inpatient hospital services. Hospital payments that would be compared to customary charges, would possibly include all fee-for-service payments for inpatient hospital services, including supplemental payments such as Medi-Cal Disproportionate Share Hospital (DSH) payments and payments made under the Quality Assurance Fee program.

MEDI-CAL APR-DRG CHARGE LIMIT

The Medi-Cal DRG Project Design Documents, prepared by Xerox and dated September 26, 2013, states:

> The 'lesser of" paid or billed logic continues to be applied under the DRG payment method as was previously done so that final payment does not exceed total charges on the claim.

CHA did not find a similar provision in the Medi-Cal State Plan Amendment that implements the DRG system. If a charge limit is applied on a claim-by-claim

basis, a reduction in charges could impact payment beyond the federal Medicaid customary charge limit since DRG payments are an average payment for cases within a particular APR-DRG; meaning that the charges for certain cases may be on the low end for the APR-DRG and, therefore, lower than the APR-DRG payment amount. Hospitals should be mindful of this potential issue when considering charge adjustments.

MEDICARE ACTUAL CHARGE LIMITS

Medicare reimbursement for certain hospital outpatient services that are not reimbursed under OPPS is limited to actual charges, which are the charges actually billed by the provider to the Medicare program. An example is hospital outpatient clinical laboratory services to the extent not packaged with other services for Medicare payment purposes. A reduction to charge rates could lead to a reduction in reimbursement if the reduced charges are lower than the Medicare fee schedule for the affected services.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

Beginning in federal fiscal year 2014 (FFY), the federal methodology for determining DSH payments under Medicare changed as a result of the Affordable Care Act. Base payments are reduced to 25 percent of the amount under the traditional payment formula. The remaining 75 percent of the DSH dollars will be reduced based on the level of uninsured and redistributed based on a hospital's level of uncompensated care, as compared to the national level of uncompensated care for all DSH hospitals. For FFY 2014, CMS finalized its proposal to use the traditional DSH methodology to calculate the 25 percent pool. For the redistribution of the 75 percent pool, CMS will use a proxy for uncompensated care for hospitals, which is the ratio of the hospitals Medicare SSI and Medi-Cal days as compared to the total nationwide. A reduction in hospital charges should have no impact under the current Medicare DSH methodology.

In the future, CMS may change the method used to determine uncompensated care for DSH purposes. CMS may, for example, determine uncompensated care cost by multiplying uncompensated care revenue by a hospital's RCC. If the RCC and revenue are for the same fiscal period, and the hospital records gross revenue using uniform charges for all patients, a reduction in charges should not have a material affect on the computation of uncompensated care.

MEDI-CAL DSH PAYMENTS

Hospitals will likely have to retain an approach to uniformly record charges for all patients so that the Medi-Cal DSH methodology works properly. Certain aspects of the DSH formula allocate costs and/or revenue based on ratios of gross revenue to total revenue for specific payer categories, such as charity care. The formula will work properly if the charge structure used in the numerator and denominator are uniform. Therefore, a reduction in hospital gross charges should not have an impact on the Medi-Cal DSH computation provided the reduction is applied uniformly to all patients.

DIAGNOSIS-RELATED GROUPS (DRG) AND AMBULATORY PAYMENT CLASSIFICATION (APC) WEIGHT DEVELOPMENT

Historically, CMS has used billed charges as a factor in determining MS-DRG and APC weights. Currently, CMS determines these weights based on national cost-to-charge ratios applied to charges. Substantial reductions in charges in one region of the country (e.g., by California hospitals) could skew the computation. The result may or may not be favorable for those hospitals reducing the charges. A significant change in the data could result in CMS proposing modifications to the weight setting methodology that could result in a mitigation of potential impact of the regional changes in the data.

REPORTING REQUIREMENTS — CALIFORNIA OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT (OSHPD)

Charges, or gross revenue, are currently required to be reported to the California OSHPD in several ways. The Annual Financial Disclosure Report requires hospitals to report gross revenue by department, separately for inpatient and outpatient services, and by different payer classifications. Within these categories, gross revenue must be separately reported for fee-for-service and managed care. Gross revenue is also used in the Annual Financial Disclosure Report to allocated expenses for certain departments, such as pharmacy and central supply.

Nothing in the OSHPD Accounting Manual or any other OSHPD requirement affects a hospital's ability to reduce charges.

While OSHPD requires hospitals to record gross charges uniformly among all patients, nothing in the OSHPD Accounting Manual or the Annual Financial Disclosure Report, or any other OSHPD requirement, affects a hospital's ability to reduce charges.

CHARITY CARE REPORTING

Hospitals report charity care to both OSHPD and the Internal Revenue Service (IRS). Charity care is reported to OSHPD on hospital Annual Financial Disclosure Reports and on hospital community benefit reports. Tax-exempt hospitals report charity care on Schedule H of the IRS Form 990. This reporting is based on gross patient charges written off under the hospital's financial assistance policies multiplied by the hospital's ratio of costs to charges.

Charity care reporting to OSHPD is based on gross revenue. Thus, a reduction in charges could reduce reported charity care, which in turn could lead to public relations challenges and inquiries. For the purposes of IRS Schedule H, the cost-to-charge ratio and charges for charity care patients are from the same fiscal period. Thus, a reduction in charge rates should not significantly affect the charity care reporting under IRS Schedule H.

CONTRACTED THIRD-PARTY PAYERS

Payments under contracts with private payers frequently include payment mechanisms that are based on charges. Contracts may have a provision limiting payment for a claim to a hospital's billed or usual charges. Stop-loss provisions often

are triggered when charges reach a certain level for a particular case, and the amount of stop-loss payments is often based on the amount by which charges exceed a specified threshold. Similarly, it is not unusual for payments for hospital outpatient services to be a percentage of billed charges. If charge rates are reduced, charge-based payment provisions would have to be renegotiated to avoid payment reductions. The levels at which stop-loss provisions are triggered would have to be reduced and the percentage of charges reimbursed increased in order to be payment neutral.

Many hospitals may still have a large portion of charge-based revenue from commercial payers. Any price adjustments made before a hospital is able to renegotiate a contract will result in a financial loss. While hospitals may not look forward to renegotiating contracts with commercial payers to mitigate financial losses that may result from price adjustments, pricing and contracting strategies are intertwined and hospitals should consider developing a plan for working with payers to achieve pricing goals. In the document, *Reconstructing Hospital Pricing Systems — A Call to Action for Hospital Financial Leaders*, published by the Healthcare Financial Management Association (HFMA), advice is provided on how to approach health plans and how hospitals can prepare for renegotiations. The document is available at www.hfma.org/Content.aspx?id=16579.

NON-CONTRACTED THIRD-PARTY PAYERS

Hospitals are generally entitled to be paid the reasonable value of their services for emergency out-of-network (OON) services or for non-emergency OON services approved by the plan (either explicitly or by operation of law). Under the California Department of Managed Health Care's (DMHC) regulations, the reasonable value of services takes into account six factors, including the fees usually charged by the provider and the prevailing charge rates of providers in the area.

The reduction by a provider to its charges could reduce the amount the provider can obtain for OON services since it is one of the factors used to determine OON rates. Furthermore, the reduction of charges, generally, by hospitals could reduce OON payments as prevailing charges are also a factor.

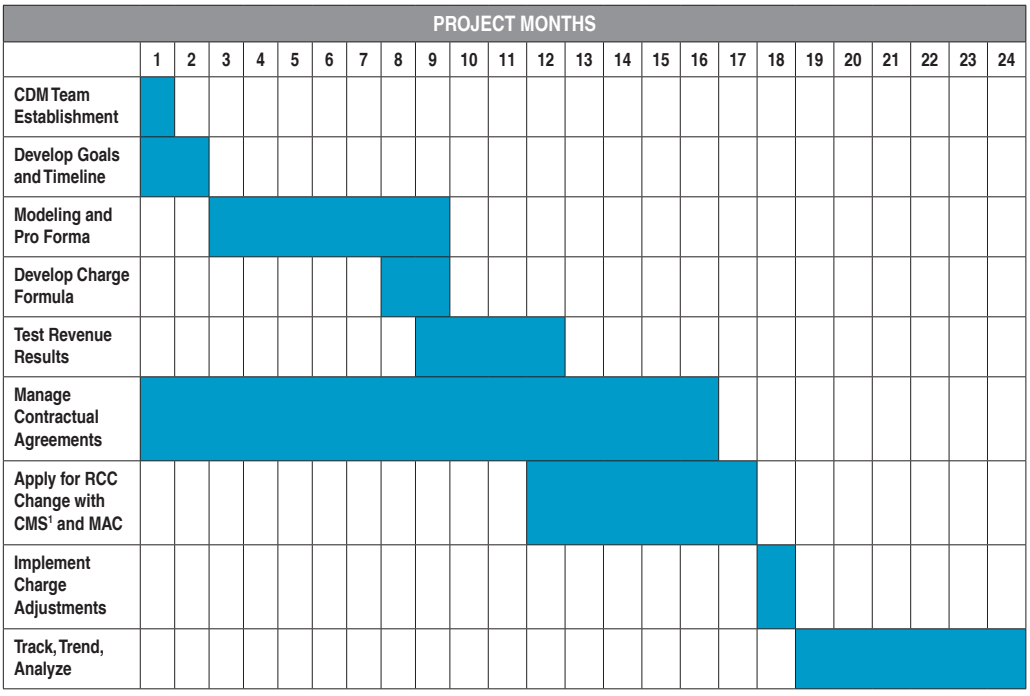
An issue hospitals should consider when reducing charges is the impact of the charge reductions and the resulting reduction in the plan's exposure for OON services on contract negotiations with plans. Plans may be reluctant to negotiate contract rates that exceed a hospital's charges, even where such charges have been substantially reduced, where the plan's exposure for OON services would likely not exceed such reduced charges.

Operational Considerations

Timing is critical when planning for charge reductions. Hospitals should allow ample time for CMS and the MAC to review the charge adjustment request, and the timing must coincide with the start of a new cost report year. The team needs to have a full understanding of the hospital's charging system and how it integrates with all other clinical and financial applications. Part of the process should include sufficient time and resources to prepare the CDM by eliminating outdated items and ensuring proper coding. Having robust cost accounting tools and information will be necessary to identify all costs that need to be captured and reflected in the charges for items and services. Allowing significant time to work with commercial health plans and other contracted third-party payers is crucial. The following chart presents key implementation steps and an estimated timeline.

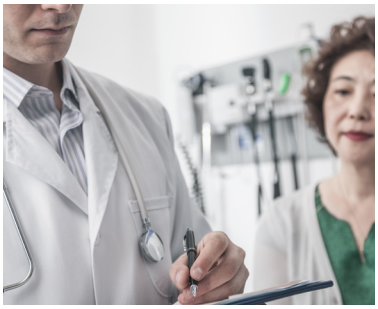
HOSPITAL CHARGE ADJUSTMENT IMPLEMENTATION TIMELINE

Estimated Timeline for Implementation



1 MAC approval and subsequent CMS approval should be completed in 90 days but allow ample time to recieve approval prior to the beginning of the cost report filing year.

Track, Trend, Analyze



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Once voluntary charge adjustments are implemented, hospitals should compare charges and actual revenue results against pro-forma amounts. A charge audit process should be established so that both the new and planned charge amounts are properly documented and reported. Hospitals should consider technology solutions to assist with charge modeling scenario development and analysis. Several factors should be considered when tracking charge adjustment outcomes, including:

- Costs — determine whether the full costs of supplies and services are being recovered by the adjusted price.
- Contracts — determine whether commercial contract terms are achieving budget neutrality as planned.
- Outlier and other government payments — monitor Medicare and Medi-Cal payments against expected results.
- Measure — analyze your cost-to-charge ratio in comparison to what has been filed with and approved by CMS and the MAC.
- Payer mix — monitor the shift of payers to ensure prices are sufficient to cover uncompensated costs resulting from increased government-funded or uninsured patients.

Conclusion

This endeavor is critically important work. To ensure that hospitals are able to continue to maintain charge levels that remain meaningful to consumers, efforts must be undertaken to ensure sustainability and to make adjustments as needed. Hospitals that have been on this journey note that they have done so in a staged approach and have continually refined their decision making and analytical framework to address the changing markets in which they operate. As the delivery system continues to evolve, payment systems evolve and, therefore, charge structures must also evolve. Remaining nimble and vigilant will ensure that the adjustments made can be sustained over time.

Other Resources

RECONSTRUCTING HOSPITAL PRICING SYSTEMS — A CALL TO ACTION FOR HOSPITAL FINANCIAL LEADERS

www.hfma.org/Content.aspx?id=16579

www.calhospital.org/cha-news-article/hfma-issues-report-price-transparency

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