CMS transparency and interoperability regulation

The EY point of view for the provider community

July 2020

Building a better working world

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Executive overview – provider perspective

Recent Centers for Medicare and Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) rules have been issued aimed at giving patients greater insight and access (transparency) within the health care system, both in terms of insurers and providers. To support this transparency, regulators believe that siloed health IT systems must learn to work together (interoperability). Providers must prepare accordingly in order to avoid penalties and capitalize on potential benefits.

Hospital Price Transparency Rule[1]

The final rule requires hospitals to provide patients with information about "standard charges" for items and services in a standardized format, through a public website, updated at least annually and including payor-specific negotiated rates and cash payment rates. It also requires hospitals display in a consumer-friendly format 300 "shoppable" services, defined as those that can be scheduled in advance, and imposes civil monetary penalties of $300 per day for those that fail to comply. Although existing regulations already require most hospitals to publish gross charges, if the rule goes into effect on January 1, 2021, the disclosure of standard charges negotiated with each payor will also be required.

CMS and ONC Interoperability Rules[2]

On March 9, 2020, both CMS and ONC publish related final rules on interoperability directed at both payors and providers. Providers must comply with electronic admission, discharge and transfer (ADT) patient event notification requirements and publicly disclose if they engage in information blocking or have unlisted digital contact information. Information blocking is defined by the rules as a practice that is likely to interfere with, prevent, or materially discourage access, exchange or use of electronic health information (EHI), with eight "reasonable and necessary" exceptions. The US Department of Health and Human Services (HHS) and ONC can impose up to $1m in financial penalties per violation; however, they won't enforce the penalties until there is additional notice and comment rulemaking.

[1] 45 CFR Part 180, *Price Transparency Requirements for Hospitals to Make Standard Charges Public*, Centers for Medicare & Medicaid Services, November 7, 2019.

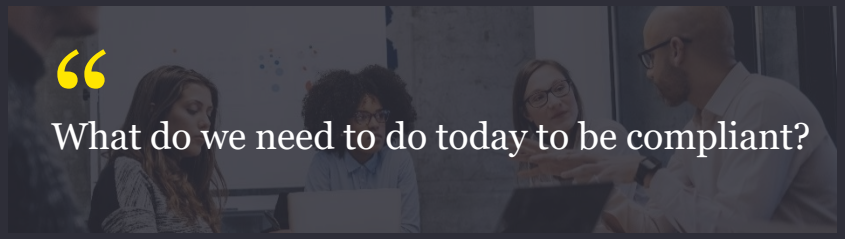
[2] 45 CFR Part 156, *CMS Interoperability and Patient Access Final Rule*, Centers for Medicare & Medicaid Services, March 5, 2020. 45 CFR Parts 170 and 171 RIN 0955-AA01, *21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program*, March 9, 2020.

Our perspective on transparency and interoperability

- *We believe the most successful health providers will embrace the long-term, strategic value of transparency and interoperability, in terms of market and brand, technology and data, clinical and risk*. Focusing on short-term compliance with the transparency rule will result in lost opportunities and increased exposure from risks that could have been mitigated.
- While COVID-19 continues to have the greatest impact on health care, we believe that the administration will maintain its long-term commitment to transparency and interoperability.
- The ultimate intent of the transparency and interoperability rules are to increase accessibility to provider pricing and negotiated rates under the belief that increased competitiveness will lower prices of health care services and increased connectivity will improve health outcomes.
- However, the promise of free flowing of information across the care continuum poses a significant disruption to the status quo, upending the delicate dynamics between existing participants and presenting new opportunities for potential market entrants.
- Research has shown that consumers want and value pricing transparency with the convenience of application programming interfaces (APIs); therefore, providers should capitalize on the pro-consumer sentiment to result from compliance.
- Providers must also prepare for negotiated rates for many services to be made public. When payors are able to see competitors negotiated rates, this will impact provider bargaining power. Providers should also ensure sufficient procedures to comply with electronic event notification requirements and disclose information blocking.

Addressing both short- and long-term business objectives

Short-term transactional requirements



Operational enablement

- Compare new requirements with existing regulations regarding gross charge transparency (varies by state) and determine updates needed
- Analyze existing contracted rates and identify outliers; determine need, ability and impact of potential renegotiation prior to 2021
- Confirm standard cash discount policy is in place and being followed
- Select “shoppable services” to be displayed and review pricing of those services, including contracted rates
- Monitor compliance to avoid penalties including increased regulatory scrutiny and monetary penalties

Long-term strategic considerations

Market and brand

- Differentiate between commodity and premium services
- Incorporate loss leader pricing to drive volume
- Better quantify the full value picture being offered
- Embrace marketing focus on shoppable services

Technology and data

- Enable patient-facing technologies (apps, kiosks, portals)
- Increased reliance on data analytics and data availability
- Transition from owner to provider of data as patients increasingly own their own data

Clinical impacts

- More retail-like environment requires providers to be informed on the costs and available data
- Patient-led care will shift where and who provides care based on personal values assigned to cost, comfort and convenience, and clinical outcomes

Contracting

- Prepare for future contract negotiations since market rates will be completely transparent to both sides, impacting historical bargaining power
- Align incentives to enable a fee-for-value environment

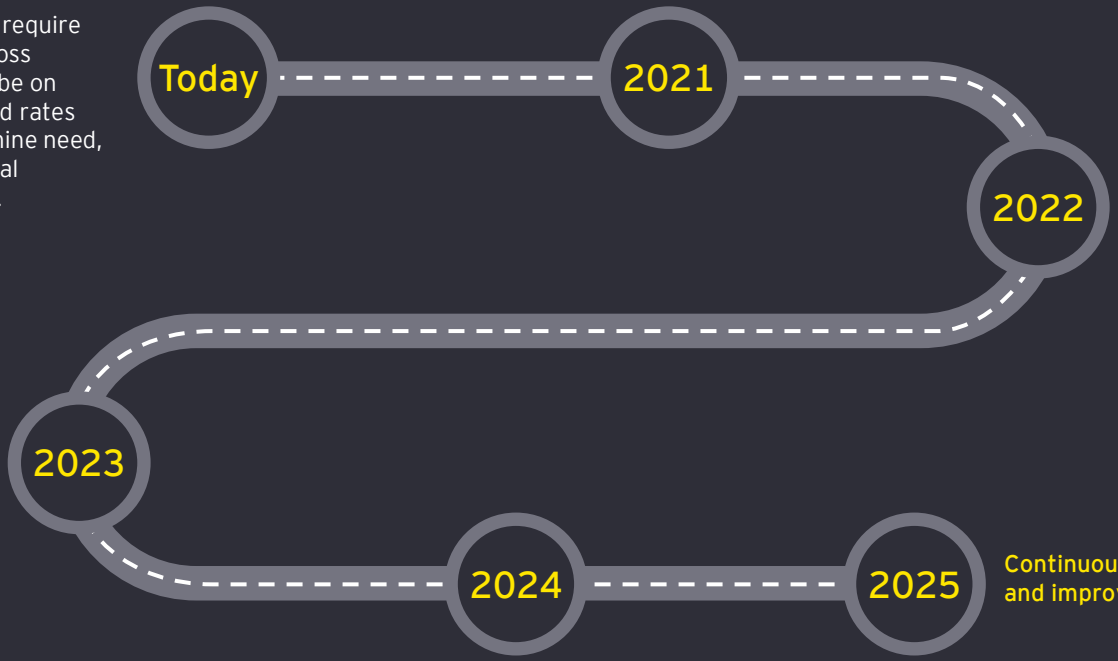
Transformation planning and strategic road map

Basic transparency

Existing regulations already require most hospitals to publish gross charges. Your focus should be on analyzing existing contracted rates and identify outliers; determine need, ability and impact of potential renegotiation prior to 2021.

Enhanced transparency

Payor-specific negotiated charges are published. By now, you should be focused on implementing a five-year road map and strategy to ensure a smooth and well-managed program.



Rate negotiations upset

The biggest operational impact will likely come in future negotiations as contracts come up for renewals and market rates are completely transparent to both sides.

New payment model evaluation

Organizations should have developed key performance indicators (KPIs), benchmarks and dashboards to evaluate their people, process and technology effectiveness to shift to new value-based payment models that require advanced capabilities.

Strategic business evaluation

As payors and providers become more connected, integrated and aligned to similar goals and incentives, the operational focus will shift to true interoperability.

Continuous re-evaluation and improvement

Providers who act strategically today will benefit from the transparency and interoperability journey tomorrow

These rules are likely just the first step to establishing new standards that will shape the market for providers, payors, and patients.

Market and brand considerations

- Premium vs. commodity
- Loss leaders
- Marketing focus

Risk considerations

- Building trust through transparency
- Minimizing downside impacts
- Seizing the upside potential

Technology and data considerations

- Patient data ownership
- Data analytics and availability
- Patient-facing technology (e.g., apps, kiosks, portals, etc.)

Clinical considerations

- Clinical variability
- More retail-like environment
- Patient-led care

What is being done across your organization to prepare for this future?

Strategic considerations

Market and brand considerations

Bifurcating pricing strategy between premium and commodity services

Premium services

Defined by market demand and ability to differentiate

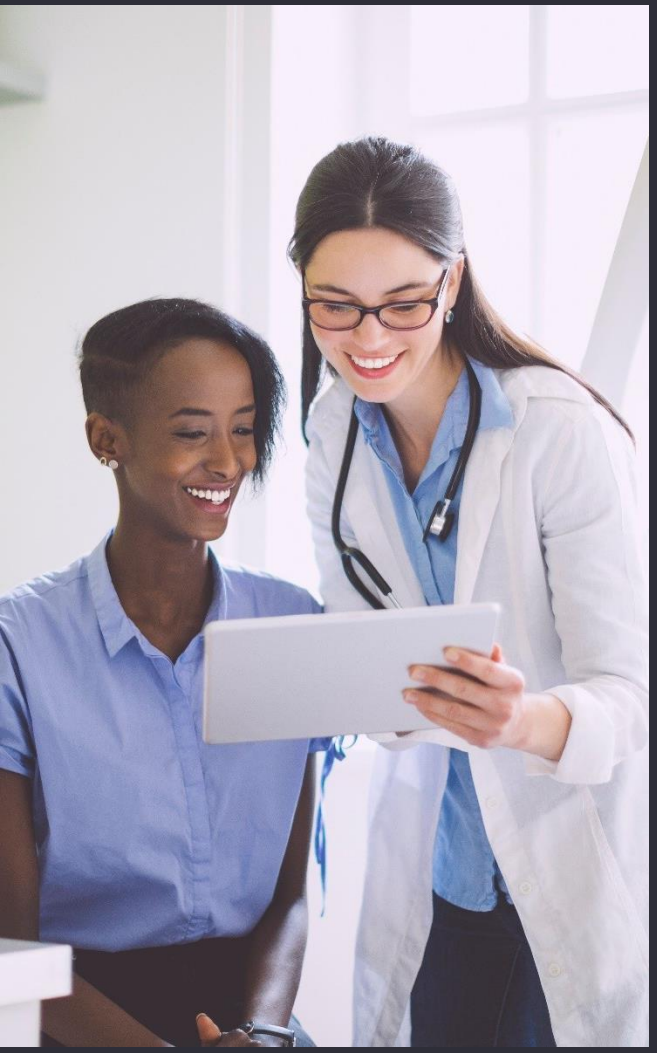
- Can serve as a magnet for provider
  - Current: cosmetic surgery
  - Future potential: labor and delivery
- Can potentially be priced above market rates, but higher prices need to be supported by true differentiators
  - Clinical quality and outcomes
  - Location/facilities
  - Innovation

Commodity services

Little opportunity to differentiate, so pricing largely should be driven by supply vs. demand

- Lower prices should drive volume
- Stand-alone imaging centers currently operate under this premise
- Hospitals generally cannot limit their services, so pricing and contracting strategies may need to accommodate and reflect both premium and commodity services

Loss leader pricing drives customer attraction but could it also drive better health outcomes?



Loss leaders are items purposely priced below cost (e.g., milk and eggs in grocery stores) in order to draw in consumers who then purchase related items at a higher margin.

Providers could adopt the loss leader pricing strategy for both patient growth **and** to incentivize patient behavior for overall better health.

Many health systems have already accepted this strategy through their vast physician networks where they may lose money, but the losses are offset through the referrals into their hospitals. However, the loss leader strategy does not need to be strictly utilized from an economic/profit perspective. The Affordable Care Act (ACA) recognized the intrinsic population health values of preventive care by requiring health insurers to cover those services at zero additional cost to patients on all plans. A related example is six-month dental cleanings and exams included at no cost on dental insurance.

Other potential items for loss leader pricing for improved patient health:

- Dietary services
- Fitness clubs
  - Currently see this for senior citizens
  - Expand to broader population
- Maternal health
- Substance abuse programs (e.g., smoking cessation)

$0.00 Additional cost to patients for preventive care services under the ACA

Pricing transparency can create marketing opportunities for providers

Surgery Center of Oklahoma (SCO) has been posting cash prices for surgeries since 2009

Not every medical treatment can or should be marketed as a "shoppable service," but where it makes sense there is a US-based model that has been around for over a decade. The SCO does not accept insurance and, as an ambulatory surgery center, it does not deliver the full breadth of services of an acute care hospital. However, the methodology around what is included in the price, how the information is presented on its website and the overall transparency of its pricing make for a good comparison point for providers thinking about their "shoppable services."

Perhaps because of price transparency, SCO has also been able to keep its prices and associated costs consistent over time. Their prices have more or less stayed the same over the last 20 years, with the exception being the three times when certain prices were lowered.[1]

> "I need a rotator cuff surgery right now. I'm thinking about flying out there and having my surgery because it was such a positive experience for us."
>
> Tom Gang from California[2]

1 Adriana Belmonte, "'The system is broken': These doctors practice a less pricey form of health care," *yahoo! Finance*, July 16, 2019.

2 "Oklahoma City hospital posts surgery prices online; creates bidding war," *KFOR*, July 8, 2013.

Data ownership will shift to patients, with providers being one of multiple contributors providing and harnessing data

Ownership and data security

- Patients: will have easier access to their records and be considered the owner of their data
- Increased need for privacy and security controls to prevent non-compliant access to patient information, both intentional and accidental
- Increased need for patient education, particularly with patients being able to send their data to third-party API

Opportunities

- Increased sense of ownership, transparency and security could lead to patients being more comfortable with the use of their data
- Strategic partnerships with research institutions, tech companies and community partners, such as Ascension and Google's relationship

In the news

- Apple Health Records puts patients' data in their hands, easily accessible on their iPhone, and gives the opportunity for patients to call out discrepancies and more easily share their data with other providers.[1]
- 23andMe has generated annual revenue estimated at $475m, allowing users to choose how their data is used for health research.[2]
- Google and Ascension's partnership, while raising media's concerns over privacy, is expected to "help develop an intelligent suite of automation tools," which will allows physicians to take better care of patients.[3]

[1] "Can Apple Health Records Become Healthcare's Data Access Solution?," *PatientEngagementHIT*, May 3, 2019.

[2] "**Live Long And Prosper: How Anne Wojcicki's 23andMe Will Mine Its Giant DNA Database For Health And Wealth,**" *Forbes*, June 6, 2019

[3] Keith A. Reynolds, "Google clarifies secretive health data partnership with Ascension," *Medical Economics*, November 22, 2019.

Data analytics and availability

- Access to new data sources provides benchmarking opportunities to lower costs and establish what services are key differentiators in outcomes
- Requires developing in-house analytical capabilities or partnerships, including establishing resources in bio-ethics to guide use of data
- Key functions necessary for harnessing potential benefits will include the ability to monitor and analyze data at different levels of granularity and evolved privacy and security protocols which take into account increased patient ownership and third-party APIs
- Barriers can include proprietary data and contractual limitations, defining what measures matter and discomfort with having performance measured and reported

> “Kaiser Permanente, the California-based health network, which has more than 9 million members, is believed to have between 26 and 44 petabytes of potentially rich data from EHRs, including images and annotations. [1]

[1] “Transforming Health Care through Big Data Strategies for leveraging big data in the health care industry,” *Institute of Health Technology Transformation*, 2013.

Patient-facing technology will further shape the market

Apps, kiosks, portals and virtual agents can help patients see costs, compare options and establish payment plans. For example, *SmartAction's* conversational IA integrates quickly with any payment processing engine, accepts full and partial payments, depending on patient preference and ability to pay and has both outbound and inbound payment processing.

External developers such as tech companies will have the opportunity to shape the market by influencing where patients seek care. As discussed, interoperability and transparency could help paint a full picture of value, including costs along with reviews, ratings and outcomes. Patient-facing technology will harness these sources to direct patients and thus will shape the market.

While there could be a first-mover advantage to developing well-designed patient-facing technologies, ultimately the publicly available results will drive the market. Providers will need to assess their weaknesses, predict what the media will report on and discover what matters to their patients in order to fully leverage patient-facing technology.

Risk considerations
Building trust through transparency

To be successful, organizations will need to shift their focus from simply mitigating risk to embracing new upside opportunities.

Striking this balance requires embedding risk and control into strategic decision-making within the front-line businesses and multifaceted approaches to the portfolio of risk.

Operational and financial downside impacts

Negative impacts of noncompliance coming from risks an organization is focused on eliminating, avoiding, mitigating or transferring in a cost-effective manner.

- Noncompliance may result in monetary penalties and increased regulatory scrutiny, including an action plan
- Process inefficiencies lead to operational redundancies and gaps, including data security
- Organizational structure is inadequate and does not address resistance to change

Outside risk

The transparency and interoperability rules are imposed, and, therefore, beyond the organization's control. However, the organization's response to this outside regulation can lead to negative or positive impacts based on the approach toward compliance.

Reputational and strategic upside impacts

Benefits generated by the organization's ability to execute its business strategy and achieve its objectives while staying compliant.

- Potential for innovations to grow consumer bases
- Increased market share through improved reputational capital, balancing reduced bargaining power in payor contracting
- Capitalizing on the rise of the "super consumer"

Minimizing downside impacts

The downside

Negative impacts of noncompliance coming from risks an organization is focused on eliminating, avoiding, mitigating or transferring in a cost-effective manner.

Considerations to minimize downside impacts

- Provision for monetary penalties: failure to comply with transparency regulation could result in $300 penalty per day, owing the government $109,500 for failing to comply with this final rule during that year.[1] The amount will be updated annually with a cost-of-living adjustment multiplier, according to the rule.
- Manage regulatory scrutiny by allocating appropriate resources to execute activities needed for compliance and to respond to audits to avoid action plans imposed by regulators. CMS estimates the cost for hospitals to review and post their standard charges under the transparency rule for the first year to be 150 hours per hospital at $11,898.60 per hospital.
- Evolve overall risk assessment processes to incorporate analysis of any people, processes and technology impacted by the regulation. Proactively identify tools that will help monitor compliance in the new model, and refresh risk assessment more frequently throughout the first year of adoption.
- Identify and design mitigation strategies related to information security risks, including the analysis of data storage, transmission and display in the public website to be used.

[1] 45 CFR Part 180, *Price Transparency Requirements for Hospitals to Make Standard Charges Public*, Centers for Medicare & Medicaid Services, November 7, 2019.

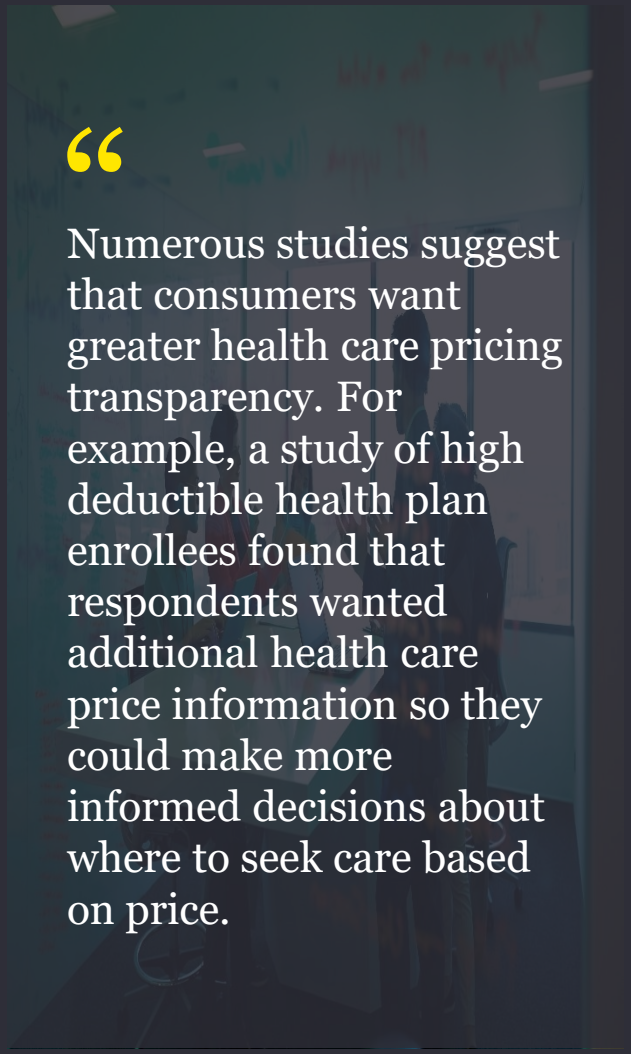
Seizing the upside potential

The upside

Benefits generated by the organization's ability to execute its business strategy and achieve its objectives while staying compliant.

Considerations for upside impacts

- Position the hospital to succeed in a more competitive environment by executing on a broader strategy that capitalizes on the regulation and on consumer trends. The regulation is aligned with the transparency that "super consumers" are seeking from providers.
- Invest in innovative practices and tools that support a patient-centered strategy. Recent health care trends place patient-centered care as the pillar of many organizational strategies. Compliance with the transparency regulation strengthens the core of provider strategy.
- The high cost of health care places a lot of scrutiny on billing. Compliance with the regulation can make health care expenses more manageable for the consumer, reflecting positively on providers.
- Review current payor contracts for early renewal opportunities and begin legal strategy in preparation for upcoming negotiations, including non-disclosure clauses.
- Define the desired customer journey, create a strategy on how the organization intends to capture customer feedback data, and leverage this data toward customer journey improvements.
- Leverage compliance success as a marketing tool to help differentiate the brand.



"Numerous studies suggest that consumers want greater health care pricing transparency. For example, a study of high deductible health plan enrollees found that respondents wanted additional health care price information so they could make more informed decisions about where to seek care based on price.

Clinical considerations

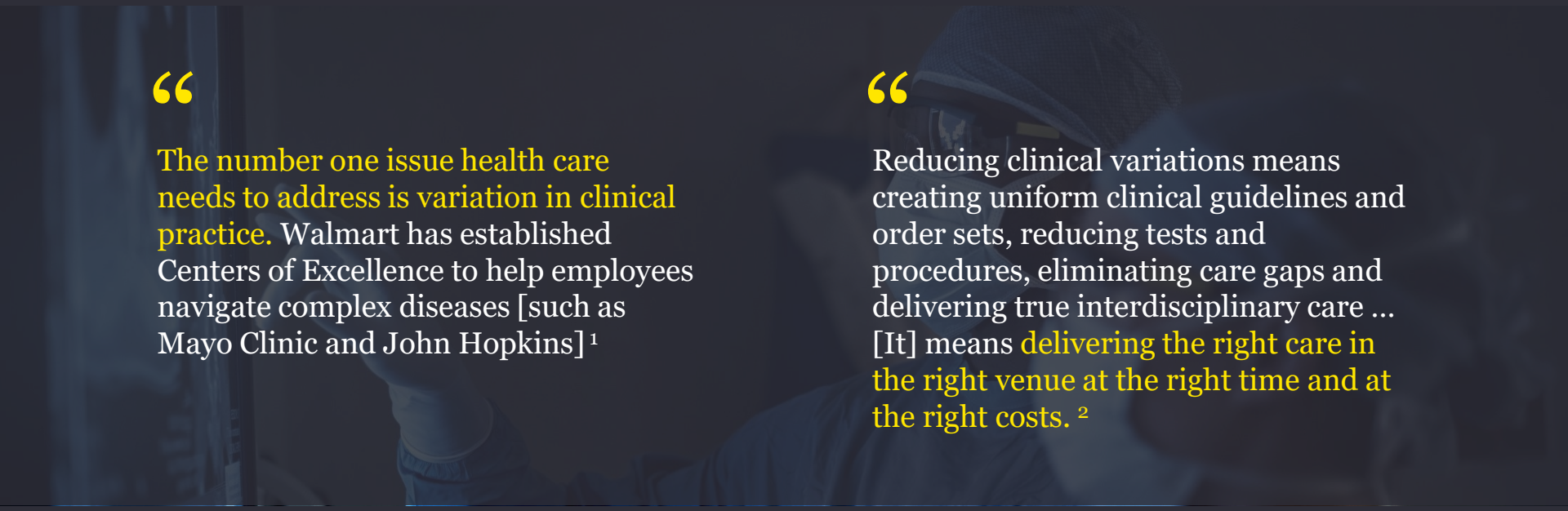
Clinicians will be expected to know the cost of care and latest information from sources available to patients. Currently, most clinicians are not able to tell a patient how much their recommended treatment will cost. There are a large number of variables affecting what any single patient will pay for a particular service; however, the shift toward a retail-like health care environment will require providers to be informed on the costs and available data.

The shift toward a retail environment will increase as patients have a greater ability to compare "shoppable" services. Patients have begun gravitating, largely for convenience and cost, to ambulatory care centers and clinics within retail stores such as CVS, Walmart or grocery stores. Walmart has formed partnerships with Quest Diagnostics and Beacon Health, and now has launched its own Walmart Health Center. [1]

[1] Bruce Japsen, "Walmart's First Healthcare Services 'Super Center' Opens," *Forbes*, September 13, 2019.

Reducing clinical variability through analytics and quality improvement will become even more important

- Availability of data will result in press coverage of differences in care, outcomes and costs
- Increases the importance of quality improvement programs and the ability to accurately benchmark
- Increased variations and services that can be seen as "differentiators," which need to be improved most rapidly
- Opportunity to reduce variation can improve operational and clinical performance



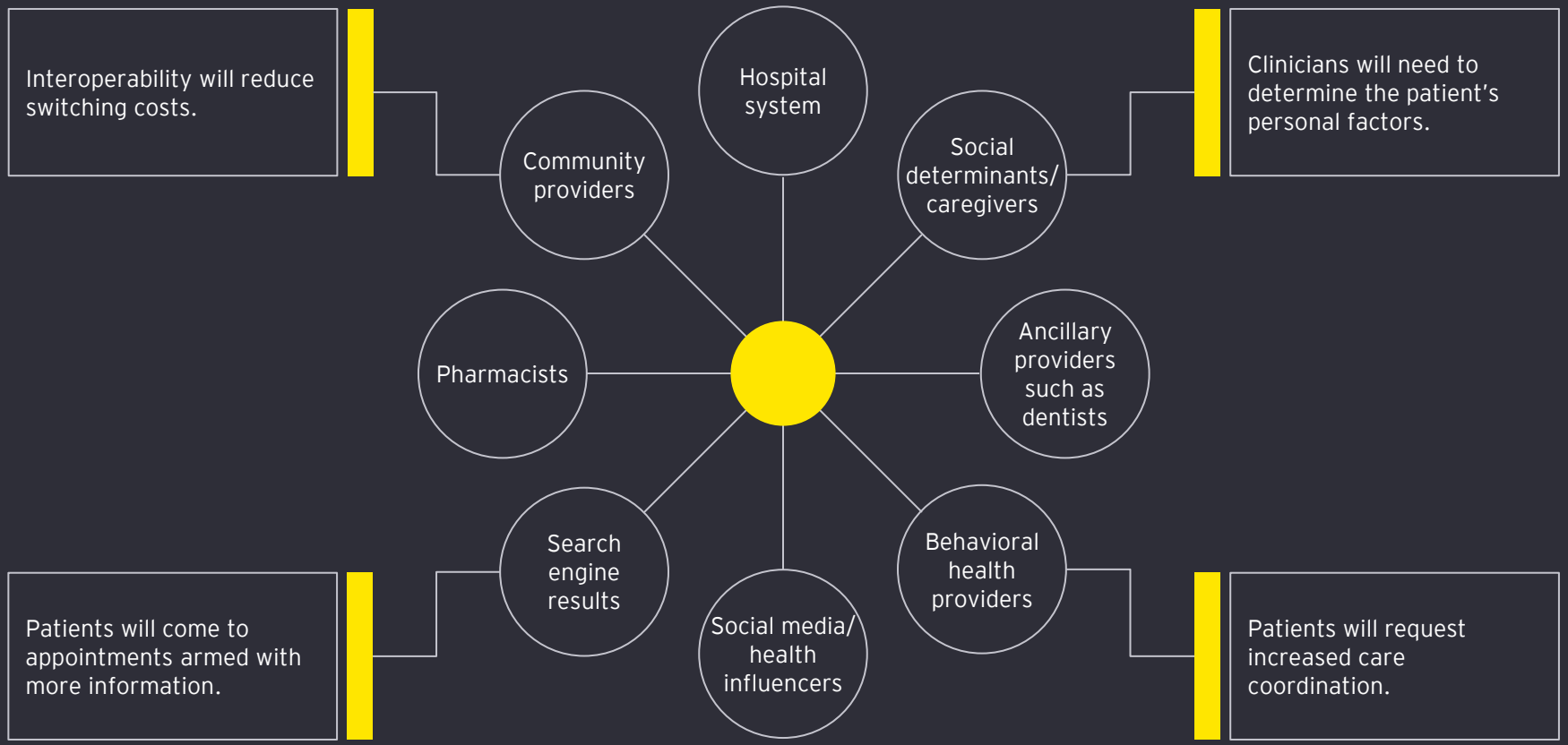
> "The number one issue health care needs to address is variation in clinical practice. Walmart has established Centers of Excellence to help employees navigate complex diseases [such as Mayo Clinic and John Hopkins][1]

> "Reducing clinical variations means creating uniform clinical guidelines and order sets, reducing tests and procedures, eliminating care gaps and delivering true interdisciplinary care … [It] means delivering the right care in the right venue at the right time and at the right costs.[2]

[1] "Where Walmart Is Headed in Health Care," *American Hospital Association*, January 29, 2019.

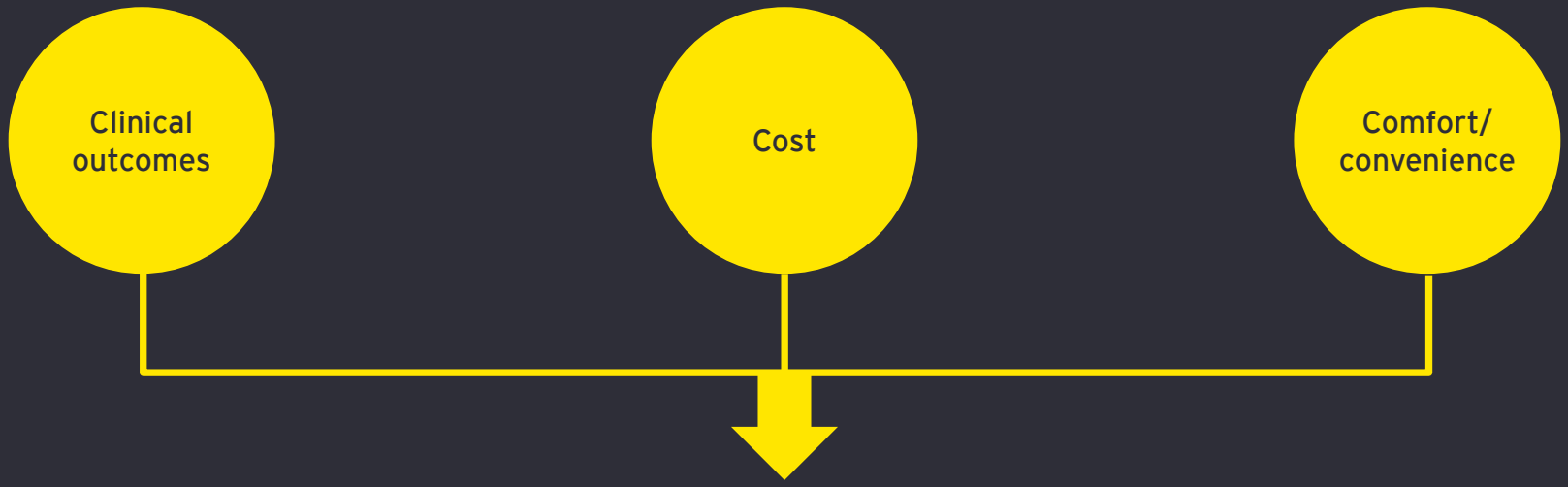
[2] "What clinical variation means to a hospital's bottom line: 4 insights from the C-suite," *Becker's Hospital Review*, 2020.

Patient-led care will require provider adaptability and awareness of each patient's sources of health information

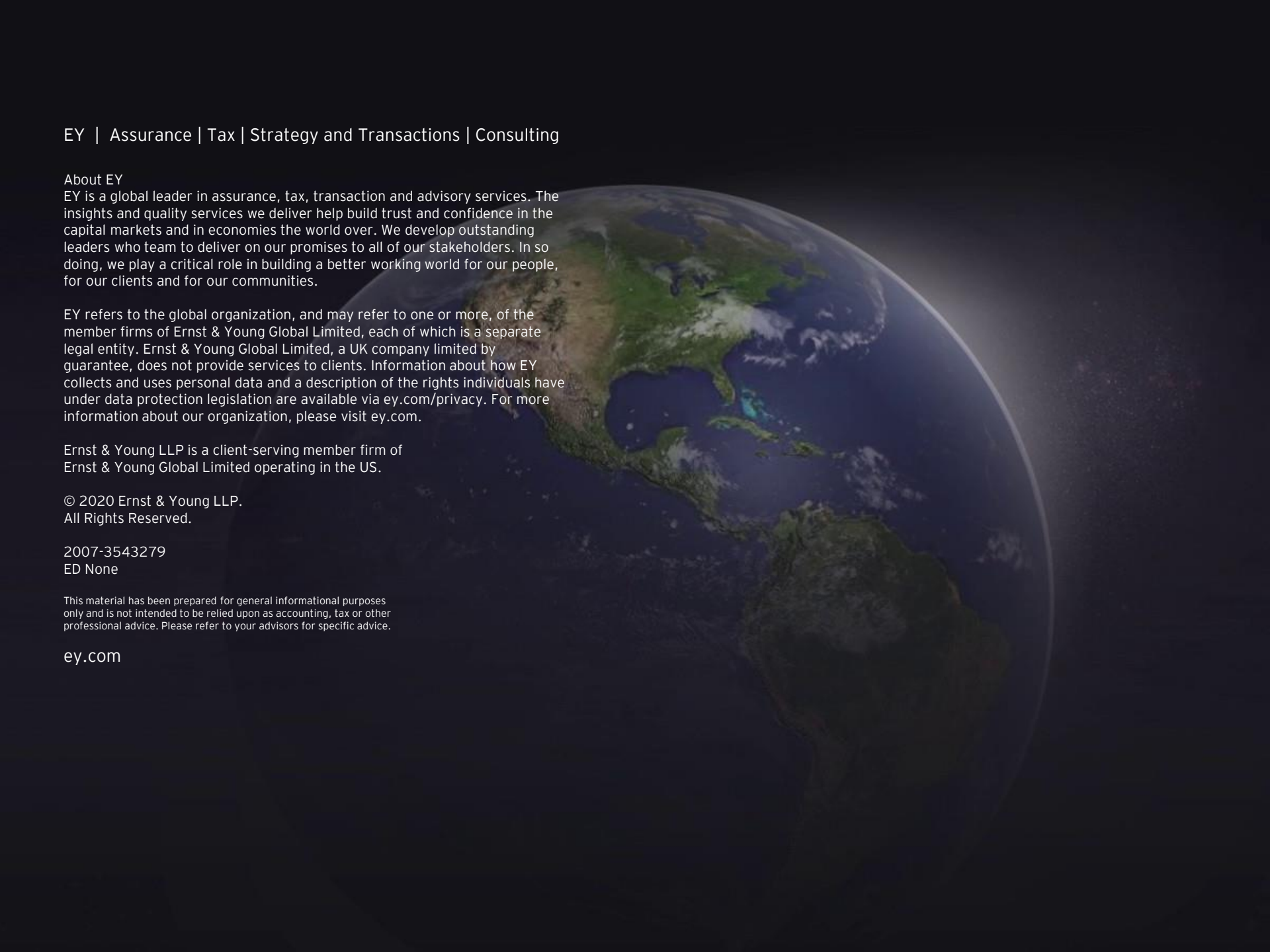


More factors will be available to influence where patients seek care, impacting acuity levels, volume and revenue

Patients will choose providers based on the ultimate value to them.



- Shift in acuity levels, patient volumes and subsequent revenue impact
- Patients may become more willing to travel far for services with transparent total cost
- payors, including employers, may further direct patients to specific providers for complex diseases or heavily value-based procedures such as knee replacements



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