

Provider Views—and Strategies—for Price Transparency

Pricing transparency is growing in importance as consumers begin to take on greater payment responsibility for their care. At the same time, hospital charging practices, particularly in relation to the uninsured, are facing increased regulatory and community scrutiny. Given today's complex payment system, however, gathering pricing information and disseminating it in a manner that will be of use to the healthcare consumer is of considerable challenge. In the following discussion, sponsored by 3M Health Information Systems, HFMA asks several senior financial executives to describe how their organizations are adapting to this changing environment and their subsequent strategies for collecting and communicating pricing information.

What are the toughest barriers hospitals face when communicating pricing information? Have any processes been successful for handling these issues at your organization?

Todd: The toughest barrier is the availability of tools with which you can present data to patients. If you look in the marketplace, there is not much functionality within our patient accounting systems for providing price quotes or estimates. Many hospitals today are still working with a blue bar sheet from their CDM [charge description master] that's about two feet thick. They page through to pull prices, or they have some type of automated database that they can query to find the past 10 examples of total charges for a particular DRG [diagnosis-related group].

We are in the process of implementing an automated solution with the vendor of our contract management system that leverages off the data it contains. We are doing so because, if you think about it, a contract management system contains a lot of information that you need to estimate what it costs for a particular diagnosis or procedure, what a payer will pay, and what a patient can expect the balance to be.

Another problem is that we don't have tools to easily determine what amount a patient's health plan will pay. I have not seen an example of a full-blown price-estimating system that can take into account a patient's contract.

Hadley: We have an internal product that will allow employees to field specific pricing questions from patients. If a patient calls and says, "I need to have an MRI,"

employees will use this estimator to find the history of MRI charges. When a patient is going to have multiple out-patient procedures, the estimator allows staff to look under general diagnostic categories and say, "Here's what the pricing history has been, here's an estimate of what your insurance pays, and here is what we anticipate you will pay."

We won't provide a price quote over the phone unless patients can give us their insurance information and we can validate that they do have insurance, so we stop competition from price shopping. But if they give us an insurance number, we can use our estimator to verify their benefits coverage, and let them know, "You have a \$200 deductible and a 10 percent coshare after that."

Smith: Many factors affect how much a patient has to pay. A patient's bill will include charges from the hospital and independent physicians, which is all mixed up with how the insurance company adjudicates the case and what their benefit structure is. But the hospital doesn't have all those pieces of information.

We have put more resources in our preregistration processes, so we can call insurance companies in advance of service and get information on behalf of patients about their copays and deductibles. We also have developed scripts and education, so we can explain to patients what they may expect to receive in a bill. It's not perfect, but patients appreciate that we've taken the time to find out about their benefits and insurance.

Nelson: In some of the contracts we have with suppliers, there are confidentiality clauses that limit our ability to communicate the cost of certain types of devices. In the past couple of years, a lawsuit was filed by a device company in relation to the confidentiality clauses. A ruling upheld the secrecy of information, such that we are prohibited from telling a patient the price paid for supplies.

We are trying to overcome this situation by making sure that we don't have these confidentiality clauses in our contracts, or, if there is a confidentiality clause, that it allows us to release the information to patients and other necessary business partners.

Clark: The toughest pricing barriers are systems, processes, and staffing resources. Best practice is to establish a consumer price line supervised by contracting staff. This involves maintaining a database of top outpatient procedures, having staff calculate allowable amounts based on contract terms, and verifying available benefits with the payer. Staff then apply self-pay discounts and provide quotes within 24 hours of the request. Scheduling is linked to the price line at the time of the call. Reporting includes the trend of calls converted into encounters and the trend in variances between quote and actual fee.

Describe some of the actions that take place when someone calls seeking a price quote. How might your response change as price inquiries become more of a norm?

Nelson: Whether patients call the department where they will have a procedure performed or a physician's office, we funnel them to the business office. Then we get all of the

pertinent information about the type of procedure, whether there is a CPT [current procedural terminology] code, etc. We have access to information on the top 50 procedures that we offer based on average price. When a patient is having one of those procedures, we will do a data search to find charges associated with patients who have had the procedure before. We will then adjust the findings for length of stay and anything else that may be relevant in quoting a price.

We've had this pricing process in place for a long time, at least a couple of decades. As pricing inquiries become more of a norm, we will need to come up with an easier way to obtain the necessary information. What we need is more of a push-button operation, so we can get the information quickly and easily.

Smith: I think it is also important to know exactly what information will be needed to address a patient price inquiry and how to communicate this effectively to the patient. I'm not completely satisfied with our process of providing quotes, because it often involves asking patients for a CPT code, which gets into this healthcare jargon that they are not familiar with. Also, patients frequently need to go back to their physicians to get additional information necessary to complete the quote.

What needs to change, so we can be more helpful for patients, is for us to partner with their insurance companies to determine not only what specific service they will be receiving, but also what plan they are on and the associated levels of coverage. That way, we can anticipate what their payment responsibility will be after adjudication. The kind of partnership I would like to see would involve electronic communication with payers to get the pricing information they have and an online adjudication process that can estimate what the out-of-pocket cost to a patient would be based on the insurance plan.

Clark: Effective communication when consumers call is becoming increasingly important. When staff don't receive proper scripting, they are not as likely to provide a positive, consistent response when asked questions such as, "Why are your prices so high?" Just a few ways to address this challenge may include customer service training for all financial services employees, brochures that describe patient financial rights and responsibilities, online access to billing policies, newspapers ads reinforcing the pricing message, and staff and physician education on applicable policies and resources.

PARTICIPANTS IN THIS HFMA ROUNDTABLE:

Elaine Anderson is senior vice president and chief compliance officer, Texas Health Resources, Arlington, Texas.

Donald Clark, CPA, CPC, is a healthcare revenue cycle management expert, 3M Health Information Systems, Salt Lake City, Utah. He previously has held positions as CFO at two healthcare organizations.

David Hadley, FHFMA, CPA, CHE, is senior vice president of finance, Texas Health Resources, Arlington, Texas.

Todd Nelson is vice president and CFO, Grinnell Regional Medical Center, Grinnell, Iowa.

Doug Smith is CFO, northern Utah division, Intermountain Healthcare, Ogden, Utah.

Hamilton Todd is section manager, patient financial services systems support and training, Mayo Clinic Jacksonville, Fla.

When determining prices, what sorts of information can financial executives use to help ensure their pricing is within market norms?

Hadley: Our gross charges are based of a number of factors: historical, cost, and market data that are available through MEDPAR [Medicare Provider Analysis and Review].

Smith: Third-party information on prices in the market can be useful. In addition, we track feedback from patients who relate choosing us or a competitor based on price. That information is not always the easiest to collect, because it has to be coordinated with the staff who are on the front-line talking to patients. But we've had some success getting that information back and using it to adjust prices.

Nelson: We have been investigating a tool that allows you to look at pricing throughout a marketplace to make sure you are falling within CMS [Centers for Medicare and Medicaid Services] norms. The defensible pricing component, which attaches to your existing system information, also will give you easier, cleaner access to your own chargemaster and can aggregate data to make it easier to get a price quote.

Clark: Deciding which market percentile is appropriate and comparing prices with market percentiles of the provider's primary service area are starting points. In some cases, market data may not be available. In other cases, market data may not be the driver behind pricing methodologies, such as when pricing drugs and supplies. Demand elasticity also needs to be taken into consideration. Adopting rational pricing requires long-term buy-in. Frequent changes in underlying costs of drugs and supplies may diminish the ability to ensure that pricing continues to track within desired pricing corridors.

What actions can providers take to help ensure their pricing strategy is defensible?

Todd: There will always be questions about how you come up with what you are charging for something. When addressing these concerns, openness is the key. You can array your charge data and do a statistical analysis of where you are in relation to some of your regional institutions, which helps you determine if you are at or below the regional norm. If you are the outlier, you had better be prepared to defend your pricing strategy. We also have a good decision support system that is utilized.

Smith: Prices are most defensible when they are based on cost. We have a good cost-accounting system to identify our underlying costs are so we can price effectively.

Nelson: The days of doing across-the-board price increases without looking at how they impact individual charges for procedures or tests are pretty much over. People may still do some type of across-the-board increases, but then they need to drill down into the information, looking at the marketplace and deciding what's reasonable based on cost.

What's more, as more people start getting high-deductible health plans and take on greater payment responsibility, the hospital's charge is going to grow in importance to them. So having a method for pricing that is understandable to the average person just makes sense.

Clark: A few key pricing considerations include variability of fee increases for services more heavily utilized by non-fixed-fee payers; price ceilings, such as market percentiles; price floors, such as mark-ups above Medicare allowable amounts or cost; frequency of pricing adjustments based on comparison with market and cost; and packaged pricing, for example, what one often sees with cosmetic procedures.

How do you balance the need for market pricing with the need to balance the budget?

Smith: That's always tough. Hospitals may feel they are able to push their prices up, but there is always a risk that doing so will come at the expense of being affordable within the community and remaining competitive with other hospitals in the area. So hospitals need to be aware of where they are positioning themselves with regard to pricing and affordability.



hfma

May 2007
HFMA Executive Roundtable
Copyright 2007
Healthcare Financial
Management Association
All rights reserved.

For reprints contact
1-800-252-HFMA, ext. 2.

This published piece is provided solely for informational purposes. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions by participants are those of the participants and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear do not constitute endorsements by HFMA.

Todd: Our people in finance spend days and days analyzing the effects of pricing. They use pricing models that look at changes in the room rate, and they plug in variables. Then they run through data and decision support and determine the impact to the bottomline. I think you constantly have to do this, because if you are not making enough income to sustain the practice, you simply won't be around. Balancing the budget is the priority—because it keeps you in business—and you have to work out the rest of it.

Nelson: When we look at our pricing strategy as we are developing the budget, we try to keep increases as low as possible. But at the end of the day, we have to decide how we are going to pay for the staff and supplies that we need.

I think it's important to note that our board, which is made up of community members, sets the financial target. So as we go through the budget by line item, we look at the board members and ask, "Can you live with this? Is this acceptable in your eyes?" If it passes their acceptability test, then those are the parameters we work under.

Price isn't the only factor consumers weigh when choosing a provider. Preference also is presumably based on value. What steps have you been taking to measure and communicate quality?

Anderson: We agree that transparency needs to be applied not only to price. It also has to be about quality and experience. A patient may be interested in knowing whether a hospital does 10 of a certain kind of procedure a year or 500. We feel it's important for the consumer to understand more than just price. Therefore, we participate in initiatives that gather that kind of information and continually work through the process of determining what's most meaningful to the consumer.

Smith: CMS and insurance companies are starting to publish clinical quality measures, but it's still a ways off before patients can understand how these measures affect their care. What is more transparent to patients is the level of service they receive. We are trying to differentiate ourselves based not only on price but quality and service. For example, we've put together a multidisciplinary care clinic. I think providing such convenience can contribute significantly to patient perceptions of service.

In the future, do you anticipate price and quality data will become an integral part of most hospitals' marketing strategies? Why or why not?

Anderson: Part of that will involve how accurate and consistent the data are. It's an evolving situation, and exactly how pricing and quality information may end up being used from a marketing perspective is not clear. We're just in a very fluid environment right now, trying to understand the data.

Smith: Health care is costly by many people's standards. Promoting value is the greatest challenge for our industry. I look forward to the time when quality data will be more understandable and will drive competition for improved quality. I anticipate there will be niches where a hospital will become better quality-wise or service-wise and then it will market that service to become the provider of choice in that area.

Nelson: All hospitals are realizing that pay for performance is gaining momentum, and the next payment system that financial leaders are going to have to deal with will be centered around quality and value. People are finally realizing that pay for performance really is here, and they need to start paying attention to it.



Health Information Systems

3M Health Information Systems, part of the 3M Health Care family, is a leading provider of advanced software tools and consulting services that help healthcare organizations capture, classify, and manage accurate healthcare data. 3M revenue management solutions include: 3M™APC Oversight Program, 3M™ Ambulatory Revenue Management Software, 3M™ Chargemaster Online and 3M™ Chargemaster Review Services, 3M™ Strategic Pricing and Market Benchmark Analysis, 3M™ Medical Necessity Online, and the 3M™ Workflow Engineering Program. More information about 3M Health Information Systems is available at www.3Mhis.com or by calling 800-367-2447.