



What's Your Strategy for Developing Rational Pricing?

This project is a collaborative effort by Innovative Health Solutions and the Healthcare Financial Management Association.

Pricing is no easy task. With intense competition among hospitals, growing availability of hospital pricing data, and increased government and public scrutiny, pressures for a process that serves the bottom line but also is defensible have never been greater. Add to these challenges the limitations associated with many standard pricing techniques, and it's no wonder financial managers may feel less than confident when it comes to their organization's strategy.

Although traditional pricing methods based on charge payer utilization and contract terms can optimize revenue within regulatory and contractual boundaries, the prices developed may not reflect actual costs. Also, if not careful, it's easy to fall below fee schedule levels thereby reducing net payment levels. With

cost-based pricing methods, prices may make sense relative to one another, but overall prices may increase substantially upon initial implementation to maintain the current net revenue levels—not the best way to meet community expectations. And while looking to market competitors is a defensible strategy, the prices that result often do not reflect cost of procedure nor do they result in optimum payment levels.

With such limitations in mind, many hospitals have found the best solution is to adopt a hybrid approach. Known as rational pricing, this strategy allows hospitals to base prices on cost, consider market factors, address contractual considerations, and present a process able to withstand public scrutiny.

Cost-Accounting Systems

When pursuing a rational pricing strategy, hospitals can establish cost-based prices for use with a full-blown cost-accounting system.

“Given today’s pricing transparency concerns, we feel that having a cost-accounting system is almost an imperative,” says James D. Beck, senior vice president, All Saints Medical Group, a 120-physician group based in Racine, Wis., and former CFO at All Saints Healthcare, which also is based in Racine and is a member of the Wheaton Franciscan System. Within the past year, All Saints decided to return to a formal cost-accounting system after a three-year period of using other proxies to estimate costs. “We had individuals who were responsible for identifying costs around a specific item or service line, and it met our needs at the time,” he says. “But given the public’s demand for transparency, we decided to return to a formal system.”

An organization’s chargemaster may contain 8,000 to 20,000 line items—too many to be scrutinized each and every year. To optimize revenue in the past, many hospitals might have made broad adjustments to their chargemasters in response to market dynamics—and created massive distortions in the process, Beck believes. “There are only a limited number of times that hospitals can do that before their chargemaster isn’t defensible anymore,” he says. “We are most concerned with how the chargemaster relates to the overall average pricing in the community. We try to benchmark our services so that we are at or below what other local communities are. That’s a better long-term strategy than any short-term strategy to alter the chargemaster to take advantage of specific contracts with payers.”

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Exploring Alternatives to Traditional Cost-Accounting Systems

While a traditional cost-accounting system can be an excellent tool for developing rational pricing, many hospitals simply cannot afford the cost of acquiring, implementing, and maintaining the technology.

A cost-accounting system could mean an investment of \$500,000, with up to \$75,000 to \$100,000 in additional costs for annual maintenance. Plus, the hospital usually needs to hire at least one FTE to implement and maintain the system.

“Some of our smaller hospitals have questioned whether they need a cost-accounting system,” says Joseph F. Corfits, Jr., FHFMA, senior vice president and CFO, Iowa Health–Des Moines. The system, an affiliate of the Iowa Health System, includes three hospitals in central Iowa, with about \$500 million in net revenue. “These days, I’m not sure how important a cost-accounting system is for a critical access hospital. That’s because they have such a high Medicare penetration, with payments based on a cost-based reimbursement methodology.”

When administrators at the organization looked at the cost-benefit of implementing a full-blown cost-accounting system for some of the hospitals, they determined that they could manage without it. Instead, they've developed another approach: "We ask our hospitals without a cost-accounting system to look at the direct costs of each department—right off of their general ledger—and apply an overhead component that is generally based on the Medicare cost-to-charge ratio," says Corfits. "We've found that this can be a reasonable surrogate for a cost-accounting system."

Your Rational Pricing Strategy

When pursuing a rational pricing strategy using in-house resources, it is important to base prices on cost, consider marketing factors, address contractual considerations, and prepare for public scrutiny.

Base Prices on Cost.

Visualizing how to build rational prices without a cost-accounting system can be a challenge. The typical cost-accounting system uses time and motion studies and actual cost analysis at the chargemaster line-item level, and then breaks this information down further into variable costs, fixed costs, direct costs, etc. In the absence of an actual time-and-motion study and a formal cost analysis, those in finance can rely on department heads to develop time and cost estimates, based on their intimate familiarity with how long procedures take and how much supplies cost (See "Establishing Unit Cost/RVU Estimates.")

The exhibits on pages 5-7 illustrate the general steps in using these estimates (or a formal cost-accounting system) as part of the process of developing rational pricing.

Establishing Unit Cost/ RVU Estimates

Absent a cost-accounting system, hospitals can take the following steps to develop unit cost/relative value unit estimates:

- Develop time and expense ranges for material labor and expense categories for each charge-master line item.
- Ask department managers to estimate the range that best fits each line item in their chargemaster area of responsibility.
- Multiply the midpoint of the ranges that were selected by the department head with the usage data for the respective line item. Make sure that all chargemaster line items with usage data for the period have time and expense estimates assigned.
- Allocate the respective labor and nonlabor expense for the same period of usage data based on the weighted time and expense estimates at the chargemaster line item level.
- For each line item, add the allocated labor and nonlabor expenses to derive total estimated costs for the respective chargemaster line item.
- Divide the total estimated costs for the chargemaster line item by the total usage statistics for the same line item to derive a preliminary unit cost estimate.
- As a reasonableness check, compare estimated expenses for the departments with the actual direct or fully allocated cost for the period.
- Divide actual expenses by the estimated expenses.
- To derive the final unit cost estimate, apply the ratio of actual expenses to estimated to the preliminary unit cost estimate for each line item. Unit cost estimates can then be used for developing rational pricing (p. 5).

Consider Market Factors.

Any rational pricing approach requires constant data collection, and key is staying on top of market trends. “The marketplace is becoming very competitive, both from other hospitals and physician-owned providers,” says Gregory Adams, senior vice president and CFO of Holy Name Hospital in Teaneck, N.J. “Market comparisons are important for assessing whether any of your services are out of line with market conditions.”

Useful Data Sources

Hospital Outpatient Prospective Payment System File

www.cms.hhs.gov/data/order/lds.asp#opps

This file, which is stripped of certain data elements that might permit identification of beneficiaries, contains select claim-level data and is derived from 2004 hospital outpatient PPS claims, updated through December, 2004. It includes more than 58 million records for services paid under the outpatient PPS. This is a flat file available on a 3490e cartridge. The LDS record length is 8119, and blocksize is 32,760.

Cost: \$3,000 Available: Proposed 2006

MEDPAR Limited Data Set—Hospital

www.cms.hhs.gov/data/order/lds.asp#ntl

The Medicare Provider Analysis and Review file contains records for 100 percent of Medicare beneficiaries who use hospital inpatient services. The records are stripped of most data elements that will permit identification of beneficiaries. The six-digit Medicare billing number identifies the hospital. The national file consists of approximately 12 million records and is approximately seven 3490E cartridges.

Cost: \$3,655 per year Available: FY93-FY04

Absent a web-based system or software package designed for comparative pricing, hospitals can collect market data using an Excel spreadsheet for key departments of high-volume procedures across all departments. The spreadsheet can record the item description, service code, HCPCS code, current hospital price, competitor or peer group price (obtained from publicly available data), and Medicare fee schedule amounts.

At Winona Health Services in Winona, Minn., finance relies on outside expertise to gather public information and organize it into a format from which to make decisions, according to Michael M. Allen, FHFMA, CPA, vice president and CFO. Winona Health includes a 99-bed hospital, 160-bed nursing home, 80-bed assisted living facility, and other clinics. “Gathering the information is probably something any hospital can do, but synthesizing the data and building various pricing models takes some sophistication that many hospitals don’t have,” Allen says.

Historically, comparative market information hasn’t been all that it could be. Some hospitals and consulting firms relied on data from random telephone surveys designed to track prices of highest volume and most sensitive procedures, such as chest X-rays, MRIs, mammograms, and ER visits. But for a hospital with a 10,000-item chargemaster, collecting information over the phone became unrealistic. Electronic information, while it was more comprehensive than survey data, had its own limitation—by the time it made it into the financial manager’s hands, it was already three to four years old. But over the past three years, more timely data have become available on prices, costs, and usage. Today, such information can be had that is often less than a year old. From that, finance managers can derive a markup factor at the HCPCS level.

A How-To Guide to Rational Pricing

To get started on developing your rational pricing strategy, you'll need the following information:

- Your current chargemaster line item prices and related service codes, HCPCS codes, and descriptions. (This information should be in the standard report or file from your billing system.)
- Usage data broken out by the chargemaster line item, by patient type (for example, inpatients, those receiving same-day surgery, emergency department patients) at the plan code level. (This information can be obtained through an ad-hoc query or custom report from most vendors.)
- A summary of contract terms for each plan. (This information should be readily available from your contract management system or gathered from finance department staff.)
- The optional peer group average price by HCPCS code. (The 2004 outpatient claims file is available from CMS. Vendors also offer reports or license systems that can be useful.)

- The optional unit cost for each chargemaster line item. (A cost-accounting system will provide this information, or staff can conduct a cost/RVU estimate [as described in “Establishing Unit Cost/RVU Estimates” on page 3].)
- The optional Medicare (or other) fee schedule at the HCPCS code level. (This information is available through CMS and/or other payers.)

The exhibits show the step-by-step process of using this information to develop defensible yet optimum prices. It's important to note that in using this process, finance managers will still need to account for additional considerations, such as relationship of pricing among related procedures, whether the procedure being priced carries particular public relations or market-sensitive implications, the impact of outliers, carve-out agreements, validity of coding (HCPCS/CPT 4), items that are uncoded or missing, and the ongoing need to monitor the pricing strategy.

Exhibit 1: Department A

Gather the information required from the hospital's chargemaster. Note that unit cost is obtained from a cost-accounting system or the process described on page 3 for developing estimates.

| Charge Code | Item Description | HCPCS | Unit Cost | Charge |
|-------------|------------------|-------|-----------|--------|
| 00001 | Procedure 1 | 00001 | \$30 | \$100 |
| 00002 | Procedure 2 | | \$60 | \$200 |
| 00003 | Procedure 3 | | \$30 | \$150 |
| 00004 | Procedure 4 | 00002 | \$10 | \$50 |

Exhibit 2: Payers

Obtain payer (plan-code level) contract identifiers.

| Payer Code | Payer Description |
|------------|-------------------|
| C | Commercial Payer |
| M | Medicare |

Exhibit 3: Usage

Assemble usage data by charge item, plan, and patient service type.

| Charge Code | Payer Code | Inpatient Volume | Outpatient Volume |
|-------------|------------|------------------|-------------------|
| 00001 | C | 1,300 | 13,000 |
| 00002 | C | 250 | 2,500 |
| 00003 | C | 400 | 4,000 |
| 00004 | C | 100 | 1,000 |
| 00001 | M | 400 | 4,000 |
| 00002 | M | 150 | 1,500 |
| 00003 | M | 900 | 9,000 |
| 00004 | M | 1,000 | 10,000 |

Exhibit 4: Contracts

Summarize the charge-based percentage by department, plan, and patient service type.

| Dept | Payer Code | Inpatient Collection Percentage | Outpatient Collection Percentage |
|------|------------|---------------------------------|----------------------------------|
| A | C | 80% | 80% |
| | M | 0% | 0% |
| B | C | 80% | 0% |
| | M | 0% | 0% |

Exhibit 5: Contribution Percentage*

Based on the payer contract terms, calculate charge paying net revenue.

| Payer | Charge Code | Charge | Inpatient Volume | Out-patient Volume | Total Volume | Inpatient Revenue | Out-patient Revenue | Total Revenue | Inpatient Charge Paying Revenue | Out-patient Charge Paying Revenue | Total Charge Paying Revenue |
|-------|-------------|--------|------------------|--------------------|--------------|-------------------|---------------------|---------------|---------------------------------|-----------------------------------|-----------------------------|
| C | 00001 | \$100 | 1,300 | 13,000 | 14,300 | \$130,000 | \$1,300,000 | \$1,430,000 | \$104,000 | \$1,040,000 | \$1,144,000 |
| | 00002 | \$200 | 250 | 2,500 | 2,750 | \$50,000 | \$500,000 | \$550,000 | \$40,000 | \$400,000 | \$440,000 |
| | 00003 | \$150 | 400 | 4,000 | 4,400 | \$60,000 | \$600,000 | \$660,000 | \$48,000 | \$480,000 | \$528,000 |
| | 00004 | \$50 | 100 | 1,000 | 1,100 | \$5,000 | \$50,000 | \$55,000 | \$4,000 | \$40,000 | \$44,000 |
| M | 00001 | \$100 | 400 | 4,000 | 4,400 | \$40,000 | \$400,000 | \$440,000 | 0 | 0 | 0 |
| | 00002 | \$200 | 150 | 1,500 | 1,650 | \$30,000 | \$300,000 | \$330,000 | 0 | 0 | 0 |
| | 00003 | \$150 | 900 | 9,000 | 9,900 | \$135,000 | \$1,350,000 | \$1,485,000 | 0 | 0 | 0 |
| | 00004 | \$50 | 1,000 | 10,000 | 11,000 | \$50,000 | \$500,000 | \$550,000 | 0 | 0 | 0 |
| Total | | | | | | \$500,000 | \$5,000,000 | \$5,500,000 | \$196,000 | \$1,960,000 | \$2,156,000 |

*Contribution percentage is the percentage of net revenue that will result from a change in gross revenue. For example, if a charge code's contribution percentage is 60 percent, then for each additional dollar in gross charges for that charge code, the hospital will realize a net revenue increase of 60 percent.

Exhibit 6: Contribution Percentage 2

Calculate the contribution percentage. Note that total and charge paying revenue is summarized at the charge code level.

| Charge Code | Total Revenue | Charge Paying Revenue | Contribution Percentage |
|-------------|---------------|-----------------------|-------------------------|
| 00001 | \$1,870,000 | \$1,144,000 | 61% |
| 00002 | \$880,000 | \$440,000 | 50% |
| 00003 | \$2,145,000 | \$528,000 | 25% |
| 00004 | \$605,000 | \$44,000 | 7% |
| | \$5,500,000 | \$2,156,000 | |

Exhibit 7: Optimization Scenarios

Examine optimization scenarios. Here, the impact based on contracts is calculated at a maximum increase or decrease of 20 percent.

| Charge Code | Old Charge | New Charge | Volume | Old Total Revenue | New Total Revenue | Old Charge Paying Revenue | New Charge Paying Revenue |
|--------------------|------------|------------|--------|-------------------|-------------------|---------------------------|---------------------------|
| 00001 | \$100 | \$120 | 18,700 | \$1,870,000 | \$2,244,000 | \$1,144,000 | \$1,372,800 |
| 00002 | \$200 | \$240 | 4,400 | \$880,000 | \$1,056,000 | \$440,000 | \$528,000 |
| 00003 | \$150 | \$120 | 14,300 | \$2,145,000 | \$1,716,000 | \$528,000 | \$422,400 |
| 00004 | \$50 | \$40 | 12,100 | \$605,000 | \$484,000 | \$44,000 | \$35,200 |
| Total | | | | \$5,500,000 | \$5,500,000 | \$2,156,000 | \$2,358,400 |
| Net Revenue Change | | | | | | | \$202,400 |
| Maximum +/- % | 20% | | | | | | |

Exhibit 8: Cost-Based Scenarios

Examine cost-based scenarios. Here, the impact based on a 400 percent markup on cost is calculated.

| Charge Code | Old Charge | Unit Cost | New Charge | Volume | Old Total Revenue | New Total Revenue | Old Charge Paying Revenue | New Charge Paying Revenue |
|--------------------|------------|-----------|------------|--------|-------------------|-------------------|---------------------------|---------------------------|
| 00001 | \$100 | \$30 | \$120 | 18,700 | \$1,870,000 | \$2,244,000 | \$1,144,000 | \$1,372,800 |
| 00002 | \$200 | \$60 | \$240 | 4,400 | \$880,000 | \$1,056,000 | \$440,000 | \$528,000 |
| 00003 | \$150 | \$30 | \$120 | 14,300 | \$2,145,000 | \$1,716,000 | \$528,000 | \$422,400 |
| 00004 | \$50 | \$10 | \$40 | 12,100 | \$605,000 | \$484,000 | \$44,000 | \$35,200 |
| Total | | | | | \$5,500,000 | \$5,500,000 | \$2,156,000 | \$2,358,400 |
| Net Revenue Change | | | | | | | | \$202,400 |

Exhibit 9: Peer Adjustment

The price for charge code 0001 is adjusted to \$130 when the peer group average is determined to be \$140.

| Charge Code | Unit Cost | Old Charge | New Charge | Volume | Total Revenue | New Total Revenue | Old Charge Paying Revenue | New Charge Paying Revenue |
|--------------------|-----------|------------|------------|--------|---------------|-------------------|---------------------------|---------------------------|
| 00001 | \$30 | \$100 | \$130 | 18,700 | \$2,244,000 | \$2,431,000 | \$1,144,000 | \$1,487,200 |
| 00002 | \$60 | \$200 | \$240 | 4,400 | \$1,056,000 | \$1,056,000 | \$440,000 | \$528,000 |
| 00003 | \$30 | \$150 | \$120 | 14,300 | \$1,716,000 | \$1,716,000 | \$528,000 | \$422,400 |
| 00004 | \$10 | \$50 | \$40 | 12,100 | \$484,000 | \$484,000 | \$44,000 | \$35,200 |
| Total | | | | | \$5,500,000 | \$5,687,800 | \$2,156,000 | \$2,472,800 |
| Net Revenue Change | | | | | | \$187,000 | | \$316,800 |

Exhibit 10: Fee Schedule Integration

Integrate fee schedules into the equation. Here, the price for charge code 00004 is increased because the Medicare fee schedule amount is \$48.

| Charge Code | Old Charge | New Charge | Volume | Old Total Revenue | New Total Revenue | Old Charge Paying Revenue | New Charge Paying Revenue |
|--------------------|------------|------------|--------|-------------------|-------------------|---------------------------|---------------------------|
| 00001 | \$100 | \$130 | 18,700 | \$1,870,000 | \$2,431,000 | \$1,144,000 | \$1,487,200 |
| 00002 | \$200 | \$240 | 4,400 | \$880,000 | \$1,056,000 | \$440,000 | \$528,000 |
| 00003 | \$150 | \$120 | 14,300 | \$2,145,000 | \$1,716,000 | \$528,000 | \$422,400 |
| 00004 | \$50 | \$48 | 12,100 | \$605,000 | \$580,800 | \$44,000 | \$42,240 |
| Total | | | | \$5,500,000 | \$5,783,800 | \$2,156,000 | \$2,479,840 |
| Net Revenue Change | | | | | | | \$323,840 |

Source: Innovative Health Solutions. Used with permission.

Many commercial products are available that can help healthcare organizations collect market data. On the inpatient side, some products use data from the Medicare Provider Analysis and Review file, which contains records for 100 percent of Medicare beneficiaries who use hospital inpatient services. On the outpatient side, the Hospital Outpatient Prospective Payment System File is available. This file, which is stripped of data elements that might permit identification of Medicare beneficiaries, contains select claim-level data derived from 2004 hospital outpatient PPS claims, updated through December 2004. Made available in August 2005, the file is an extremely current resource. It includes more than 57 million records for services paid under the outpatient PPS, including observation, multiple, and single claims. The database also features a hospital's average prices, costs, and charge-to-cost mark-up factors by HCPCS line.

Iowa Health-Des Moines uses a commercial software product that utilizes MEDPAR data. Previously, the organization had worked with an outside consultant who helped establish a good foundation for rational pricing: The firm completed a chargemaster validation, scouted public databases for market data, built a model, and completed some pricing sensitivity studies in aggregate. Two years ago, the system migrated to a commercial product so it could bring the process in house.

State hospital associations also can be a key source of market data. Iowa Health-Des Moines compares its aggregate charge per case and charge per day with competitors through information obtained from reports provided by the Iowa Hospital Association. These data are not case-mix adjusted, so finance managers need to estimate that impact. Depending on where the hospital is located, it also may be possible to explore charge

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information collected through the state. At least two states require charge information to be published online: California (www.oshpd.cahwnet.gov/hid/hospital/chrgmster/) and Wisconsin (<http://dhfs.wisconsin.gov/healthcarecosts/index.htm>).

A hospital's product line managers also can provide invaluable information to finance. They are often aware of local competitors' prices through patient word of mouth or advertising. "Most of our market analysis comes together during the budget process," says Corfits. "Our budget is a top-down process—after product line volumes are agreed upon, we push down the cost based on standards. Our VPs and managers are provided the opportunity to adjust expenses based on known factors. If there are market-sensitive services that will be adversely affected due to external competition, we will adjust a charge accordingly."

St. Francis Hospital, Wilmington, Del., recently enlisted the help of a vendor to examine market data and fee schedules. "We look at market data about

every other year, on a project basis,” says Bernie Citerone, vice president of finance and CFO at the 395-bed community hospital, which has net revenues of \$130 million a year. “It takes a lot of effort, and you don’t get that much out of it if you do it too frequently.” St. Francis compiles much of its market information from its state hospital association and MEDPAR data. St. Francis also reviews contracting data available through its system, Catholic Health East, which includes 32 hospitals. Leadership collects information at the aggregate level to look at how the hospital’s charges compare with costs. When examining the cost-to-charge ratio across the state, St. Francis recognized that it needed to make some adjustments to establish prices at a reasonable yet optimum level.

“In some ways, pricing is easier than in the past because we have better tools,” Citerone says. “But it is also more difficult because there are more services and changes in medical practice. For example, take the introduction of drug-eluting stents, which cost three times as much as traditional stents. We don’t know how quickly the changeover will take place. And that poses a challenge for rational pricing.”

Address Contractual Considerations.

Contracting considerations also are a critical piece of pricing decisions. Contract optimization takes into account what payers are willing to pay for key line items based on a weighted average. It’s important for finance managers to take into account contract terms before they implement new line item prices in their chargemaster—otherwise, they may leave some money on the table. It’s also important to look at individual procedure contract exclusions—for example, a contract may stipulate that a given department is paid at

60 percent of charges, with the exception of specific procedures paid on a fee schedule. It is also common for entire departments to be paid on a percentage of charge basis while others are paid on a fee schedule basis. Financial managers must ensure the new prices are not established below the fee schedule amounts.

During budget time at Iowa Health-Des Moines, finance managers develop a matrix for inpatient and outpatient charges by payer to establish the incremental increase for every dollar they increase rates. “Generally, Medicare is not going to participate in any inpatient rate increase while some commercial payers may participate to a modest degree. The focus here is to identify what the overall net yield will be based on current payer contracts in place as well as payer mix. Due to the high percentage of prospective or fee screen contracts, the incremental improvement is modest at best,” Corfits says.

During this process, financial managers have a fiduciary responsibility to perform net revenue modeling before implementing a new pricing structure. A practical way to model the impact of price changes on net revenue is by dealing only with those aspects of the contract that are relevant. For example, if a PPO pays per diems for inpatients, fee schedule for radiology and lab services, and 70 percent for all other procedures, the most important factor in a net revenue model is the portion of services that each payer is paying for a percentage of charges. In other words, these are the only services that will affect net revenue through a price change.

When it comes to contracting, Winona Health’s Allen is one finance manager who prefers to keep it simple. “We primarily stay on the percent of charges for all of our contracts,” he says. “This helps us understand the situation better and allows us to be on a level playing

field with the managed care companies, which typically have better information than we do. We want to maintain pricing that reflects the cost of operations and avoids deep discounting. We also want to generally be below the market with pricing that is consistent with our discounting policy.”

A Glimpse at Rational Pricing in Action

Consider how rational pricing may be used for two chargemaster line items. Procedure 1 has a high-charge payer mix and Procedure 2 has a low-charge payer mix. Assume volumes are the same for each line item. Procedure 1 is initially increased by 20 percent, and Procedure 2 is decreased by 20 percent to increase net revenue while keeping gross revenue budget neutral.

The new price for Procedure 1 is compared with the market area price, and the new price is found to be higher than the desired percentage of market. So, the price increase is reduced to 15 percent to keep it slightly below others in the market while still increasing net revenue for the hospital.

The new price for Procedure 2 is compared with the fee schedule, and the new price is found to be slightly lower. Therefore, the price decrease is changed to 17 percent so as to ensure that the hospital isn't paid less than the fee schedule due to its prices being too low.

Note: When addressing cost as part of rational pricing, the first step should be to increase unit costs by line item to achieve current net revenue levels (e.g., add overhead and profit margin consideration) and then proceed to examining contractual considerations and market data.

Preparing for Public Scrutiny

Clear communication and transparency regarding pricing policies are key to positive community relations. Many provider organizations have discussed how they can do a better job of letting patients know what they can expect to pay for care.

Holy Name Hospital focuses on presenting a clear, unified message. “Hospitals should develop specific policies on charging and collecting from patients, establish a central means for responding to patient inquiries, and use forums available to the public, such as the hospital’s website, to provide information on charges and charge and collection policies,” advises Adams.

At Iowa Health-Des Moines, financial counselors provide estimates to patients upon request. That estimate is a range, based on the anticipated procedure. “We explain to patients that their charges may vary due to complications, or lack thereof, and physician choice,” Corfits says. “In our registration areas, we also make available the prices of some of our more common procedures and room rates. In addition, we explain to patients that our charges do not include physician fees.”

The larger issue for financial managers is that the need for rational, defensible prices has never been greater. When public scrutiny is high, tools like strategic pricing systems may be used to actually lower prices—and do so in a way that minimizes the unfavorable impact on net revenue. That was the case when Douglas Myers was CFO and senior vice president of finance at Saint Vincent Health System in Erie, Pa. “We actually wanted to lower our prices without affecting our net revenue too much—a kind of rate minimization,” says Myers, who is currently heading finance at the Children’s Hospital and Research Center in Oakland, Calif. “With help from an outside consultant, we looked at all of our chargeable items and determined which were impacted by prices

and which were not. After determining which changes were reimbursed, we could determine how sensitive our prices were to increases or decreases. By using vendor tools, we didn't have to reinvent the wheel. That's important, particularly for smaller hospitals. It's a compliance issue, too. And it's your fiduciary responsibility."

When fiscal managers arrive at prices, they not only have to consider cost factors but they must now consider a new factor, public perception, says George Quinn, senior vice president at the Wisconsin Hospital Association, Madison, Wis. "Part of the public perception problems that we have are because the public hasn't been informed well enough."

For the past 15 years, the state of Wisconsin has mandated hospitals to release their inpatient charge information. Each hospital in the state must submit all discharge billed information and complete an annual fiscal survey and annual uncompensated care report. Two years ago, the WHA persuaded the state legislature to delegate the responsibility for collecting and reporting that information to the association. The result was PricePoint, www.wipricepoint.org. This public web site publishes average charge information by DRG by hospital. PricePoint also provides aggregate "discount" information for each hospital for the three major payer types: private insurance, Medicare, and Medicaid. This helps users understand how hospitals' charges compare with the amount of revenue they actually collect for services to the patient groups.

While some members were reluctant to make the information public, Quinn stresses that the data available relate to charge information, not actual

Taking the lead on transparency by making charge information available is critical in an environment in which pricing data can be misunderstood.

payment information by DRG. The data are typically at least 120 days old and are replenished every quarter. Currently, the Oregon Hospital Association is a licensee of the technology. Other states also have expressed an interest in making charge information available online, Quinn says. The WHA currently is working to make outpatient surgery charges from hospitals and ambulatory surgery centers available online.

Taking the lead on transparency by making charge information available is critical in an environment in which pricing data can be misunderstood, Quinn says. "Posting charges online is one more way to educate the public on what prices are all about. It helps people understand that hospitals are willing to provide this information, and it gives the public a sense of what costs they might incur," he says. "The public consciousness has been raised, and we need to take a leadership role in promoting pricing transparency."



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