The Opportunity of Price Transparency

hfma
healthcare financial management association

THIS HFMA EDUCATIONAL REPORT IS SPONSORED BY McKESSON CORPORATION.

A patient referred to the hospital for acute abdominal pain expects to stay overnight for some blood work and a gastroenterology examination. During the next 72 hours, he is repeatedly surprised by visits from not only a gastroenterologist, but a neurologist, a cardiologist, a psychiatrist, and a dietician, not to mention a battery of tests including X-rays and an MRI. Those surprises are nothing compared with his shock upon receiving a bill for all of these services. Clinical justification after the fact does little to remedy the patient's shock; he bitterly refers to this as the moment he found out he had a "$15,000 stomachache."

The need for price transparency is clear and urgent for consumers and healthcare providers alike. Patients want to know up front what charges they can reasonably expect to pay for a medical intervention. Providers want to know how and when they will be paid.

The goal of price transparency seems simple: provide patients with real-time estimates of their out-of-pocket expenses for recommended medical procedures. Yet executing this goal is relentlessly complex. Utilizing two distinct groups of data—provider data and patient data—together does not create a new group only twice the size, but one exponentially greater. What appeared to be one-dimensional pieces of information are transformed into multi-tiered data sets that must be repeatedly broken down and reassembled algorithmically into a price package that reflects a unique episode of care for a unique patient delivered by a specific provider on a specific day.

Healthcare providers who have already implemented price transparency believe that it is best understood as an opportunity to create a more productive provider-consumer relationship, not as an end in itself. "Being able to give your patients estimates of their financial obligations should lead directly to the next step—having a conversation about how they will pay or otherwise resolve their obligations," notes Terry Rappuhn, project leader of the **PATIENT FRIENDLY BILLING®** project, a collaborative endeavor spearheaded by HFMA, with support from the American Hospital Association, the Medical Group Management Association, providers, and other interested parties to promote improved billing practices. "You should be able to offer options to your patients such as paying before or at the time of service, agreeing to a payment plan, or applying for Medicaid coverage or financial assistance. This becomes a win-win scenario for you and your patients," she says.

The Means of Price Transparency

Providing patients with an advanced estimate of their expected financial obligation requires a fundamental understanding of both provider data and patient data involved.

Provider data

The most fundamental provider data in the price transparency equation consist of a clear identification of the required procedure and all of the knowable components. The paradox is that the more closely the data are examined, the less clarity they provide. For example, will the patient need any pre- or post-procedure support? What laboratory or imaging services are planned? Which services are not planned but may be necessary, and how marginal is the necessity? What is the anticipated length of stay? How might that change based on diagnostic testing? Physicians, medications, patient co-morbidities, case management, and rehabilitation must each be considered separately and together in the scores of possible permutations that may become necessary while the patient is at the hospital.

Once those data are detailed, they must be compared against historical examples of how the hospital typically codes and charges for each component of the episode of care. Parsing out the similarities and differences should provide a reasonable starting point for constructing a unique price package, but even in the best circumstance it may be only a starting point.

Patient data

Patient-specific data collection begins with a determination of whether the patient has health insurance. If a patient is uninsured or underinsured, this provides an opportunity to counsel the patient on available financial aid. Basic income information should be collected to determine qualification for Medicaid or charity care.

If a patient has insurance, then the next step is to determine the insurance benefit for the proposed care episode. Minimally, this requires a consideration of intertwining variables: the patient's deductible, year-to-date payment against the deductible, annual out-of-pocket maximum, year-to-date payment against the out-of-pocket maximum, the contracted rate for the specific procedures (this rate will vary depending on whether the hospital is an in-network provider), whether the patient is precertified for the proposed procedure and any or all of the associated services, and whether the patient is required to sign a Medicare advance beneficiary notice.

Barriers to Price Transparency

Potential barriers to effective and efficient communication of healthcare price transparency can be found at the patient, payer, provider, and individual process level.

Patient barriers

Many patients don't clearly understand either the procedure being ordered or the parameters of their insurance benefit,

An Automated Answer?

Providing patients with meaningful price information is no easy task. To give a patient an advance estimate of his or her expected financial obligations, a provider must be able to overlay the patient's insurance benefits with his or her specific medical condition and expected treatment. Fortunately, automated tools are making some of the steps involved easier. The following are just a few areas where providers are moving away from manual processes.

Electronic benefits management. Solutions can help providers track and match coverage, rules, exclusions, limitations, copays, and employers across the entire delivery network.

Identification of financial assistance eligibility. Capabilities include identifying patients who may qualify for charity care or uninsured discounts in compliance with the organization's policies, and identifying patients who qualify for Medicaid care.

Calculation of out-of-pocket charges. Solutions vary. Under one system, the program takes information entered by the registrar and prints out an estimate statement based on diagnosis-related group, contract, historical data, and benefit information obtained from payers and patients. Using another solution, preregistration teams input diagnosis and procedure codes and a technology solution will match these with the patient's insurance plan and payer contracts to create an advance explanation of benefits form that can be sent to the registrar to present to the patient.

notes Diane Watkins, corporate director of patient financial services at Saint Luke's Health System in Kansas City, Mo. This misunderstanding can skew the accuracy of a preservice estimating process from the outset.

"The difference between what the patient communicates is being done and what is actually ordered may make a significant difference in the price information and the patient's out-of-pocket responsibility," she says. "Insurance plan identification is also tricky. A patient may understand his or her insurance is through XYZ company, but not understand the importance of the network logo. We have seen insurance cards with over 20 logos. If a patient doesn't know which one applies, it can be difficult to determine over the phone."

In the instance of the "$15,000 stomachache" described earlier, the patient vastly underestimated the scope of service he would receive. Patients are ultimately responsible for asking questions about their health care, but they can't ask questions if they don't know the questions exist. It is incumbent on healthcare providers to give patients the information they need to be able to adjust their expectations before services are delivered.

Payer barriers

Most insurers can provide electronic confirmation of select basic patient profile information, such as scope of coverage or copayments. Pure price transparency requires real-time patient estimate of benefits information; those data are difficult to access and require manual processes, even within the payer organizations. Patient deductible information is a constantly moving target, and most insurance companies simply do not have the infrastructure in place to report that information in real time.

The challenge is compounded by the variability in the age and quality of eligibility information that is available to patients and healthcare providers. Some payers provide information that is relatively old, but detailed; some provide newer, but insufficient, data; and still other payers' information is neither current nor complete. "Providers must go to the payer web site or actually call the payer to get additional information," Watkins says, noting that the process is time-consuming and creates additional administrative burdens for the hospital.

Provider barriers

The hospital may not have accurate information about the specific healthcare services to be provided. Often a physician has not provided the information or the hospital database may not have been updated since the clinical and ordering information was entered by that physician. Hospitals cannot move forward with point-of-service estimating unless they can ensure timely, accurate clinical information is accessible.

Rappuhn notes another, more subjective, barrier. "Some clinical staff may not want pricing transparency because they don't want to discuss pricing with patients," she says. Price transparency requires clinicians to be as exacting in conversation with patients as they are during examination. As consumers bear increasing responsibility for the cost of their care, they will expect increasing clarity about those costs, and providers will likely have to set their discomfort aside in order to make (and justify) specific projections to consumers.

Process barriers

Many manual processes tend to be used when trying to estimate prices in health care. The reason is that often there is not a single point of contact for pricing information.

Physicians are one contact point that subdivides into a labyrinth of fee structures and preferences for medications and supplies, each of which compounds the potential cost variations of a care episode. Differences in charge codes and healthcare discounts (which vary by patient insurance, diagnosis, and income) further confound the development of a productive, manageable preservice pricing system.

Emerging Technologies, Emerging Solutions

Hospitals that are willing to acknowledge the complexity of the challenge and explore new ways of doing business can find a broad spectrum of evolving technology designed to bring price transparency within their reach. Combination databases with algorithms embedded in the software,

One Provider's Experience with Pricing Technology

Atlantic Health is currently working to automate the process of providing price estimates and patient liability estimates for customers prior to services being rendered. This information will be available to patients by accessing the organization's web site and by phone. In addition, hospital registration staff will have access to this information and can request payment of the patient liability prior to services.

"We currently have most of the front-end processes automated, such as patient scheduling, preregistration, address and credit verification, and insurance verification, so this new application fits perfectly into the flow," says Nancy Kaminski, director of patient financial services and patient access at New Jersey-based Atlantic Health.

Below, Kaminski shares some of the highlights of Atlantic Health's experiences in planning and implementing the technology thus far.

Key considerations when weighing investment in the technology… "ROI, degree of user friendliness, ability to improve the revenue cycle, adaptability to changing regulations, and how well it would integrate with the current system."

Primary criteria when choosing the technology over competitors… "The Patient Financial Services team within Atlantic evaluated several vendors in regard to pricing tools/software. The solution we chose offered advanced functionality and was able to integrate with our various other software applications from the vendor."

Process changes that needed to be made as a result of the technology… "We are in the process of expanding our cashiering functions to accommodate more point-of-service collections throughout the facilities. Additionally, registrars are being cross-trained in the area of financial counseling, so they can have financial discussions with our customers."

Biggest benefits resulting from implementation of the technology… "We will see accelerated cash flow and decreased collection expense. Also, consumers will now be able to do price comparisons, which will distinguish us in the market."

Advice to offer CFOs looking to maximize their investments in similar technology… "Try to keep it simple. Look for products that can work off of your existing databases."

consumer-friendly web applications with direct links to insurance carrier web sites, and well-trained customer service call centers can successfully retrofit existing systems for success in the new marketplace.

Watkins is optimistic that emerging technologies such as automated insurance eligibility and benefit verification will make it easier to calculate patient expenses in advance. "The inquiry mimics a real person accessing the payer web site," says Watkins. "More and more providers are abandoning the 270 inquiry transaction and moving to automated access to the payer web site for their major payers. The payer web site provides more complete, and in some cases more up-to-date, information."

On the consumer side, Watkins sees web-based price calculators cascading to the individual level, aimed at consumers who are increasingly aware of and involved with measures to control their healthcare costs. "The new price quote technology is also being introduced as self-service for patients to access via a provider's web site. For simple requests, the patient can obtain a price quote without calling the provider. Of course, if the patient selects the wrong procedure from the list and gets what he or she perceives to be an inaccurate quote, you have a customer service issue to resolve."

Access through provider web sites may hold challenges as well. Some providers may find the Internet too transparent for information as complex and potentially sensitive as price. "By making the functionality available on the provider web site there is also some risk that other providers may inappropriately obtain price quotes for competitive purposes," Watkins cautioned. "Providers need to be careful about how much information is made available and the manner in which it is displayed."

Of course, hospitals don't have to harness the Internet to achieve their price transparency goals. Although web-based systems are the best way for hospitals to consolidate and calculate myriad pieces of data into a meaningful whole, they're not the only way. All providers have historical databases of charge codes and access to internal IT systems that allow them to bill for services, which means that even in a non-web-based system the essential pieces are in place; they're just not all in the same place. Manual data management is staggeringly slow and labor-intensive, but providers who are skittish about the Internet and who have robust administrative resources may choose that approach.

The Business Case

The business case for price transparency can be made on many levels. On a simple level, the benefits extend to healthcare providers as well as to consumers. Providers who are progressive and aggressive in developing preservice pricing protocols can expect a more fluid revenue stream without some of the administrative costs associated with billing patients after care has been delivered. On a higher

April 2007
HFMA Educational Report

OUR SPONSOR SPEAKS

Maximizing Pricing IT Investments

Jim Morrison, vice president, Product Management, Revenue Cycle Solutions, McKesson Corporation, describes steps organizations can take in developing a technology strategy that supports price transparency.

Q What advice would you offer to CFOs looking to maximize investments in technology related to determining patient financial responsibility?

A Three key steps in determining a technology strategy for pricing transparency are assess the community, assess current processes, and assess current technologies. First, consider that consumerism and the increasing uninsured population are affecting each community differently. Analyze the organization by trending bad debt, charity care, and up-front collections as a percentage of net revenues. Determine whether these numbers are increasing or staying relatively constant. Also, consider the volumes of consumer pricing requests. Are these calls increasing at a rapid rate, or are calls received rarely? Finally, analyze the competitive landscape of your service area. These factors will help you to determine the benefits of providing transparent information.

The second step is to assess the current process for determining patient financial responsibility. Process changes need to be considered along with new technology initiatives. Key items to consider include:

- Which departments are involved in estimating patient financial responsibility?
- Is the patient out-of-pocket estimate process well defined?
- Is the process a manual process or are there tools available to expedite the process?

Last, assess the technology currently available within the organization. Is a contract management system being utilized? Is an insurance eligibility system available? If so, a number of vendors, including McKesson, are offering ways in which these solutions can be leveraged to provide an accurate out-of-pocket estimate with minimal cost and effort to the organization. These three assessments will help address where efforts will need to be concentrated for maximum impact of a technology solution.

Source: McKesson Corporation.

level, proactive providers may also find that they have a competitive edge in the marketplace when compared with providers who do not provide price transparency. When consumers become aware that some hospitals provide out-of-pocket estimates in advance, those that are unwilling or unable to provide such information may be eliminated from consumer consideration altogether.

Rappuhn notes some inroads already are being made. "It is difficult to give patients meaningful price information, but there are providers who have been doing it successfully for years," she says. "They believe that the benefits greatly exceed the cost and effort required to provide estimates to patients."

About HFMA Educational Reports

HFMA is the nation's leading membership organization for more than 33,000 healthcare financial management professionals employed by hospitals, integrated delivery systems, and other organizations. HFMA's purpose is to define, realize, and advance the financial management of health care. HFMA Educational Reports are funded through sponsorships with leading solution providers. For more information, call 1-800-252-HFMA, ext. 330.

Getting Started

The move toward price transparency begins with a philosophical shift in the provider-patient relationship. Providers need to get comfortable with a higher degree of patient inquiry about the specific costs associated with specific services. "Start with defensible pricing—prices that are logical and that you can explain," advises Rappuhn. "You can start small, with one type of service such as imaging, or with those patients who proactively contact you to ask for pricing information. As you learn from your initial efforts, you can expand to other areas."

Watkins emphasizes the importance of an interdisciplinary approach to developing and managing price transparency protocols. "Individuals from patient financial services, health information management, managed care contracting, and IT must all work together to understand exactly how the technology solution supports meaningful pricing," she says. "A clear understanding of how the technology solution works and options for how it is set up must be understood by a representative from each area that may provide patient care."

The benefits to hospitals of price transparency are clear. It remains to be seen which hospitals will embrace the opportunity and aggressively pursue the technology and culture changes that price transparency demands, which ones will eschew the perceived risks of early adoption and follow sometime later, and which ones will be dragged along kicking and screaming. Eventually, price transparency will be the standard, and the patient who experiences a post-service case of "$15,000 stomachache" sticker shock will be relegated to the past.