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Consumer-Directed Health Care

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Preparing for Pay for Performance: The Executive's Role

The connection between high quality and lower healthcare costs is no longer theoretical. Results of the CMS/Premier Pay-for-Performance Demonstration, which were released in August, conclusively show what quality advocates have preached in the past: Strict adherence to evidence-driven hospital care protocols not only improves clinical outcomes, it also lowers overall system costs.

These findings multiply the financial advantage that hospitals with comprehensive quality improvement programs stand to gain under the Centers for Medicare and Medicare Service's pay-for-performance program, now slated to begin in FY09.

Findings from the CMS/ Premier project multiply the financial advantage that hospitals with comprehensive quality improvement programs stand to gain under the Centers for Medicare and Medicare Service's pay-for-performance program, now slated to begin in FY09.

While quality improvement requires active involvement of medical staff and other clinical personnel, it also requires extensive administrative support. Hospital executives play a central role in creating the conditions required for successful implementation of care protocols, says Denise Remus, PhD, RN, vice president for clinical informatics at hospital alliance Premier, Inc.

"For evidence-based processes to be used, every one in the hospital must be aware of them, and all the equipment and processes must be in place," Remus says. "This can only happen in a culture that makes quality measurement and improvement a priority." Below Remus shares steps that executives can take to improve hospital performance.

☑ Get the Board on Board

Board-level support is essential to communicate quality improvement as an organizational goal, and to create accountability for achieving it. Remus notes that at least one hospital board in the CMS/Premier project promised executives bonuses if they could demonstrate that their facilities were performing all of the project's evidence-based care processes frequently enough to fall within the top 20 percent of

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participating organizations (which is the threshold for earning extra payments from Medicare under the proposed CMS pay-for-performance reward structure).

☑ Spread the Word to Hospital Staff

Articulating the clinical and financial importance of adopting evidence-driven practice helps establish a quality improvement culture. One idea: Incorporate pay-for-performance goals into individual performance evaluation criteria for both supervisors and line employees.

☑ Make Resources Available for Improving Care Processes

Executive support is crucial to free resources that address administrative barriers that prevent clinicians from complying with evidenced-based protocols. For example, providing runners to deliver lab tests can have a huge impact on the ability of clinicians to shorten lab turnaround times and provide care in a timely fashion. Even something as simple as posting reminder signs in the operating room helped clinicians comply with one of the demonstration project's protocols: administration of prophylactic antibiotics within an hour of surgery.

Providing targeted resources also reinforces a cultural commitment to quality improvement.

Executive sponsorship of "rapid improvement plans" that implement clinical protocols on an experimental basis—without going through a lengthy medical staff approval process—can help demonstrate the value of evidence-based practices to physicians.

☑ Exercise Clout with Medical Staff

As much as quality improvement is a team effort, physicians play a key role. Executive recognition of physicians who support quality improvement—and frank discussions with those who don't—can increase medical staff participation. "We need to talk to physicians who don't use the evidence-based processes. We need to tell them we support your clinical decisions, but we want all patients to get this proven standard of care," Remus says.

Executive sponsorship of "rapid improvement plans" that implement clinical protocols on an experimental basis—without going through a lengthy medical staff approval process—can help demonstrate the value of evidence-based practices to physicians. Executive support also can be instrumental in adopting evidence-based standing orders, which nurse and emergency department staff can implement without an order from a physician specialist.

☑ Spread the Word to Patients

Community outreach also has a role, Remus says. For example, a hospital that wants to increase the use of prophylactic antibiotics before surgery might consider publicizing this evidence-based practice to patients. Advise surgery patients to ask their physicians about prophylactic antibiotics via advertising or in targeted patient education, such as a list of questions to ask before surgery that is posted on the hospital's web site and mailed out in pre-registration materials.

"When every patient knows they should receive antibiotics an hour before surgery and they ask about it, it will happen," Remus says.

☑ Support the Sharing of Best Practices Among Institutions

Process improvement is more than an internal process. It also requires sharing of best practices among institutions. Executive staff must make resources available for conferences, user groups, and other knowledge-sharing functions.

Remus stresses the need for cooperation among hospitals—rather than competition. The CMS/Premier study results call into question whether rewarding only those in the top 20 percent of performers (as CMS proposes) makes sense. Remus believes establishing a performance threshold, and giving hospitals the tools they need to meet that goal might be a better approach.

"Quality of care should not be a competition. All hospitals have opportunities for improvement, and we do it by sharing information and processes," she says.

For more information about the CMS/Premier Pay-for-Performance Demonstration, contact Denise Remus, PhD, RN, vice president for clinical informatics at hospital alliance Premier, Inc. (denise_remus@premierinc.com). You can also visit www.qualitydemo.com.

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About the CMS/Premier Demonstration Project

Goal: Evaluate the validity of adopting a pay-for-performance approach to hospital reimbursement based on adherence to evidence-based hospital care processes.

Participants: More than 250 hospitals across the country.

Method: Measure the use of 33 evidence-based care processes in the treatment of acute myocardial infarction (heart attack), heart failure, pneumonia, coronary artery bypass graft, and hip/knee replacement. Example protocols include:

> Giving heart attack patients aspirin within 24 hours before or after hospital arrival
> Providing percutaneous coronary intervention to heart attack patients within 90 minutes after they arrive at the hospital
> Administering an initial antibiotic regimen to immunocompetent, non-intensive care patients with community-acquired pneumonia during the first 24 hours of care
> Counseling pneumonia patients about smoking cessation during their hospital stay

The 33 evidence-based measures were developed by government and private organizations, including the Joint Commission on Accreditation of Healthcare Organizations and The Leapfrog Group. For more details, visit www.qualitydemo.com.

Pay-for-performance model: Participating hospitals receive larger or smaller Medicare payments based on their compliance with the 33 evidence-based protocols. Hospitals that perform in the top two deciles receive a payment bonus. Beginning in the third year of the project, hospitals that perform below the adjusted payment threshold in any of the five clinical focus areas receive a penalty on their Medicare payments.

Results: U.S. hospital costs could have been as much as $1.35 billion lower in 2004 if caregivers across the nation had achieved at least 76 percent compliance with the evidence-based practices used in the CMS/Premier demonstration project. Wider adoption of all the quality measures could also have prevented 5,700 deaths, 8,100 complications, 10,000 readmissions, and 750,000 fewer days in the hospital.

Key learning: Quality improvement works best when hospitals share best practices. Compliance with measured processes increased sharply as a result of knowledge-transfer meetings among participants. A pay-for-performance model that forces hospitals to compete for rewards may inhibit knowledge transfer that benefits all.

Next steps: Refine outcome measures in the five clinician conditions that the pilot focused on, and add measures for other conditions. Consider changing the pay-for-performance model to establish a performance reward threshold for all to meet, instead of limiting rewards to only the top performers.

For more information, visit www.premierinc.com/p4p/press.

British Physicians Are So Good They Strain Pay-for-Performance Budget

General practitioners in the United Kingdom greatly exceeded performance expectations in the first year of an ambitious pay-for-performance plan, earning bonuses that cost the National Health Service about $700 million more than anticipated, according to coverage in *Health Affairs*.

In the first year of the program, which began in April 2004, general practitioners scored 91 percent compliance with 146 quality measures established under the Quality Outcomes Framework. Under the program, general practitioners can earn bonuses of up to 30 percent of salary based on performance.

NHS local health authorities expressed surprise at the level of compliance and dismay at the unbudgeted overrun. General practitioners countered that care has always been better than people have realized, and the numbers bear that out.

For more information, read the *Health Affairs* article "Pay-For-Performance: Too Much Of A Good Thing? A Conversation with Martin Roland" at www.contenthealthaffairs.org.

Almost 40 Percent of Americans Would Shop for Health Care, if They Could

A study by CDHP provider Discovery Health found that 10 percent of survey respondents would be "extremely likely," and 29 percent "very likely" to shop around for medical services—if they could obtain information on the prices and quality of physicians and hospitals.

The national survey of 1,000 consumers also found that respondents on average spent twice as much time researching cars and computers as finding a physician. Responses averaged 20 days of research on the household purchase and only 9.7 days on the doctor. Destiny believes these numbers will improve as more consumers receive both financial incentives and information on provider cost and performance.

For more information, view the press release at http://destinyhealth.mediaroom.com/index.php?s=press_releases&item=45.

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Families Troubled by Healthcare Costs

About half of middle-income families reported serious problems in paying for their health care, according to a study by The Commonwealth Fund. Even more affluent families said they had troubles with medical bills:

- For families earning $35,000 to $49,999, 48 percent reported trouble paying medical bills in the last two years, and 50 percent had difficulties affording health insurance.
- For families earning $50,000 to $74,999, 33 percent said they had trouble paying for medical bills, and 35 percent reported difficulty paying for health insurance.
- For families earning $75,000 or more, 21 percent reported trouble paying medical bills, and 23 percent had trouble paying for insurance.

The study also found that 48 percent of those surveyed worried that wouldn't be able to pay their medical bills in the event of a serious illness, regardless of their income.

For more information, download a pdf of the Commonwealth report at www.cmwf.org/usr_doc/Collins_squeezedrisinghltcarecosts_953.pdf.

Cancer Hospital Chain Is Banking on CDHC to Fuel Its Expansion

Cancer Treatment Centers of America is hoping the consumer-directed healthcare movement will fuel its planned expansion, believing that patients will opt for facilities that offer conventional as well as alternative cancer treatments, reports the *Chicago Tribune*.

Ninety-five percent of CTCA's business consists of patient self-referrals. The privately owned company spends $35 million annually on direct-to-consumer advertising and offers such patient amenities as organic food, massage, and vitamin therapies. "At most organizations, the doctor is the center of the healthcare system and that is not the case here," Edgar Staren, CTCA's chief medical officer, told the *Tribune*.

CTCA currently has three cancer hospitals in Zion, Ill.; Tulsa, Okla.; and Philadelphia, and has submitted a proposal to build a $76 million hospi-

A Hole in the Consumer-Directed Approach?

Most healthcare costs are incurred by people who are very ill, often in emergencies, when "shopping" for price and quality are not an option

10%

The percentage of the sickest patients who account for about 70 percent of all healthcare spending

Source: S. R. Collins, *Health Savings Accounts and High-Deductible Health Plans: Why They Won't Cure What Ails U.S. Health Care*, Invited Testimony, Committee on Finance, Subcommittee on Health, United States Senate Hearing on "Health Savings Accounts," September 26, 2006.

tal in the Seattle suburb of Kent, while looking for additional sites in the Southeast and Southwest.

For more information, read the *Chicago Tribune* article "Mother Standard Guides Cancer Care as Alternative Approach Gains Favor, Patients Make More Choices" (www.chicagotribune.com).

Replace Medicare Payment System with a Pay-for-Performance Approach, Urges IOM Report

Because Medicare's current fee-for-service payment system apparently does little to promote improvements in the quality of health care, the Department of Health and Human Services should gradually replace it with a new pay-for-performance system for reimbursing participating healthcare providers, says a new report from the Institute of Medicine.

The report recommends that, for an initial period of three to five years, Congress should reduce base Medicare payments across the board and use the money to fund rewards for strong performance. At the same time, efforts should be made to evaluate other ways to fund bonus payments that could be used longer term. Healthcare providers and organizations that already have the capacity to begin participating in the pay-for-performance system should be required to do so as soon as it is launched. But participation by small physician practices should be voluntary for the first three years, at which time the HHS secretary should decide whether to implement broader mandatory participation.

The committee deferred to Congress to determine how much to decrease Medicare base payments to create a pool of funds for bonus payments, but it suggested that Congress may have to appropriate new funds to ensure that the rewards pool is sufficient. Using savings generated by improved efficiency and cost-reducing reforms has great potential to sustain the rewards pool, said the committee, and it urged CMS to test ways to make this funding source work. To increase the likelihood of participation by healthcare providers, the program should reward those who improve their performance significantly as well as those who meet or exceed designated thresholds of excellence.

You can obtain the IOM report, *Rewarding Provider Performance: Aligning Incentives in Medicare*, at www.iom.edu.

Health Coaches for Elderly Patients Reduce Hospital Costs

A study published in the September 25 issue of *Archives of Internal Medicine* found that 8 percent of elderly patients assigned a health coach following a hospitalization were readmitted after 30 days. In comparison, 12 percent of elderly patients without a coach were readmitted. After six months, 9 percent of those with a coach were readmitted, versus 14 percent of the control group.

Hospital costs were $2,058 for those with a coach, compared with $2,546 for those without at six months.

The Centers for Medicare and Medicaid Services is conducting a three-year demonstration project to provide coaching to 115,000 Medicare patients who have heart failure or diabetes after discharge from the hospital, with results expected next summer.

For more information, read "The Care Transitions Intervention. Results of a Randomized Controlled Trial" in the September 25 issue of *Archives of Internal Medicine* (http://archinte.ama-assn.org/).

Quality Differences Between Highest- and Lowest-Performing Hospitals Widen

A typical patient, on average, has a 69 percent lower chance of dying at the nation's five-star-rated hospitals compared with the one-star hospitals, according to the *Ninth Annual HealthGrades Hospital Quality in America Study*. This "quality chasm" between the highest- and lowest-performing hospitals has grown by approximately 5 percent since last year's study, even as overall mortality rates have improved by nearly 8 percent.

The study, which analyzed 40.6 million Medicare hospitalization records from 2003 to 2005, claims that 302,403 Medicare lives could have been saved during that time period if all hospitals performed at the quality level of top-rated hospitals across the 18 procedures and diagnoses studied. Fifty percent of the potentially preventable deaths were associated with four diagnoses: heart failure, community-acquired pneumonia, sepsis, and respiratory failure.

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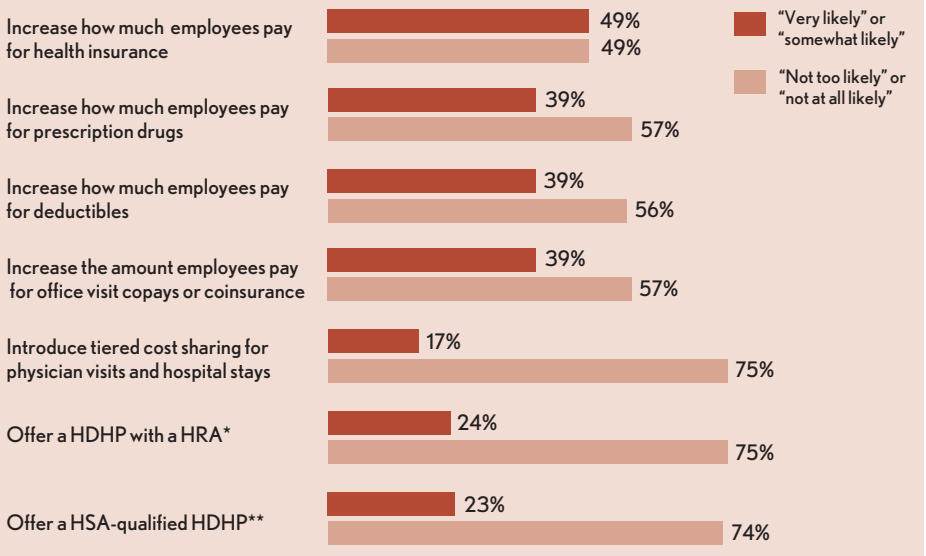
How Do Employers Plan on Sharing Healthcare Costs with Employees?



* This is among firms not currently offering a high-deductible health plan with a health reimbursement account.
* *This is among firms not currently offering a health savings account-eligible HDHP

Source: "Employee Health Benefits 2006 Annual Survey." The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, September 2006. Reprinted with permission. .

A recent survey by Kaiser/HRET revealed that U.S. firms that currently offer health benefits plan to share healthcare costs in various ways with employees in 2006. Offering a high-deductible health plan with some type of health savings account is only one option.

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According to the study, five-star-rated hospitals improved their risk-adjusted mortality rates over three years by 19 percent more than the U.S. hospital average, and 57 percent more than one-star-rated hospitals.

For more information, visit HealthGrades at www.healthgrades.com.

Americans Don't Use Quality Data for Decision Making, Says Survey

Although Americans have developed a better understanding of medical errors over the past two years, they haven't made gains in using quality data to make decisions about their care, according to a new survey by the Kaiser Family Foundation and the U.S. Agency for Healthcare Research and Quality.

Fifty-five percent of Americans who responded said they understand what the term "medical error" means. This is up from 43 percent in 2004, and 31 percent in 2002. Also, 43 percent said they believe preventable medical errors occur somewhat or very often.

Thirty-six percent of those polled said they've seen information that compares the quality of care from health plans, physicians, and hospitals, but only 20 percent say they've used it to make healthcare decisions. These numbers are unchanged from the previous survey, conducted in 2004.

The newest poll, a telephone survey of 1,216 adults conducted in early August, showed that Americans take some measures to reduce errors and improve coordination of care:

> Seventy percent said they check medication they get from a pharmacist against their physician's prescription

> Fifty-four percent said they bring a list of their medications to a physician appointment

> Forty-five percent bring a friend or relative to help ask questions during a physician appointment

Physicians' 24-hour Emergency Facility to Compete with Hospital EDs

Three Houston physicians have created a 24-hour freestanding emergency care facility with all the services of a hospital emergency department but at a fraction of the wait, reports the *Houston Business Journal*.

When the $9 million Emergency Health Centre at Willowbrook opens in March, patients will receive a promise that they will be seen by a physician within 30 minutes and that they will stay in the facility no longer than 90 minutes. Patients can also preregister at the facility to save time, so that a swipe of a card can instantly deliver a medical history and insurance information.

Eight emergency physicians, four nurse practitioners, a radiologist, and a lab director will staff the facility, which is expected to treat 60 to 90 patients a day. Unlike most of the other 20 freestanding emergency facilities that will populate the Houston area in the next few months, Emergency Health Centre distinguishes itself by keeping the same hours that hospital EDs do. The facility, however, will not accept Medicare patients, and it is positioning itself as an upscale emergency care center with valet parking and gourmet coffee. The physicians say they have plans to open as many as 20 more centers in the next three years if the model is successful.

For more information, read "Unique Emergency Center to Deliver the Rush" in *Houston Business Journal* at www.bizjournals.com/houston.

"Health care is said to be different from other markets, but the difference that really jumps out is that we are unwilling to let people go without these services just because they can't pay. The solution is equally obvious, if easier said than done efficiently: provide subsidies to those who can't afford care."

— Holman W. Jenkins, "Consumer Theory Isn't Cure-All," *Wall Street Journal*, September 20, 2006

"Some people just like the convenience of one-stop shopping. They like the fact that their medical group keeps a complete electronic health record and that their primary care physicians talk about them with their specialists in the group, and they consider that the doctors can and do produce the desired outcome. Some small and uncertain gains in results might just not be worth traveling for."

— Alain Enthoven on why multi-specialty providers will remain competitive, *Health Affairs* Blog, October 11, 2006

"You'd better hope you don't get sick, because you won't be able to afford medical care"

— Rep. Pete Stark, California Democrat, responding to party-line vote in House Ways and Means Committee to increase health savings account deductible and contribution limits

Insurers' Revenue from CDHPs Is Low, But Growing

97%

Percentage of HMO and PPO respondents that currently offer—or plan to offer—a high-deductible health plan with a health savings account

3.6%

Percentage of premium revenue coming from consumer-directed health plans in 2006, per HMO and PPO respondents

5.1%

Percentage of premium revenue expected from CDHPs in 2007

72%

Percentage of HMO and PPO respondents that currently offer, or plan to offer, quality information on providers

50%

Percentage that plan to share hospital and physician pricing information

Source: *Milliman 2006 Group Health Insurance Survey* (www.milliman.com)

Hewitt Helps Corporations Roll Out Consumer-Directed Plans

Who: Hewitt Associates, in Lincolnshire, Ill., is a benefits consulting company serving more than 2,500 businesses with 20 million employees and retirees in 35 countries, including more than half of the Fortune 500 companies in the United States.

Consumer-Directed Strategy: Hewitt bills itself as a firm that provides value to corporations by maximizing the value derived from investments in employee benefits and human resources. Hewitt is helping corporations negotiate for and roll out consumer-directed health plans to employees in order to help slow health benefit cost growth.

Recent Success Story: Hewitt helped Owens-Corning roll out two new consumer-directed health plan options to employees, a strategy that was projected to trim a $100 million increase in benefit costs. Hewitt worked with Owens-Corning management to shape a positive message about consumer-directed plans. Employees were invited to engage with leadership in tackling the health-care cost problem together, through a commitment to quality and joint financial responsibility.

A provider network was set up offering rates 10 percent below other plans. The rollout also involved supplying effective communication materials, including online health plan decision-making tools. As a result of the effort, 71 percent of Owens-Corning employees enrolled in two high-deductible options, rather than preferred provider organizations and health maintenance organizations—exceeding the 50 percent target Owens-Corning needed to reach financial goals.

Market Impact: Well-executed introduction of consumer-directed plans by major corporations could sharply accelerate penetration of these plans. Continuing financial success and employee acceptance at large firms will move the concept into the mainstream.

The Bottom Line: Human resources consultants like Hewitt are thought leaders for corporate America's health benefit policies. Organizations that work with such firms may gain a market advantage in contracting for future business.

For More Information:
Visit www.hewittassociates.com.

Managing Patients' Sticker Shock

For years most patients fell into two major financial categories: those who paid their bills because their insurance covered almost everything, and those who did not because they had no insurance and couldn't afford the full price of care. Telling them apart was usually no more complicated than asking for an insurance card.

With the emergence of consumer-directed health plans, hospitals now face a third group: patients with high-deductible insurance plans. While some patients will pay deductibles and co-payments ranging up to $10,000 without question, many will resist for a variety of reasons, says Allan P. DeKaye, a patient accounts management consultant based in Oceanside, N.Y.

"They've got sticker shock. They've never seen bills like this from the hospital before. It changes the payment dynamic."

One goal of consumer-directed health plans is to control costs by giving patients economic "skin in the game." However, healthcare professionals need to be sensitive to the significant difference that consumers will experience under such plans. Not only are many consumers facing larger deductibles and co-pays, some may not even realize the type of coverage they have, which makes the deductible or co-pay an even bigger shock. Healthcare providers are very concerned that such health plans not result in patients avoiding necessary treatment. Yet they also need to be sure that they take appropriate steps to secure payment that is due. And that requires understanding a patient's likelihood of paying or not paying a healthcare bill.

Identifying Who Will Pay

Telling good payment risks from poor payment risks among this rapidly growing category of high-deductible patients is more complicated than just checking insurance status. But it can and should be done, DeKaye and others say.

If you know in advance how likely each patient is to pay, you can tailor your limited staff resources so that their actions are best suited to the patient's ability or willingness to pay. In particular, staff may need to be refocused from collecting after an invoice is mailed to working with patients at the point of service.

Credit companies routinely consult FICO scores showing propensity to pay consumer bills. But FICO scores don't apply to health care because "patients pay medical bills considerably differently than they pay credit or car bills," says Bruce Nelson, vice president of sales and marketing at SearchAmerica in Maple Grove, Minn..

In addition to FICO scores, a history of medical payments and any history of bad debt or payment delays at the institution can be helpful in predicting patient payment behavior, Nelson says. For a fee, credit reporting agencies provide credit scores just for medical payments. Patient payment history at other healthcare institutions may also be highly relevant. Pooled data is increasingly available through regional health information organizations.

A FICO Score Isn't Enough

Commercial credit scores don't necessarily tell who will pay their hospital bill. In addition to FICO scores, revenue cycle experts suggest looking at the following to help determine a patient's healthcare credit risk:

Previous bad debt at your hospital. This red flag should not be ignored. Experts recommend that you collect previous debt before treatment, and get a deposit covering the current out-of-pocket estimate.

Payment history at your facility. If your collection experience with a patient includes delinquencies, they are a high credit risk regardless of FICO score. Experts recommend that you get a deposit.

Healthcare payment history in general. Regional health information systems may be able to provide you with a patient's payment history outside your system. If other providers have had trouble, you likely will too. Once again, experts recommend that you get a deposit.

Patient liability relative to income. Even middle-income patients with good credit may have trouble coming up with $5,000 to $10,000 out of pocket. They're simply not used to taking on that much unplanned debt. Experts say that these patients may need your assistance accessing credit or establishing a payment plan.

Severity of illness. Patients disabled by illness or injury may not be able to pay their bills even if they have a good credit history. Experts remind us that patients with catastrophic conditions may need assistance accessing disability or public benefits.

This information can be analyzed using an algorithm that can predict healthcare payment behavior with 98 percent accuracy, Nelson says. He advises sorting patients into three groups: the "green lights," who are very likely to pay their bill, the "red lights," who probably won't pay, and the "yellow lights," who will need some additional communication before they will pay.

Different Methods for Different Risks

Experts interviewed suggested you don't have to worry much about the green light patients, though you'll always collect sooner and at lower cost if you ask for payment at the time of service. But if you have to bill later, you're probably OK.

You may need to request up-front payment from patients in the yellow group. They probably have resources, but you're more likely to persuade them to pay if you politely insist before the time of service. Ask *how* they would like to pay, not if they would like to pay.

Patients at high risk of default often require a more thoughtful approach, Nelson says. One place to start is with a credit search. If the patient gives permission, credit card companies will report the remaining credit that the patient carries. Nelson says staff can then say, "The balance comes to $300. I see you will be able to pay that with your Visa card." In some cases, the patient may not even know they have available credit.

Nelson emphasizes that staff must take action on the spot, before or during the time of service, and not later when they owe money, because "patients are much more cooperative than debtors."

Estimates for All

All patients are more likely to pay their bills on time if they know in advance approximately what the charge will be. "Staff will need to ask for considerably larger sums, and patients will need to be prepared to pay these amounts," DeKaye says.

Providers can often be successful simply by relocating existing staff. Staff devoted to following up on accounts can be retrained to gather and verify information for incoming patients. Intake staff can be trained to collect from patients and find payment options for those who are poor credit risks.

To do this, staff will need to have an accurate picture of just how much the patient needs to pay, which can be complicated by factors such as figuring out how much of the deductible still remains unpaid.

Then, when asking the patient to pay, staff also need to know such things as how much is in the patient's health savings account or their credit card account, DeKaye says.

Ray Shealy, president and CEO of HTP Inc. in Columbus, Ohio, advises hospitals to estimate bills upfront and go over payment arrangements with all patients. "A lot of hospitals do not have staff sit down with patients and go over payments, except for the very expensive procedures like hip replacements," he says.

"At preregistration or registration, staff should go through a simple interview and check with the insurance company in real time," he says. Through verification software, providers can connect directly with all insurers doing business with them.

"Let's say the insurer indicates that the patient has a $5,000 deductible and has only met $1,000 of it to date, and he also has a 20 percent coinsurance payment," Shealy says. "Then staff can tell him he will owe so-and-so much out of pocket. Shining a bright light on the bill can increase patient satisfaction. When they have an estimate, patients don't feel like they have been taken."

Once the amount owed is known, "you find out very quickly if the patient will pay," Shealy says. But without staff doing the legwork, the bills might never be paid, he adds.

Invest in Technology and Process Changes

It may seem that this extra work will require more staff, but Nelson says providers often can be successful simply by reallocating existing staff. Staff devoted to following up on accounts can be retrained to gather and verify information for incoming patients. Intake staff can be trained to collect from patients and find payment options for those who are poor credit risks. Analyzing credit risk also helps staff across the board focus their efforts on patients and accounts that require additional help, rather than giving equal attention to all accounts, he says.

Once staff have the proper data and workflow, Nelson says they can greatly reduce bad debt. He maintains that his company has saved hospitals at the 250-bed level millions of dollars in this way.

He also stresses the need to automate data collection from insurers, credit agencies, and others. Otherwise, staff will simply be overwhelmed.

"Any hospital that takes on a lot of self-pay patients without the proper technology is going to fail," he says. "It's like that episode of the 'I Love Lucy' show, where Lucy is working on the conveyor belt and it just keeps going faster and faster."

Fixed-Price Packages Could Create Marketing Edge

Fixed-price service packages tailored to specific patient preferences could gain popularity and offer a marketing advantage in light of emerging market forces, says Anthony Cirillo, CHE, president of Fast Forward Marketing Consulting in Huntersville, NC. Some foreign hospitals are already taking this approach to grab a piece of the lucrative, but increasingly price-sensitive, U.S. healthcare market.

What is the biggest challenge hospitals face in communicating pricing and value information?

Cirillo: The biggest challenge is providing an all-inclusive price for a package of services. Without that, consumers really don't know what they are paying for or what they are getting, so it is difficult to make a value judgment. To provide a true, all-inclusive price you need to rein in the entire organization, including physician charges. There are some hospitals overseas that are doing it. Take a look at Bumrungrad Hospital in Thailand (www.bumrungrad.com), which is accredited by the Joint Commission on Accreditation of Healthcare Organizations. Bumrungrad markets all-in-one packages for cardiac, obstetric, and cosmetic surgery directly to foreigners—and quite successfully. Price is just part of Bumrungrad's success. The level of service offered, including personal concierge service before you enter the country, sets them apart as well.

It will be much more difficult for U.S. hospitals to get physicians on board to create service packages because our mind-set about clinical independence is so different. For one thing, the notion of malpractice liability is completely different here. It is literally nonexistent overseas and that, in part, is why prices are so low.

So, what makes you think U.S. hospitals will need to offer packages that include physician services?

Cirillo: The market is really changing. We are seeing more higher-income people self-selecting consumer-directed and other high-deductible plans. Some opt for catastrophic insurance only, choosing to pay for routine care. These are people who shop for services based on perceived value.

It used to be that most of the charges that patients paid before hitting their deductible limit were for physician services, but the higher deductibles are starting to impinge on major procedures. The higher deductibles go, the more hospitals will have to compete based on value, and they will have to bring physicians into the package to make it work.

How do you deal with the problem of predicting what services will be used in a given encounter?

Cirillo: Not all services are defined in terms of treating an acute illness. Preventive services, such as comprehensive check ups, are a good example. Preventive services are defined in scope, and they have the added advantage of creating a logical entry point into the healthcare system. This gives you an opportunity to create relationships with patients before they have a major medical need.

The key is value, not price. And value is defined by the needs and desires of consumers.

As far as acute care services go, it's impossible to know with certainty when complications will arise that will increase costs. But you can still quote a price for a typical package of services with the caveat that additional services may be required and will be charged.

Does this mean that healthcare marketing will become a race based on price?

Cirillo: No. The key is value, not price. And value is defined by the needs and desires of consumers. People will be willing to pay more for a package of services that meets their needs. Starbucks can charge so much because the company offers a range of products and an experience based on asking customers what they want and delivering it.

Again, some foreign hospitals are out in front on this. The Apollo Hospitals chain in India offers lodging alternatives ranging from a standard semi-private room at the equivalent of about $275 per day to a VIP suite for about $1,500. Bumrungrad advertises recuperating on the beach in Thailand for $140 a night, so there is a vacation aspect to it as well.

We are starting to see self-funded plans looking outside the United States for services, and even offering employees bonuses to travel abroad for high-end procedures. If U.S. hospitals want to compete on that basis, they will have to pay much more attention to what drives consumer purchasing decisions, and develop service packages that deliver.

Anthony Cirillo, CHE, is president of Fast Forward Marketing Consulting in Huntersville, NC (Anthony@4wardfast.com).

Key Performance Indicators for the Evolving Customer-Focused Revenue Cycle

As patient out-of-pocket payments rise, revenue cycle managers need to shift their focus from billing insurers on the back end to collecting from patients on the front end. Here are some key performance indicators for monitoring emerging patient-focused financial processes.

Pre-registration and Pre-authorization Pre-registration is a key step for financially screening, educating, and collecting from patients. Key goals include accurate data collection, consistency in determining insurance coverage, applying financial assistance standards, and following upfront collections best practices.

Key Performance Indicator	Standard
Overall pre-registration rate for scheduled patients	≥95%
Overall insurance verification rate of pre-registered patients	≥95%
Deposit request rate for co-pays and deductibles	≥95%
Deposit request rate for elective admissions/procedures	100%
Deposit request rate for prior unpaid balances	≥95%
Data quality compared to pre-established department standards	≥98%

Insurance Verification

Insurance verification with high-deductible plans requires estimating the deductible still outstanding and the impact of co-payments and services not subject to the deductible. The goal is accurately determining patient liabilities to educate the patient and collect at the time of service or before discharge, when possible.

Key Performance Indicator	Standard
Overall insurance verification rate of scheduled patients	≥95%
Overall insurance verification rate of pre-registered patients	≥95%
Insurance verification rate of unscheduled inpatients within one business day	≥95%
Insurance verification rate of high-dollar outpatients within one business day	≥95%
Data quality compared to pre-established department standards	≥98%

Patient Access/Registration The amount of time patients spend registering—and waiting to register—is a key to patient satisfaction

Key Performance Indicator	Standard
Average registration interview duration	≤10 minutes
Average patient wait time	≤10 minutes
Average inpatient registrations per registrar/per shift	35
Average outpatient registrations per registrar/per shift	40
Average emergency department registrations per registrar/per shift	40
Data quality compared to pre-established department standards	≥98%
Advanced Beneficiary Notices and Medicare Secondary Payer Questionnaires obtained when required	100%
Master patient index duplicates created daily as a percentage of total registrations	≤1%

Patient Financial Counseling Many patients need help to finance higher out-of-pocket costs. The goal is to identify those needing financial assistance or credit counseling, and to collect where possible. Performance standards vary from 100 percent for elective services to whatever can be reasonably attained for emergency patients and unscheduled inpatients. Tracking performance will help set reasonable goals and improve performance.

Key Performance Indicator	Standard
Collection of elective services deposits prior to service	100%
Collection of inpatient patient pay balances prior to discharge	≥65%
Collection of outpatient patient pay balances prior to service	≥75%
Collection of emergency department patient pay balances prior to departure	≥50%
Screening of uninsured inpatients and high-balance outpatients for financial assistance	≥95%
Payment arrangements for non-charity eligible inpatients/high-balance outpatients	≥95%
Prompt payment discount percentage(s)	5-20%

The key performance indicators were provided by David Hammer, vice president, revenue cycle solutions, McKesson Provider Technologies (David.Hammer@McKesson.com).

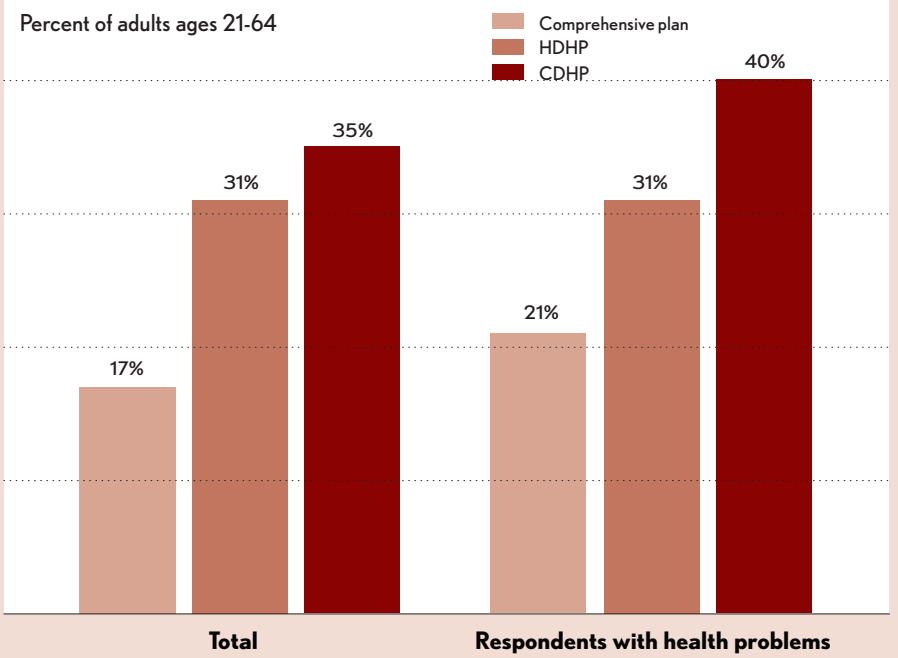
How Are High-Deductible Plans Influencing Healthcare Purchasing Patterns?

It seems like a natural outcome of increased cost sharing: Many patients might think twice about going to the emergency department, filling a prescription, or getting a CT scan if they can't afford their deductible or co-insurance.

But is this really happening? More importantly, are patients in high-deductible plans forgoing care they really need—or just unnecessary care? In addition, how are high-deductible plans influencing the healthcare services that patients seek out?

Experts cannot yet offer definitive answers to these questions. Study findings vary. However, early research offers a glimpse into what might happen as high-deductible plans gain a foothold in the market.

Some Research Shows CDHP Members Delay or Avoid Care*



* Comprehensive plans had deductibles <$1,000 (individual) or <$2,000 (family); high-deductible health plans had deductibles ≥ $1,000 (individual) or ≥$2,000 (family); consumer-directed health plans include a savings account and a high deductible.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

More food for thought: Forty-eight percent of CDHP members surveyed with an annual income less than $50,000 said they had delayed or avoided care due to cost. In comparison only 26% of lower-income respondents with comprehensive health insurance waited to get care because they didn't have the money to pay.

Could CDHPs Affect Acute Care Services?

A UnitedHealth Group study compared healthcare behaviors of 40,000 people in high-deductible, consumer-directed health plans to about 15,000 members of preferred provider organizations between 2003 and 2005

22%

Fewer hospital admissions among CDHP members than PPO members without adverse health effects

14%

Fewer emergency room visits among CDHP members than PPO members without adverse health effects

Source: UnitedHealthGroup (NYSE:UNH), 2005

Preventive Care Usage Tends to Go Up

Early research suggests that CDHP members are as—or more—likely to get annual check ups, mammograms, prostate exams, and other preventive care. Many CDHPs offer various financial incentives that encourage patients to stay on top of health prevention.

60%

Percentage of employees in high-deductible plans with health reimbursement accounts who had some preventive services paid for before their deductibles were met

5%

More CDHP members than PPO members sought out preventive care services over a three-year period

25%

More CDHP members were likely to engage in healthy behaviors than those with traditional health insurance

Over 20%

More CDHP members were likely to participate in company-sponsored wellness programs than those with traditional health insurance

Sources:

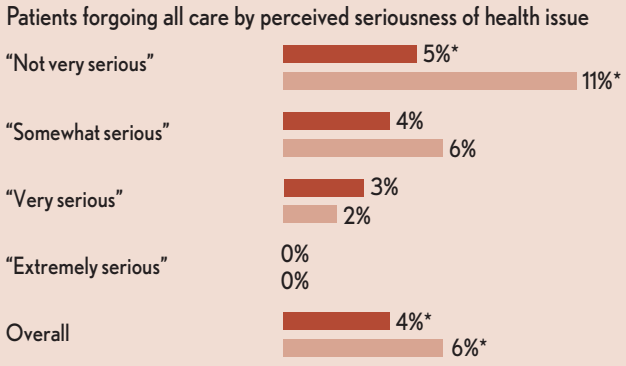
G. Claxton, et al, "What High-Deductible Plans Look Like: Findings from a National Survey of Employers, 2005," *Health Affairs* 24 (2005): w434-w441.

UnitedHealthGroup (NYSE:UNH), 2005

Consumer-Directed Health Plan Report—Early Evidence Is Promising, June 2005. McKinsey & Company ©2005.

Seriousness of Illness Influences Whether CDHP Members Skip Care

Patients forgoing all care by perceived seriousness of health issue

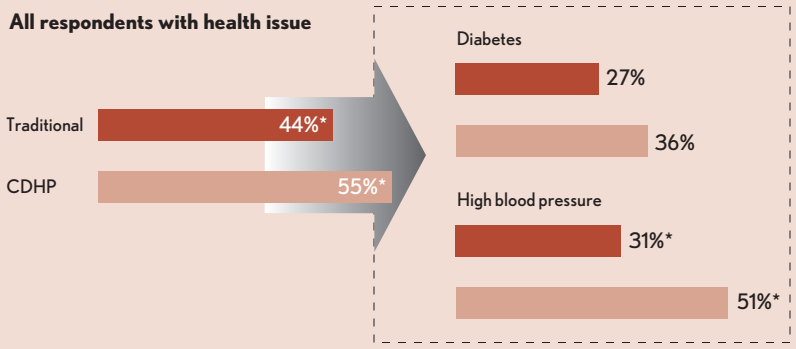


Source: *Consumer-Directed Health Plan Report—Early Evidence Is Promising*, June 2005. McKinsey & Company ©2005.

CDHP members seem to be more "value-conscious" than people in traditional health plans, conclude McKinsey researchers. For example, the CDHP members studied were three times more likely to choose a less extensive—and less expensive—treatment than their peers in traditional health plans. The study findings are based on the consumers' self reports. So, the researchers could not tell if the CDHP members' treatment decisions were medically appropriate or not.

Do CDHPs Help Chronic Disease Patients Adhere to Treatment Regimens?

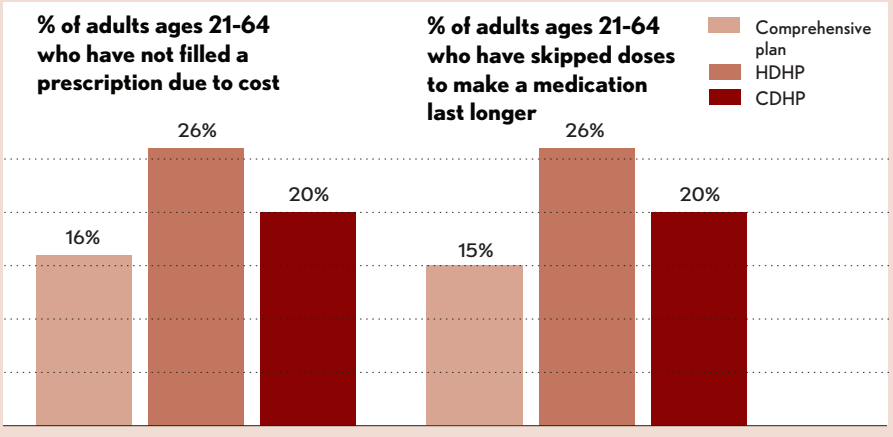
Chronic disease patients who "very carefully follow treatment regimen."



* Statistically significant

Source: *Consumer-Directed Health Plan Report—Early Evidence Is Promising,* June 2005. McKinsey & Company ©2005.

Do High Deductibles Influence Medication Usage?*



* Comprehensive plans had deductibles <$1,000 (individual) or <$2,000 (family); high-deductible health plans had deductibles ≥ $1,000 (individual) or ≥$2,000 (family); consumer-directed health plans include a savings account and a high deductible.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Can You *Really* Afford to Compete on Price?

Many hospital leaders think they can compete for increasingly price-sensitive patients just by cutting prices. They'll make it up on volume—or so the thinking goes. But that thinking can often be wrong, says Michael Nugent, a director with Navigant Consulting in Chicago.

In many cases, hospitals cannot afford to lower their prices enough to compete for the services for which patients are most likely to shop. These include things like elective outpatient surgery and diagnostic procedures that have historically generated high contribution margins for many hospitals.

In many (but not all) instances, hospital costs are just too high compared with those of specialized niche competitors.

Conduct Some Research

Before committing to a price competition strategy that could prove costly, Nugent recommends doing some research and analysis:

- For each service, determine how sensitive consumers are to price, using industry research and consumer surveys. This will show how much extra volume you can expect at a given price point.
- Calculate your break-even costs for the service relative to volume. This will tell you how much volume you need to make a profit at any given price point.
- Calculate your competitors' or potential competitors' costs for providing the service. This will tell you how much others may be able to underprice you.

If the patient demand curve falls below your break-even curve, as in the illustration at right, you probably can't afford to compete on price for that service.

Partnerships with lower-cost outlets are one way hospitals can build a retail presence.

"This has been a disappointment to some CFOs and CEOs who were interested in under-pricing competition and/or entering more retail medicine products and services," Nugent says. "It also re-emphasizes the importance of managing costs in more competitive, retail-oriented businesses."

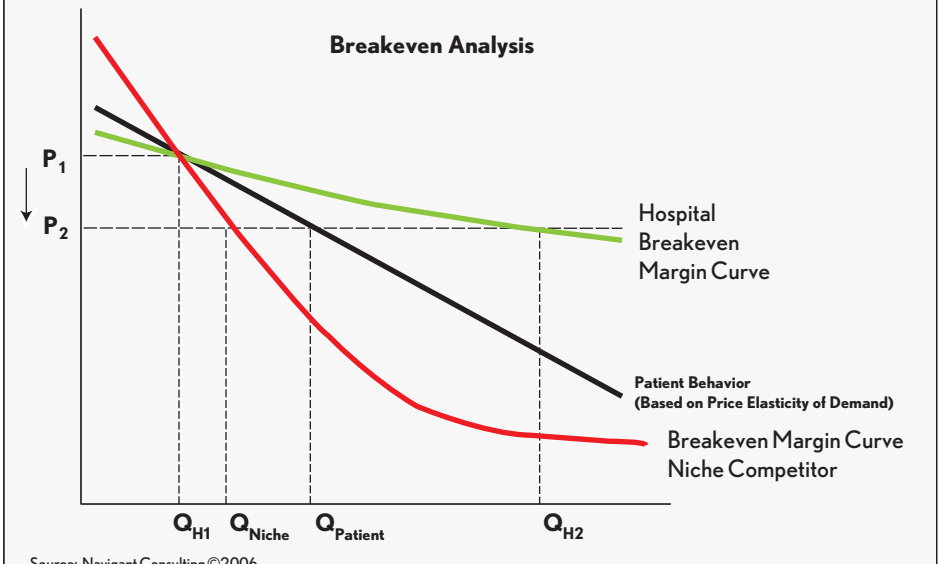
Consider Partnerships

Partnerships with lower-cost outlets are one way hospitals can build a retail presence, Nugent says. Pharmacies or other retail stores may be candidates for offering walk-in primary care. Local physicians may be good partners for free-standing diagnostic and surgery facilities. These help build referral streams for services the hospital can offer profitably.

"It may be that your best use of capital is for inpatient services that don't face as much competition," Nugent says. "Hospitals that use pricing analysis to guide their service development strategies are going to build a cost advantage in the market, and also ensure they invest their limited capital investment dollars wisely."

For more information, contact Mike Nugent, director with Navigant Consulting in Chicago (mnugent@navigantconsulting.com).

Can Hospitals Afford to Offset Price or Rate Decreases with Volume Increases?



Source: Navigant Consulting ©2006.

This hypothetical analysis of consumer price response and cost structures shows that the hospital is in a poor position to compete on price with a niche competitor. The lower the price goes, the more the hospital loses. Given expected patient behavior (based on industry research and Navigant surveys), the niche competitor's contribution margin would increase from a P1 to P2 price decline, but the hospital's contribution margin will decline because volume will only increase from QH1 to QPatient.

Prepare your organization for the pricing, performance and bottom-line challenges it faces now and in the future. Find ideas to address increasing consumerism, physician collaboration, pricing transparency, long- and short-term financial performance and the changing capital markets.

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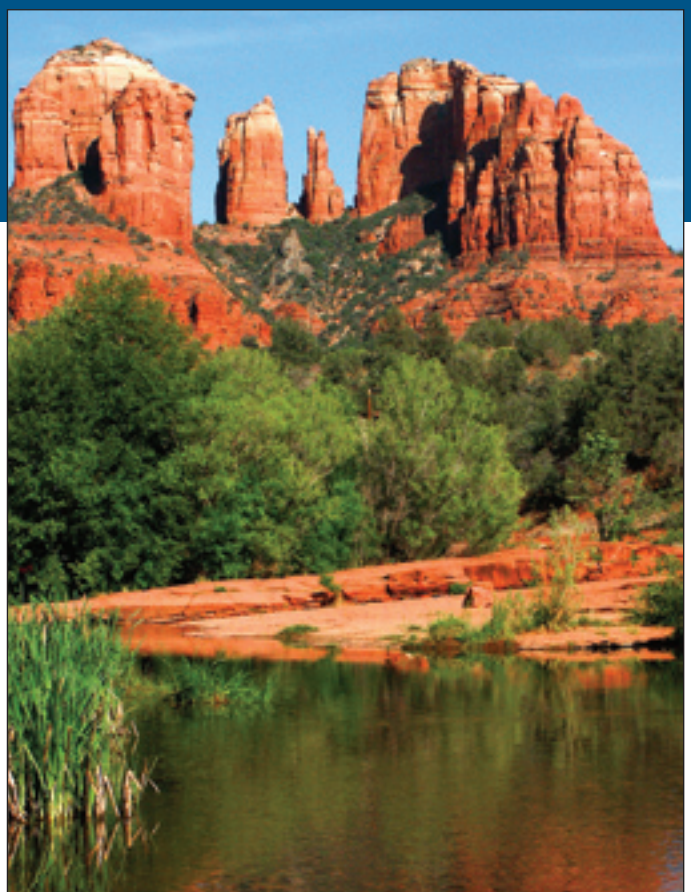

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