Pricing and Quality Transparency – Who's In Charge?

National Consumer Driven Healthcare Summit
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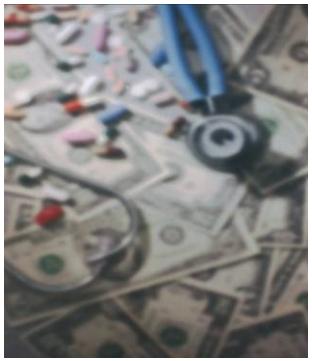
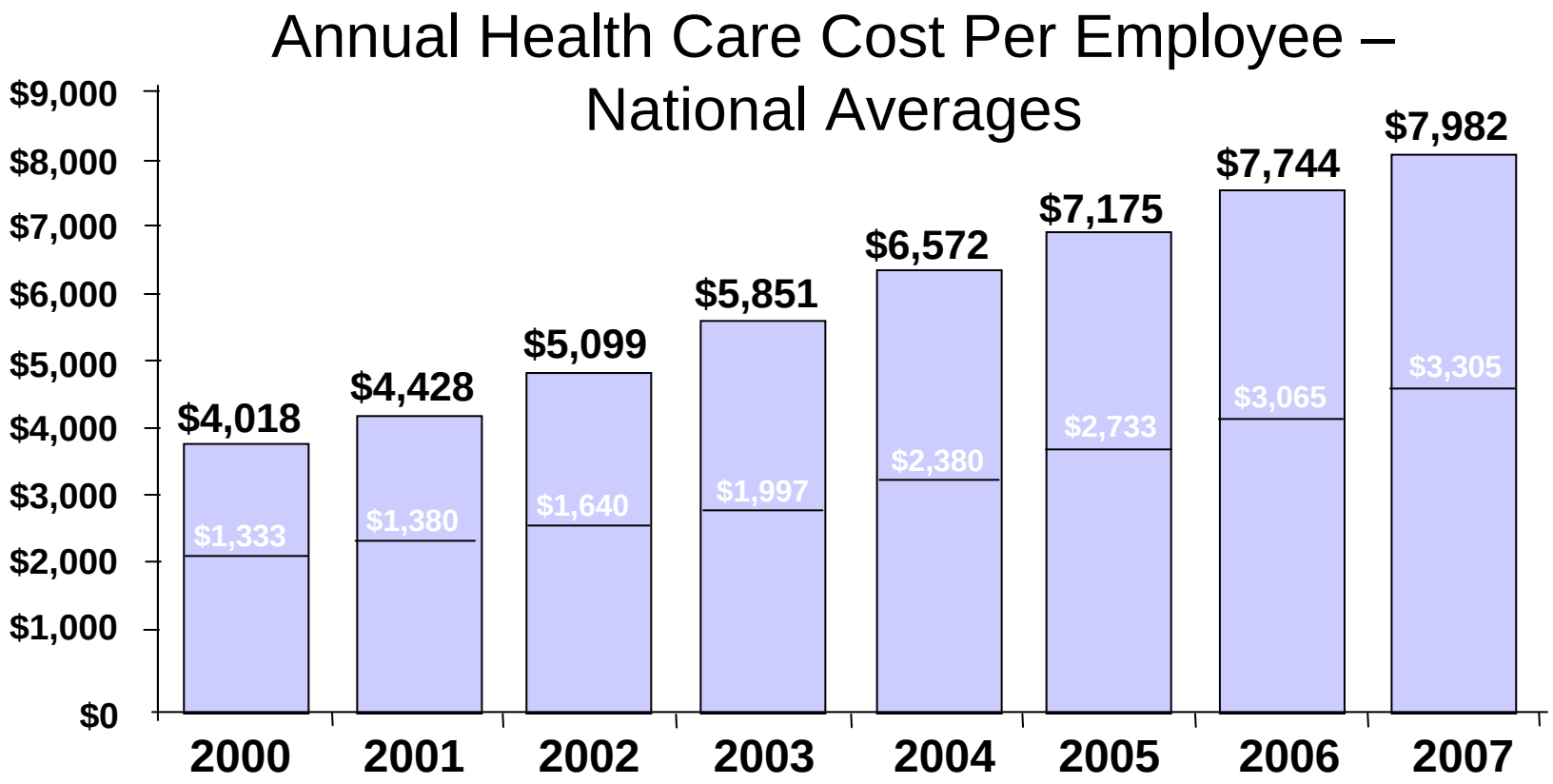
Transparency
The Payor Perspective



David Hammer

Healthcare Costs Continue to Rise



SOURCE: Hewit Health Value Initiative™

Consumer contribution (premium & out of pocket)

What are Payors Doing About the Cost of Healthcare Today?

- Payor Market – A convergence of trends to address healthcare costs and quality
- Current Payor Initiatives
  - Transparency (cost, quality, business rules)
  - Pay for Performance
  - Electronic Health Records (PBHR)
  - Contract Management Tools
  - Claims / Payment Policy Disclosure
  - Connectivity Strategies

Payor Transparency

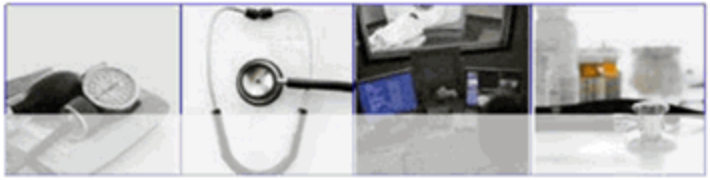
- Transparency is about…
  - Making "health plan data and operations" more visible
  - Allowing providers and health plans to use shared data
  - Encourage more informed healthcare decisions
- In order to…
  - Create operational efficiencies
  - Improve patient outcomes
  - Support new initiatives

Four Cornerstones Plan

Executive Order signed by Bush (9/06) that directs federal agencies to:

U.S. Department of **Health & Human Services**

- ***Increase Transparency in Pricing***
- ***Increase Transparency in Quality***
- ***Encourages Adoption of Health Information Technology Standards***
- ***Provide Options that Promote Quality and Efficiency in Health Care***



SOURCE: http://www.hhs.gov/transparency/

Transparency Continuum

Payors are Driving

Payor / Provider Transparency
- Quality evaluations
- P4P evaluations
- Claims payment policies
- Contract terms
- Patient data (PBHR)

Payors

Payor / Consumer Transparency
- Price information
- Provider quality data
- Cost-comparison tools
- Clinical content
- Patient data (PHR)

Provider / Consumer Transparency
(Payors Facilitating)

Providers ⟷ **Consumers**

Transparency

Challenges and Controversies

Providing price / quality info is complex and, at times, controversial

Consumers tend to equate higher quality with higher price

Many procedures are complex, and tailored to the individual… not amenable to standard pricing

Approved quality metrics are not widely available for selected specialties

Some sources of price and quality information are more trusted by consumers than others

Not all consumers have the same appetite, or ability to utilize, quality and price information

Carriers and providers are not always willing or able to disclose negotiated rates

Some consumers have limited access to online tools

The accuracy of reported price and quality date is, at times, suspect

Systems to capture and publish price and quality information are underdeveloped

Transparency Initiatives

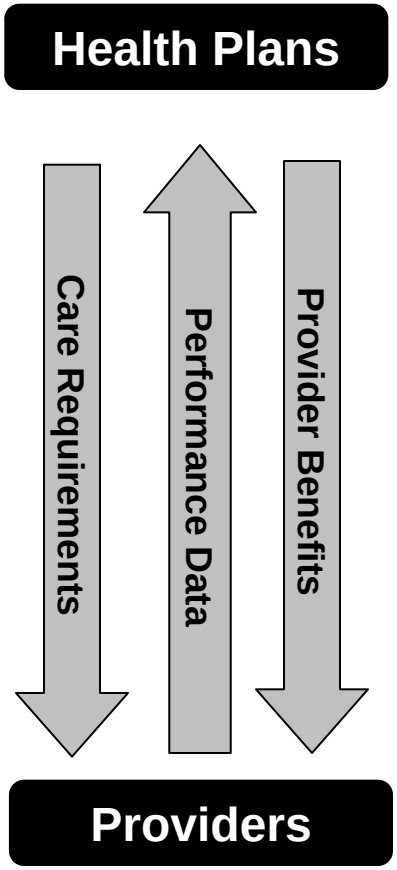
An evolving process...

- Price transparency
  - *Typically average or relative cost for procedures or conditions*
  - *Minimal focus on out-of–pocket costs*
  - *Pharmacy (drug) pricing and comparison tools most advanced*
- Quality transparency
  - *Metrics borrow heavily from CMS / AHRQ*
  - *Current focus primarily on hospitals*
  - *Physician / specialist metrics are in development*
- Medical / payment policy transparency
  - *Currently being linked available through web portals*
  - *Eventual linkage to real-time adjudication*

Pay for Performance (P4P)

Why, and Why Now?

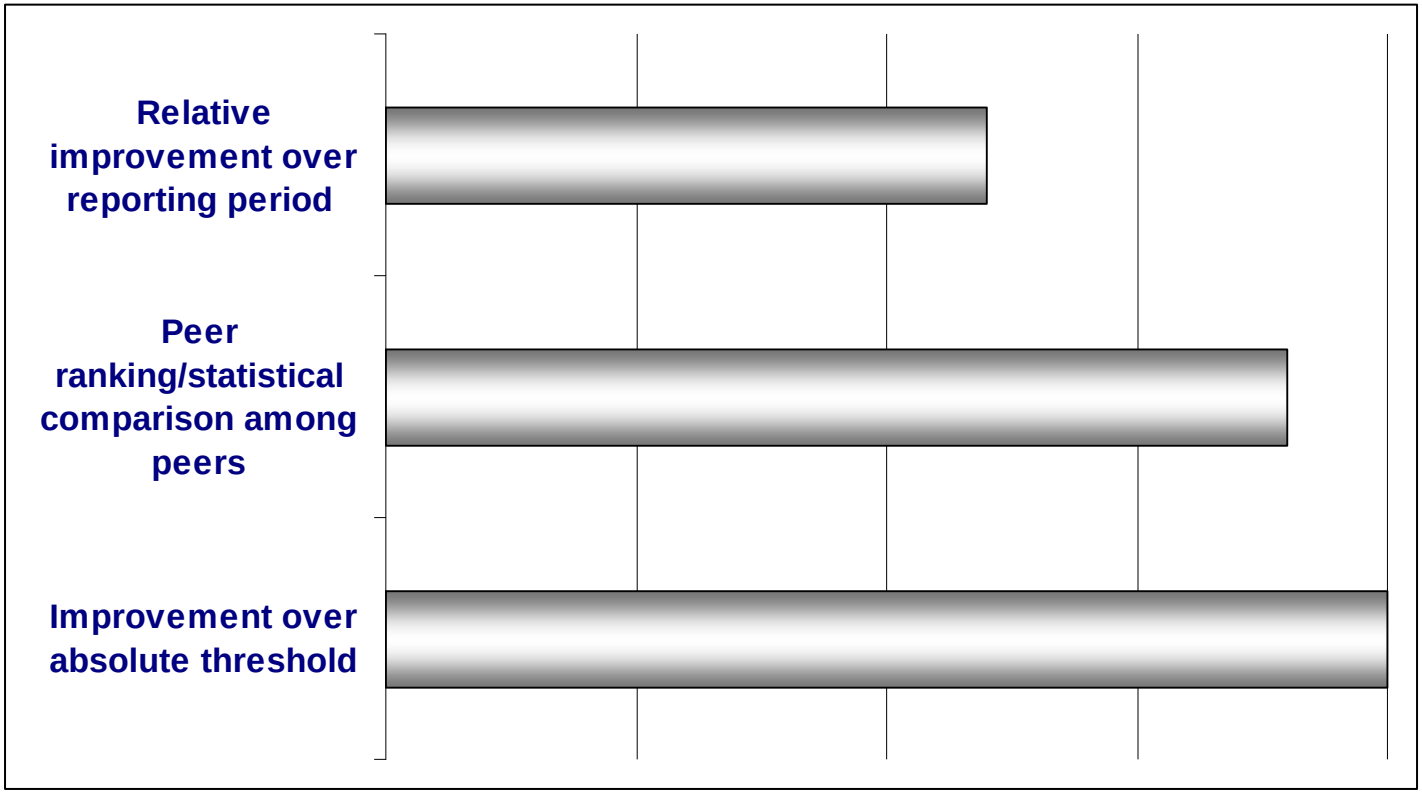
- Awareness of medication errors and patient safety
  - *Quality is not advancing rapidly enough*
- Employer pressure to improve quality
  - *Health Plan selection criteria*
- Publishing hospital morbidity data
  - *Suboptimal results*
- Improving consumer choice
  - *Suboptimal results*



Pay for Performance

What does "performance" mean?

- Currently over 100 health plans offer P4P programs
- Different methods exist to measure physician performance



Consumer Access

Health plan and provider performance information

Health Plan (HMO)	Care for Staying Healthy	Care for Getting Better	Care for Living with Illness	Member Rating of Health Plan
Aetna Health of California Inc.	★	★	★★	★★
Blue Cross of California - HMO	★	★	★★★	★★
Blue Shield of California	★	★	★★	★★
CIGNA HealthCare of California	★	★★	★★★	★
Health Net of California	★	★★	★★★	★★
Kaiser Permanente - Northern California	★	★★★	★★	★★★
Kaiser Permanente - Southern California	★★	★★★	★★	★★★
PacifiCare of California	★	★★	★★	★★★
Universal Care	★	★	★★	★★
Western Health Advantage	★	★	★★	★★★

Medical Group Ratings

California Medical Group	Getting the Right Medical Care	Patient Rating of Care Experiences
The Permanente Medical Group - North Valley	★★	★★

Excellent 3 stars
Good 2 stars
Fair 1 star
Poor 0 stars

EMRs: The Road to Transparency

A "building blocks" approach for payors

Target: All

Purpose: Ability to share health info with other systems (e.g. EMR, RHIOs, etc.)

Integrated EHR

Target: Members

Purpose: Interactive access to comprehensive health record

Personal Health Record

Target: Providers

Purpose: View-only access to claims info at point-of-care

Electronic Health Record

Target: Providers and Care Managers

Purpose: Interactive longitudinal health record

Payor-based Health Record

Where will payors place their bets?

RHIOs a long-term strategy, but market demands something sooner

- While hundreds of RHIOs have been formed throughout the country the vast majority are "people with a little bit of grant money, a mission statement, and a PowerPoint stack."*
- Fewer then 10 RHIOs have launched pilot tests of data exchange systems.
- Santa Barbara County Data Exchange representing more than 5 years and $11M, is not yet operational

- Health Plans will press forward with their own member-centric health records
- Claims, DM records & member demographics, although far short of a comprehensive E.H.R, will provide clinicians a much better view than they have today
- The PBHR solution is 'good enough' – and much less expensive than a RHIO

SOURCE: Forrester Research, "RHIOs' Modest Start," Feb 2006

Claims Disclosure

Disclosure mandates and critical business issues

❑ Disclosure Mandates

- California, Texas, North Carolina, Minnesota, Virginia, Florida
- The National Association of Insurance Commissioners (NAIC) has recently been asked by the AMA to develop standards that require disclosure of payment practices between payors and providers

❑ Critical Business Issues

- Strengthen provider relations
- Decrease appeal rate
- Reduce administrative activities and cost
- Embrace a proactive approach related to current legislation

What is Claims Disclosure?

Industry imperative due to regulation

- "…explanation of all payment and reimbursement methodologies that will be used to pay claims…" *Texas DOI Rules*

- This includes:
  - Fee schedules
  - Coding methodologies
  - Bundling processes
  - Down coding policies
  - Any other applicable policies or procedures that affect payment

What is Claims Disclosure?

Industry imperative due to settlement of litigation

- On April 27, 2007, 23 Blue Cross Blue Shield plans and the BCBS Association agreed to settle the Thomas / Sullivan class-action suit
- Establishes standardized business practices for BCBS plans
  - *Criteria for claims adjudication and fee schedules will be shared with providers*
  - *Plans will align with AMA CPT coding guidelines (as a base)*
  - *Dispute resolution processes consistent across the nation*
- The 23 plans and the Association also agreed to
  - *Increase the transparency of fee schedules and reimbursement*
  - *Set up a review board to address disputed claims*
  - *Give providers an active role in future business practices*

Success Story

Blue Cross Blue Shield of North Carolina

Problem

Needed to comply with state legislation requiring payors to give providers access to claims auditing rules and clinical rationale(s)

Solution

- ✓ Easy access to claims payment rules and edit rationale through secure provider portal
- ✓ User friendly – no technological ability required
- ✓ 82% of providers are registered users; average of 3000 hits/month
- ✓ 73% of providers rated the functionality as 'somewhat to strongly effective and helpful to their office'

Call Volume

- ✓ Decrease in call volume and talk time
- ✓ Fewer questions regarding how claims were processed
- ✓ Efficiencies in number of medical record pulls

Appeals

- ✓ Reduction in claims payment appeals
- ✓ Avoids costly clinical review

Provider Relations

- ✓ Increases stability of provider networks
- ✓ Shows commitment to standards-based decision making
- ✓ Provides consistent messaging

Claims Transparency

2008 trends – Claims disclosure is a small first step

Use of these tools will facilitate *adoption of high deductible health plans (CDHPs, HSAs, etc.)*

Step 5: Real Time Reimbursement

- Adoption an estimated 8 -10 years away

Step 4: Real Time Adjudication

- The "holy grail." Exists currently for Pharmacy only

Step 3: Proprietary Payment Calculator

- Customized to payer-specific payment policies

Step 2: Generic Payment Calculator

- Generates 'best guess' regarding claims payment & member liability

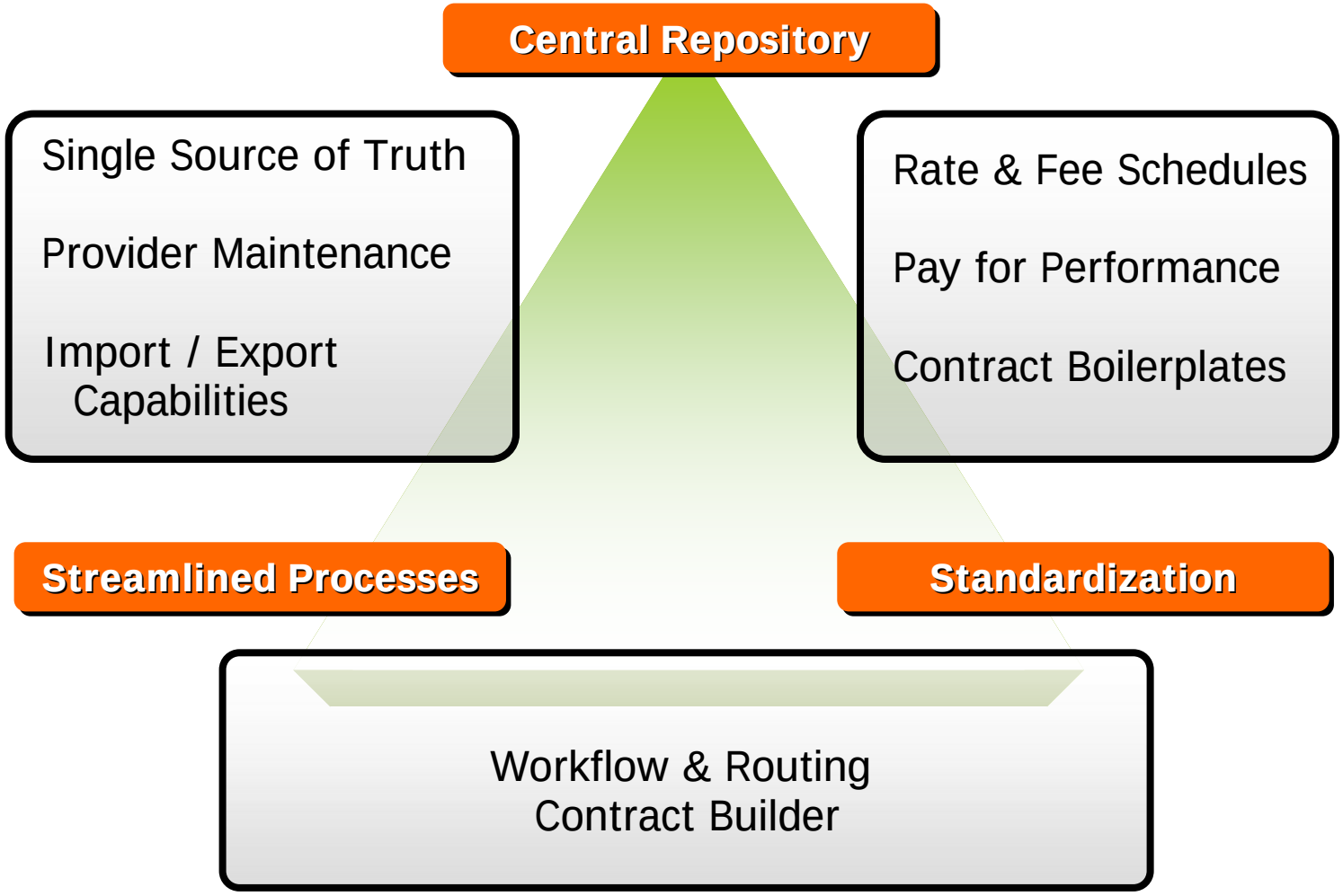
Step 1: Disclose Payment Policies

- Will need to be exposed to members to support CDHP

Contract Management Tools

- Contract Management Tools allow for:
  - *Improved contract transparency*
  - *Standardized and expedited contracting process*
  - *Mitigation of risks and improved contract compliance*
- Using contract management tools, payors can improve provider relationships by:
  - *Fostering transparency and clarity of contractual requirements*
  - *Streamlining the contracting process*
  - *Standardizing provider data and contracts*

Contract Management Value



Payor Transparency Summary

Connecting stakeholders and providing transparency will build trust

- Access to information
- Pay for performance (EBM)
- Electronic health records (PBHR)
- Claims / payment policy disclosure
- Contract management tools
- Connectivity strategies (i.e. portals, e-visits, direct links)

Share information, garner trust, improve care

Payor Transparency Value

- Consumers "Need to Know"
  - *The best available information regarding quality and cost efficiency*
- Quality Performance Measures
  - *Mutually agreed-on measures to support quality improvement and provider incentives*
- Provider Trust and Enablement
  - *Transparency with providers regarding performance evaluations, contract terms, and payment rules*

Transparency
The Provider Perspective

What is "Healthcare Transparency?"

Pricing Information

- Self pay pricing
- Insured view of pricing = out of pocket expenses

Quality Information

Standard measures:
- JCAHO accreditation
- Number of cases
- Surgical infection rates

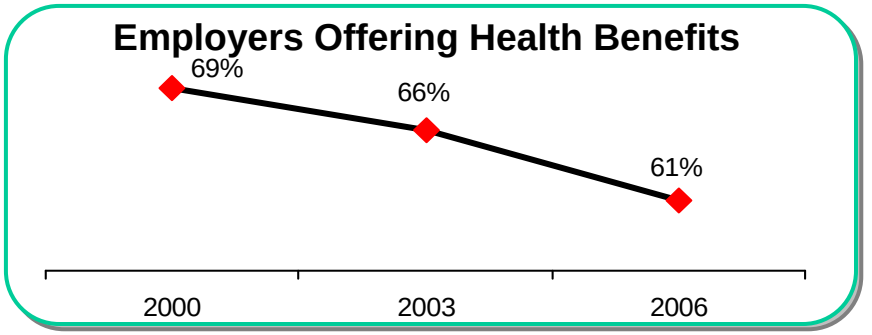
Provider differentiators:
- Location
- Awards and Accolades
- Modern equipment

Patient satisfaction feedback:
- Press Ganey scores
- Open forum for comments

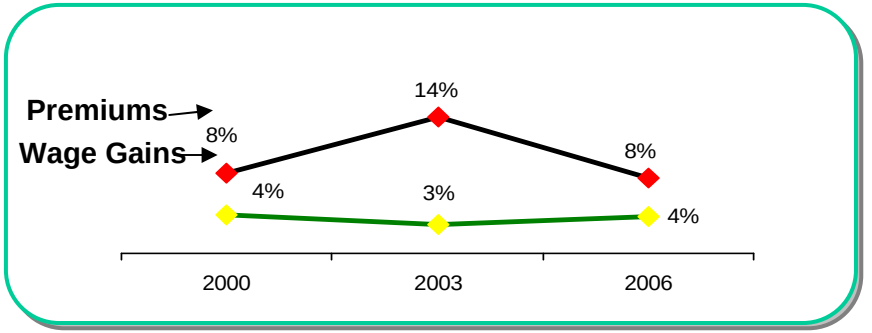
Why is Transparency Important?

Rise in the patient portion of A/R

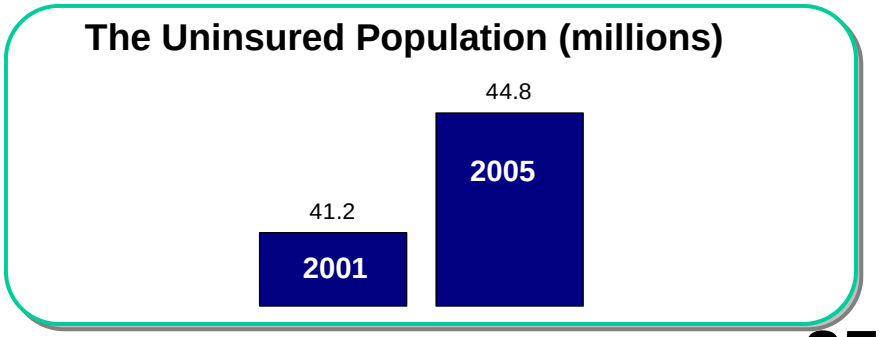
Number of Employers Offering Health Coverage is Declining



Rise in Insurance Premiums Continue to Outpace Gains in Earnings



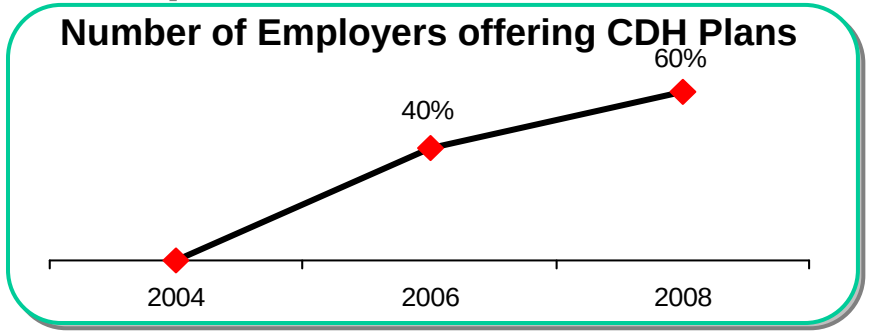
Number of Uninsured is Climbing



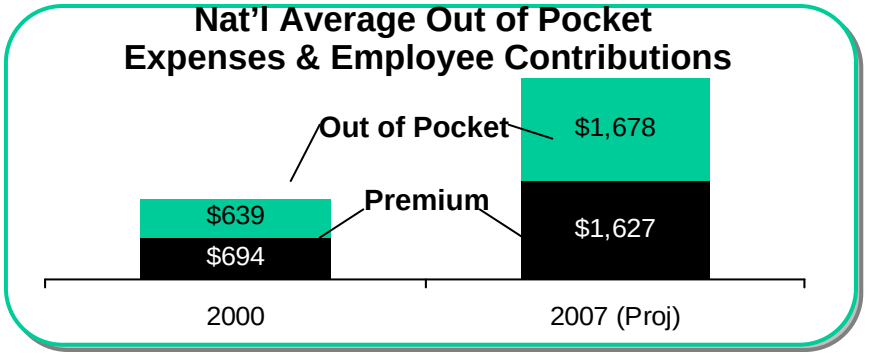
Why is Transparency Important?

Rise in out-of-pocket expenses

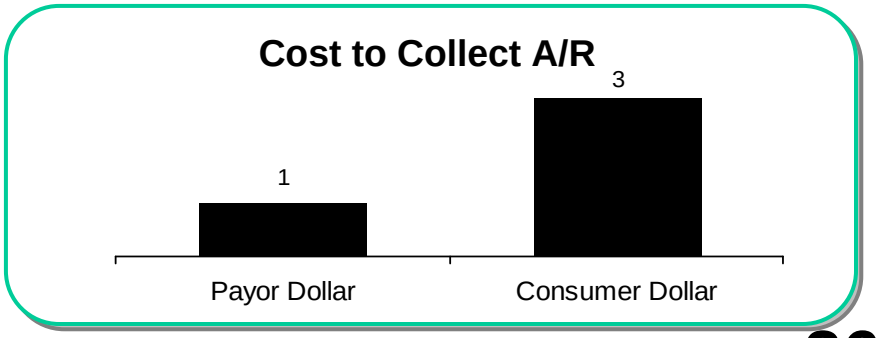
Higher Co-Pay & Deductible Plans Proliferating



Average Employee Healthcare Costs Up Nearly 150% Since 2000



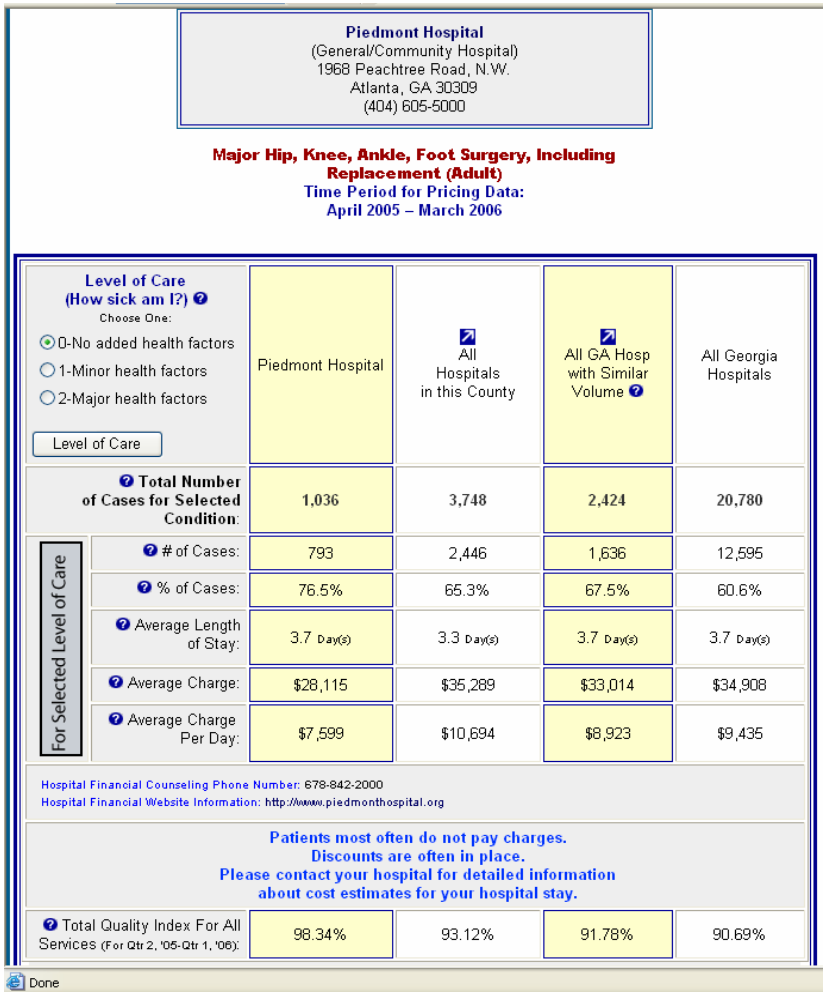
Cost to Collect from Consumers Far Higher than Payors



Why is Transparency Important?

Legislative, State Pressures

- August 22, 2006 Presidential Order mandating price and quality transparency
- 38 states require hospital reporting of quality data
- 32 require reporting charges for selected procedures:
  - "GA Hospital Price Check" – reporting is voluntary



Piedmont Hospital
(General/Community Hospital)
1968 Peachtree Road, N.W.
Atlanta, GA 30309
(404) 605-5000

Major Hip, Knee, Ankle, Foot Surgery, Including Replacement (Adult)
Time Period for Pricing Data:
April 2005 – March 2006

Level of Care (How sick am I?) Choose One:	Piedmont Hospital	All Hospitals in this County	All GA Hosp with Similar Volume	All Georgia Hospitals
0-No added health factors / 1-Minor health factors / 2-Major health factors — Level of Care				
Total Number of Cases for Selected Condition:	1,036	3,748	2,424	20,780
For Selected Level of Care — # of Cases:	793	2,446	1,636	12,595
For Selected Level of Care — % of Cases:	76.5%	65.3%	67.5%	60.6%
For Selected Level of Care — Average Length of Stay:	3.7 Day(s)	3.3 Day(s)	3.7 Day(s)	3.7 Day(s)
For Selected Level of Care — Average Charge:	$28,115	$35,289	$33,014	$34,908
For Selected Level of Care — Average Charge Per Day:	$7,599	$10,694	$8,923	$9,435

Hospital Financial Counseling Phone Number: 678-842-2000
Hospital Financial Website Information: http://www.piedmonthospital.org

Patients most often do not pay charges.
Discounts are often in place.
Please contact your hospital for detailed information about cost estimates for your hospital stay.

Total Quality Index For All Services (For Qtr 2, '05-Qtr 1, '06):	98.34%	93.12%	91.78%	90.69%

Done

Healthcare Connectivity Strategy

Portals

Hospital

- Health System
- Community

Physician Office

- Integrated
- Independent

Connectivity

- Patient
- Payor
- Pharmacy

Connectivity Assets

Pharmacy Solutions

NDCHEALTH

- Real-time retail pharmacy claim network
- Value-added pre- and post-edits on claims
-
-
-

- webVisit consultations
- Virtual business office
- Telehealth Advisor
- eScrip generation

Provider Solutions

McKESSON
Empowering Healthcare

- Financial clearance
- Print services/document outsourcing
- Medicare direct entry
- Virtual remittance services
- Revenue cycle outsourcing

- **1 billion financial transactions**
- **1 million patient records**
- **8.5 billion pharmacy transactions**
- **Connections to 90% of retail pharmacies**

Patient Connectivity

Connectivity

- Secure data exchange
  - Physicians
  - Patients
  - Hospitals

Communication

- webVisit®
- Lab results
- Rx refills

Convenience

- Request appointments
- Check eligibility
- Pay bills
- Calculate out-of-pocket expenses

Coaching

- Chronic-care support
- In-home monitoring services

Financial Connectivity

Self-Service and Cash Management

Consumer

- Financial clearance
- Financial settlement
- Price transparency

Financial Institution

- "Smarter" swipe cards
- "All Payment" processing
- Expanded EFT

Payor

- HSA / FSA crossover
- Payor-based health record
- Price transparency

Financial Connectivity

Improving Revenue Cycle Performance

Connect

Consumer	Financial Institution	Payor
❑ Financially-clear patients ❑ Financially-settle accounts ❑ Offer self-service options	❑ Accelerate cash ❑ Reduce back-office payment reconciliation ❑ Expand EFT capabilities	❑ Improve transparency ❑ Submit/ adjudicate claims in real-time ❑ Integrate HSAs and eligibility

"Next Generation" Integrated Revenue Cycle

Payor / Provider Contract-Transparency Issues

- Consistent understanding of how to execute contract terms
- Disconnect between the contract and the execution
  - Terms and rules are in English
  - Payment is enforced by coding systems and mathematical equations

Correct Payment Is A Challenge

- Different systems
  - Claims management vs. revenue cycle management
  - Different capabilities and different data
- Assumptions being made
  - No synchronization or coordination
  - Retrospective reconciliation because of perceived errors

Contract Transparency Examples

- Providers expect payment on claims for medical trays, the claims for which may lack HIPAA-compliant codes
- Payors pay lump-sum payments to account for underpayments, instead of making sure the contract is executed correctly

Financial Connectivity

Consumer-Driven Health Care Backlash

"One of the greatest public-relations coups in the history of the health-care industry is the creation of the term 'consumer-driven health care.'

Anyone that follows healthcare knows that consumers had nothing to do with this latest cost-saving invention from the minds of employers and health insurers."

David Burda
Editor, Modern Healthcare
Oct 10, 2005

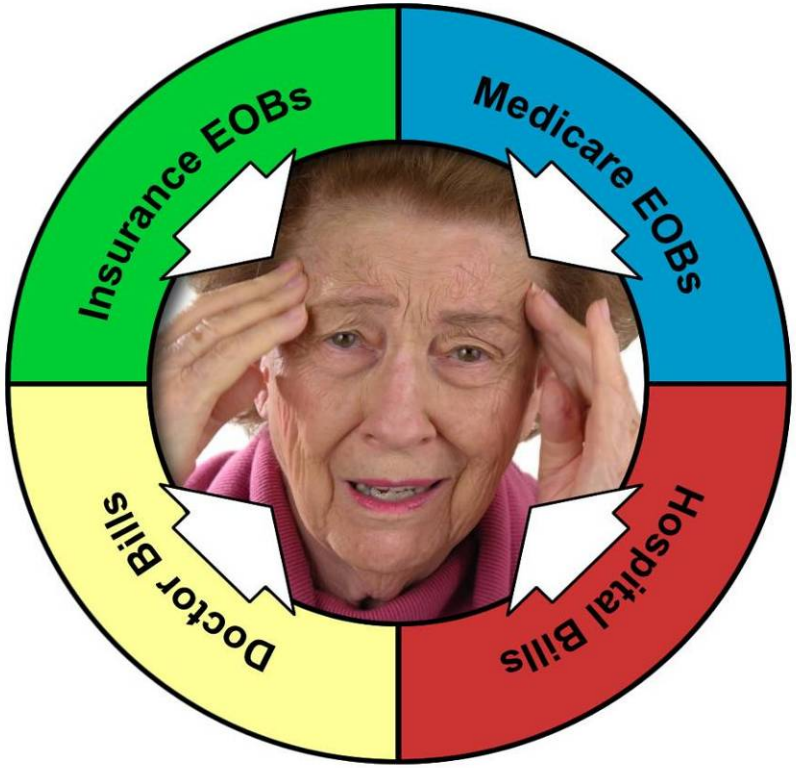
Financial Connectivity

The Confusing and Complicated Patient Billing Experience

Patients receive multiple bills from hospital and physicians

Patients receive multiple bills for every episode of care at hospital

Patients have to call hospital, physician(s), and payor(s), and are often put on hold



Patients receive multiple EOBs for every provider bill

Bills do not contain full disclosure of financial and insurance information

Bills with patient balances are often sent 25 days after Insurance payment received

Provider websites do not enable self-service account management

Financial Connectivity

Possible CDHC Financial Ramifications

- Rising pressure to increase financial transparency
- Summer 2005 McKinsey & Company study of 2,500 insured people (1,000 in CDHC plans) showed
  - CDHC-plan members felt they lacked sufficient info to make meaningful healthcare-choice decisions
  - Wondered about how much MDs and hospitals get paid
- Yet, McKinsey study also showed CDHC plan members were
  - 50% more likely to ask about cost
  - 33% more likely to independently find alternative care
  - 300% more likely to have chosen a less extensive, less-expensive treatment

SOURCE: Snowbeck, C., Pittsburgh Post-Gazette, Sep 18, 2005

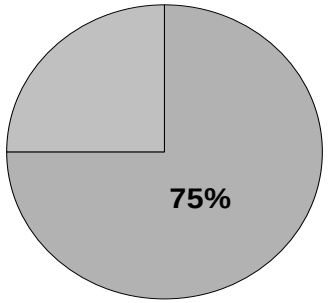
Providing Information Transparency

Manual Yet Valuable

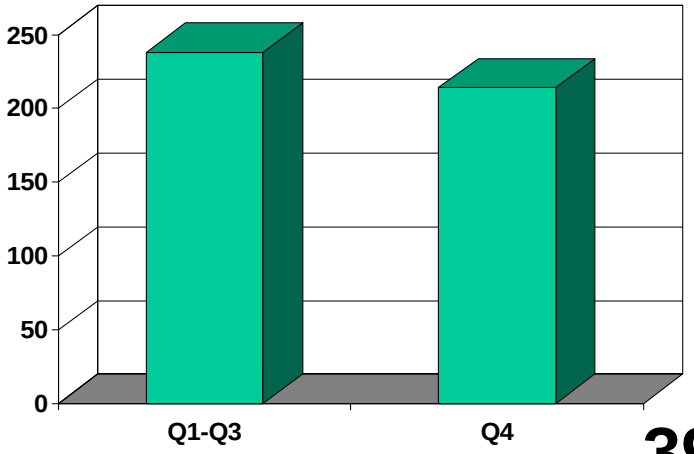
- A SE health system proactively provides out-of-pocket estimates
  - 5-6 FTEs
  - Collects 75-80% out-of-pocket obligations prior to service

- A MO health system initiated a phone line dedicated to price estimate requests
  - Approximately 45 minutes to generate a quote
  - Call consumer back within 2 days

Percentage of Patient Obligations Collected Prior to Service



Increase in Phone Inquiries: 2005



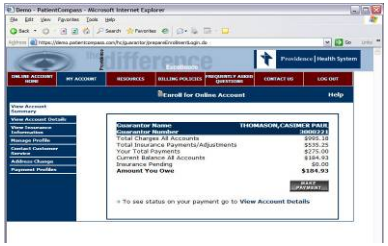
Vision of a Transparent Healthcare System

Consumer experiences knee pain:
-Researches health problem on-line
-Chooses physician

Physician determines a knee replacement is necessary:
-Consumer chooses hospital
-Physician communicates procedure information to hospital via secure messaging

Consumer contacts the hospital via web or telephone:
-Estimate procedure cost
-Schedule surgery and pre-register
-Pre-pay out of pocket estimate
-Apply for financial assistance
-View procedure education on-line

In the waiting area, Consumer:
-Reviews pre-reg information
-Pays co-pay/balances
-Signs forms and checks in
All without help from the registrar



Following the procedure, the Consumer:
-Views post procedure education on-line
-Manages accounts on-line
-Asks questions of the care provider and makes follow-up appointments on-line
-Receives clear and concise paper bills

Planned Solution Phasing

Phase I

Point-of-Service Optimization

Provider View:

Predict total estimated charges

Estimate insured and self pay obligations prior to services being rendered

Consumer View:

Out-of-pocket estimates on-line for select procedures through virtual business office

Phase II

Quality Transparency

Provider View:

Real-time eligibility inquiry

MPI integration

HIS FCW integration

Consumer View:

Quality Data template

"Blind" payments via price estimate module

Spanish

Customers w/o in-house managed care system: ASP transparency solution

Phase III

Pulling "It" All Together

Provider View:

Integration focus:

Scheduling integration

Kiosk integration

Secure messaging

Physician orders direct to acute care facility

Financial Counseling / financial assistance link

Link to FSA/HSA dollars

Phase IV

The Consumer Experience

Consumer View:

Clinical content as front end to consumer UI

Enhanced quality content

Ambulatory integration

Vision of a Transparent System

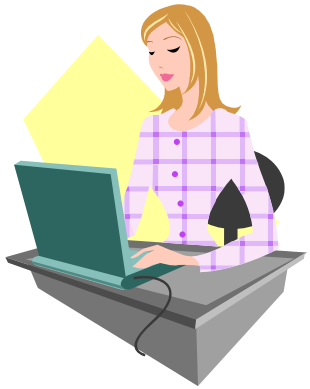
Step I – Pricing transparency: telephone version

Consumer

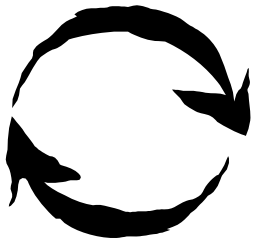
Requests Price Estimate

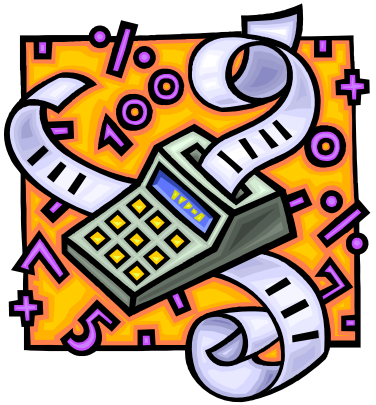
Routed to financial counselor or pricing dept

Hospital



Logs into POS estimation tool





System calculates out-of-pocket estimate, based on:

- Historical claims
- Insurance-benefits info from HIS system / eligibility check / consumer feedback

Vision of a Transparent System

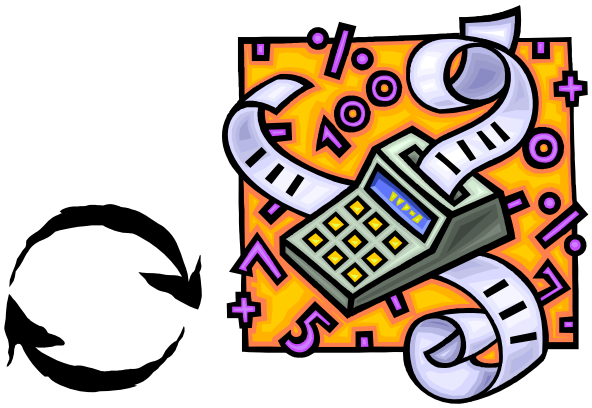
Step I – Pricing transparency: "virtual business office" version

Consumer

Consumer needs price estimate and researches pricing online

Hospital's Virtual Business Office

Consumer enters key information into system's pricing module

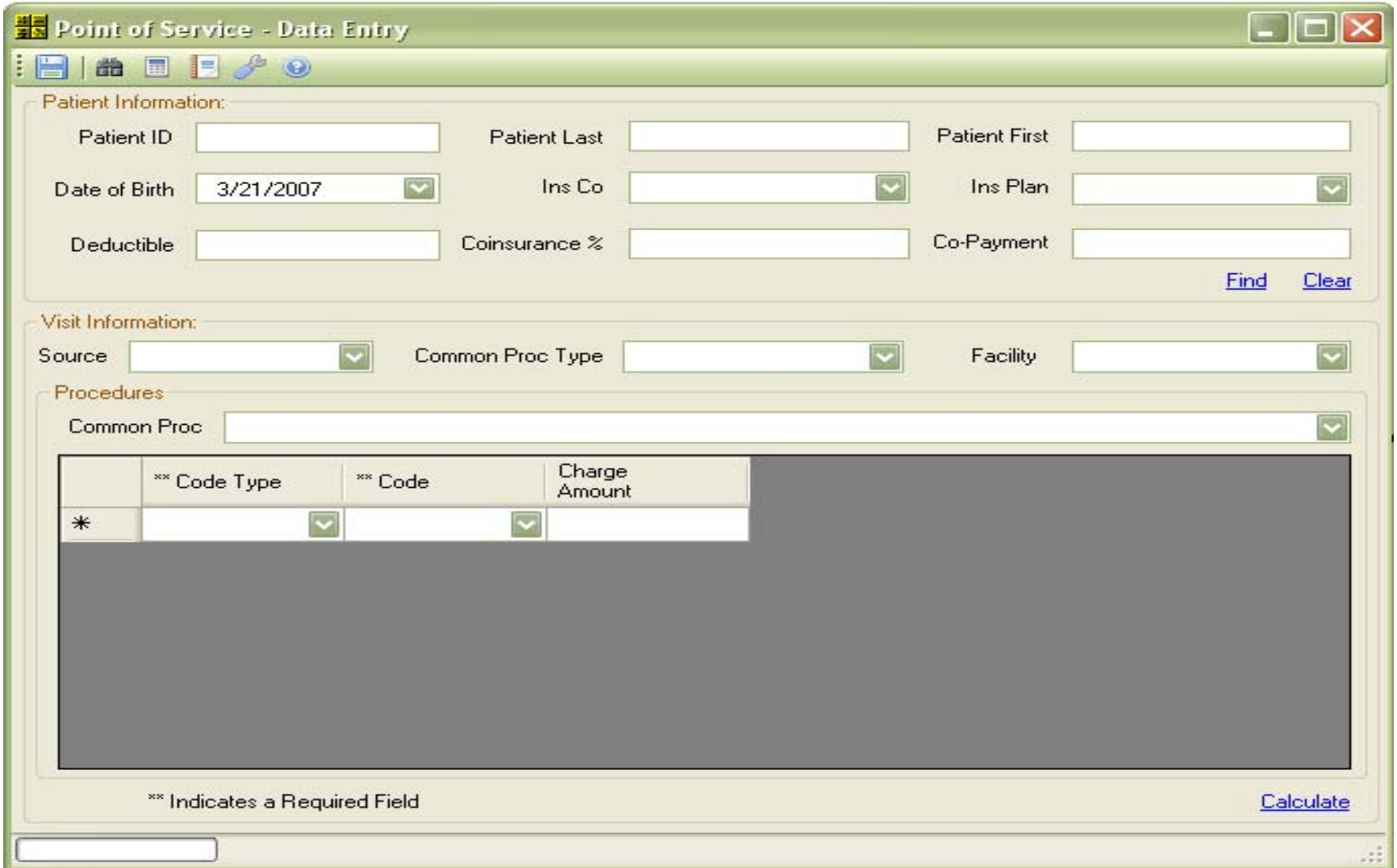


System generates out of pocket estimate based on: historical claims

Insurance benefits info, based on consumer feedback (if provided)

Virtual Business Office

Out-of-pocket price estimation



Virtual Business Office

Estimated patient-portion calculation – version 1

Estimated Patient Portion Calculation

* Estimated Patient Responsibility valid for information submitted as of 4/11/2007.

Description	Charge Amount
15850 - Desc for 15850	$1,500.00

Patient ID	99-PA113552
Patient Name	Tom Smith
Patient Date of Birth	12/19/1969
Insurance Company	PAYORQ
Insurance Plan	ASCCHG
Facility	A

Total Estimated Charges		$1,000.00
Negotiated Rate	x	$750.00
Coinsurance Percent	=	20.00%
Coinsurance	+	$150.00
Deductible Remaining	+	$50.00
Co-payment	=	$0.00
Total Estimated Patient Responsibility		$200.00

Updated 4-11-2007

Pro fees, Etc.

* Estimated Patient Responsibility valid for information submitted as of 4/11/2007.

Virtual Business Office

Estimated patient-portion calculation – version 3

Virtual Business Office

Estimated patient-portion calculation – version 4

PROGRESSIVE MEDICAL CENTER

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- Obtain Out of Pocket Estimate
- Frequently Asked Questions About Out of Pocket Expenses
- Definitions of Important Terms

Estimated Patient Portion Calculation

Patient Name	Carla Shields
Account Number	A000008594
Social Security Number:	XXX-XX-7862
Date of Birth:	03/25/1954
Insurance Company:	Aetna
Insurance Plan:	Point of Service (POS)
Type of Procedure:	Eye
Procedure:	Cataract removal, insertion of lens
Total Estimated Charges:	$1,414
Co-Payment:	$250
Coinsurance:	$0
Annual Deductible Remaining:	$425
Total Estimated Responsibility:	**$675**

MAKE PAYMENT

To see status on your payment go to **View Account Details**

*Estimated Insured Responsibility valid for information submitted as of January 1, 2007.

If you participate in a Health Reimbursement/Savings account, your out of pocket cost may be reduced by your balance. The information provided in this estimate is not a guarantee of final billed charges. Estimates are based on the information provided by you and your insurance company. Timeliness of claims processing may affect your overall out of pocket estimate. Professional fees, such as physician, radiologist, anesthesiologist and pathologist are not included in this estimate, and you will be billed separately. Cost estimates are based on your use of an in-network provider for your health insurance plan.

Healthcare Transparency

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Speaker's Resume

McKESSON
Empowering Healthcare

David Hammer, Vice President, McKesson

Mr. Hammer is a Vice President in McKesson's Business Performance Solutions group. He focuses on revenue cycle, consumer-directed health care, and pay for performance issues for hospitals, health systems, and related entities. In his more than 22 years of industry experience, Mr. Hammer has held a variety of positions with leading health systems, Big-4 consulting firms, I. T. vendors, and revenue cycle outsourcing companies.

Background and Affiliations

Mr. Hammer received an MBA in Management and an MHS in Health Care Administration from the University of Florida in 1987. He also received a BBA in Accounting with a minor in Information Systems (Magna cum Laude) from the University of North Florida in 1985. Mr. Hammer is certified by HFMA as a Fellow (FHFMA) and as a Certified Healthcare Finance Professional (CHFP). He has been named an HFMA Distinguished Speaker for five consecutive years, and has received HFMA's Gold, Silver and Bronze service awards. Mr. Hammer is a nationally recognized speaker on revenue cycle management, consumer directed health care, pay for performance, and electronic health records.

Recent Publications

Mr. Hammer authored the February 2008 cover story in HFMA's healthcare financial management journal, entitled "Beyond Bolt-Ons – Breakthroughs in Revenue Cycle Information Systems." He also wrote the July 2007 cover story, called "The Next Generation of Revenue Cycle Management," as well as the July 2005 hfm cover story, entitled "Performance is Reality: Is Your Revenue Cycle Holding Up?" Another one of his recent articles, "UPMC's Metric-Driven Revenue Cycle," appeared in the September 2007 issue of hfm, and "Data and Dollars: How CDHC is Driving the Convergence of Banking and Health Care" was published in hfm's February 2007 issue. His article "Black Space Versus White Space – The New Revenue Cycle Battleground" appeared in the January 2007 issue, and "Customer Service Adapts to CDHC" appeared in the September 2006 issue. He also publishes regularly in McKesson Provider Technologies' Answers magazine.

Contact Information

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