



RECONSTRUCTING HOSPITAL PRICING SYSTEMS

A CALL TO ACTION FOR HOSPITAL FINANCIAL LEADERS

Guiding principles for a rational pricing system

Research findings on barriers and progress

Steps toward a new pricing system

A Report from the *PATIENT FRIENDLY BILLING*[®] Project



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Reconstructing Hospital Pricing Systems:
A Call to Action for Hospital Financial Leaders
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Healthcare Financial Management Association
Two Westbrook Corporate Center, Suite 700
Westchester, IL 60154-5700
www.hfma.org
resourcecenter@hfma.org

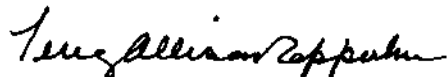
Dear Colleagues:

We are pleased to present this latest report from the **PATIENT FRIENDLY BILLING®** project. Titled *Reconstructing Hospital Pricing Systems: A Call to Action for Hospital Financial Leaders*, the report offers an overview of the current hospital pricing system, its evolution, and critical objectives of pricing system reform. This report is designed to help all healthcare stakeholders—providers, payers, employers, government, and consumers—understand the critical issues and barriers that must be addressed to bring positive and lasting change to the healthcare pricing system. It includes results from an HFMA survey of hospital and health system financial leaders to help quantify the significance of certain barriers and the predominant methods of pricing and cost accounting. This report also offers short-term actions providers can take to start the reconstruction process. Subsequent reports in the Patient Friendly Billing project will suggest collaborative actions that we believe will be required for system improvement.

Sincerely,



Richard L. Clarke, DHA, FHFMA
President & CEO
Healthcare Financial Management Association



Terry Allison Rappuhn, CPA
Project Leader
Patient Friendly Billing project

EXPERTS CONSULTED

This report of the **PATIENT FRIENDLY BILLING®** project is based in large part on insights from the following experts:

- Dennis Barry, JD, partner, Vinson & Elkins LLP, Washington, D.C.
- Richard L. Clarke, DHA, FHFMA, president and CEO, Healthcare Financial Management Association, Westchester, Ill.
- William O. Cleverley, PhD, president, Cleverley & Associates, Worthington, Ohio
- Joseph J. Fifer, FHFMA, CPA, vice president of hospital finance and CFO, Spectrum Health Hospitals, Grand Rapids, Mich.
- David S. Fuller, executive director of patient access/patient finance/HIM, The Nebraska Medical Center, Omaha, Neb.
- Keith Hearle, president, Verité Healthcare Consulting, LLC, Washington, D.C.
- Richard Raskin, JD, partner, Sidley Austin LLP, Chicago
- Gregory M. Snow, MPM, vice president, revenue cycle, Geisinger Health System, Catawissa, Pa.

The following have reviewed the content and offered additional valuable insights:

- Mary Beth Briscoe, FHFMA, CPA, CFO, University Hospital, UAB Health System, Birmingham, Ala.
- Robert L. Broadway, FHFMA, vice president, corporate strategy, Bethesda Healthcare System, Boynton Beach, Fla.
- David Canfield, FHFMA, president, A/R services division, PHNS, Inc., Cerritos, Calif.
- Joseph F. Corfits, Jr., FHFMA, senior vice president finance/CFO, Central Iowa Health System, Des Moines
- Phyllis Cowling, FHFMA, CPA, president and CEO, United Regional Health Care System, Wichita Falls, Texas

- Lisa Goldstein, senior vice president/healthcare team manager, healthcare ratings, Moody's Investors Service, New York, N.Y.
- Sarah G. Hull, FHFMA, vice president/CFO, Ministry Medical Group, Wausau, Wis.
- Catherine A. Jacobson, FHFMA, CPA, senior vice president of strategic planning & finance, CFO, and treasurer, Rush University Medical Center, Chicago
- Debora Kuchka-Craig, FHFMA, CPA, vice president, Baltimore Managed Care, MedStar Health, Baltimore
- James Logsdon, vice president of business operations, Texas Health Resources, Arlington, Texas
- Ron Long, FHFMA, CPA, executive vice president and CFO, Texas Health Resources, Arlington, Texas
- Lawrence E. McManus, FHFMA, CPA, vice president and CFO, St. Joseph's Hospital & Medical Center, Phoenix
- Francisco J. Mendez-Gonzalez, FHFMA, CPA, partner, Lomba, Luciano, Mendez & Dolagaray, PSC, San Juan, Puerto Rico
- John A. Orsini, CPA, vice president financial operations, Catholic Healthcare West, Phoenix
- Richard Rodriguez, FHFMA, assistant administrator, University Hospital, University Health System, San Antonio
- James S. Stewart, health systems director of budget & reimbursement, Cedars-Sinai Medical Center, Los Angeles
- Joyce A. Zimowski, FHFMA, CPA, senior vice president, Unity Health System/The Unity Hospital, Rochester, N.Y.

HFMA extends its appreciation to these experts for the energy and expertise they contribute to make a difference in their profession.

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PATIENT FRIENDLY BILLING GUIDING PRINCIPLES FOR A RATIONAL PRICING SYSTEM

- **Price is important to consumers.** Pricing and price transparency are important issues because our current, complicated system reduces public trust. A price system that inspires trust has a clear rationale that relates to objective data and is communicated in a way that is easy to understand.
- **Rational price systems require broad collaboration and communication.** All key players—hospitals, physicians, payers, purchasers, and system support vendors—must work together to assess the effects of price system changes and ensure all facets work together to achieve a rational system. As the focal point for healthcare prices, hospital leaders are logical catalysts for dialogue and cooperation among these stakeholders.
- **Market forces affect prices.** In a market-based healthcare system, market forces (the rates set by competitors and the amounts paid under health plan contracts) profoundly affect the prices set for services. These forces should be addressed in the hospital's pricing structure.
- **Cost is an important price component.** Because of the strong role of managed care contracting in setting prices, cost typically has not been the primary driver of pricing for many hospitals. A rational price system, however, requires methods to determine the fully loaded and incremental cost of each item to be priced. These methods should be applied consistently and be easy to administer and explain.
- **Quality must be integrated into the pricing system.** To set the groundwork for payment that encourages excellence and preventive care, quality must be factored into the price equation.
- **Rational pricing requires clear structure.** To support the healthcare provider in making consistent decisions over time, pricing must be based on an organizational structure that will guide redesign and update efforts. This structure addresses the processes for how factors such as cost, market forces, and the unique value offered by the organization are assessed and balanced. This structure also addresses matters such as what services should be bundled and what incremental measurement should be used for basing prices.
- **Prices must cover all financial requirements.** The pricing of products and services must ensure the hospital's complete financial needs are met, including a reasonable margin. Factors that influence the financial requirements include payer mix, service mix, capital demands, effects of government payment shortfalls, and community benefit (including charity care) costs. These total revenue requirements must be clearly identified and the pricing structure must support them to ensure business stability.
- **Centralized pricing functions are preferable.** Because of the importance of consistency in communications about prices, pricing functions should be centralized as much as possible within a facility or health system, with specified responsibilities, procedures, and input from all affected departments.

EXECUTIVE SUMMARY

Payment for healthcare services has evolved into a bewildering array of cross subsidies, hidden taxes, and conflicting incentives. This system is incredibly complex and costly to administer for both providers and payers of care. Furthermore, the resultant pricing of services is almost impossible for the general public to understand, inhibiting transparency, price comparisons, and trust in healthcare institutions. Payment for health services and the pricing methods established by providers must be changed to ensure that precious resources are not diverted from community health needs. For a multi-faceted national healthcare system to work, we need a foundation for healthcare service pricing that is rational, dependable, and open to public scrutiny.

Although this report focuses on the pricing system, issues of pricing, payment, and financing are in fact closely intertwined. For the purposes of this project, “financing” refers to the means by which funds get into the healthcare system; “payment” refers to the process of distributing those funds to providers of health services, and “pricing” provides the incremental measure for this distribution.

A rational pricing system should:

- Be simple to administer and communicate to various stakeholders, including members of the general public
- Be established using a framework that is rational and defensible in relation to objective benchmarks, such as cost and market price
- Create accountability by empowering consumers to make price comparisons
- Allow for full coverage of financial requirements related to providing care and other community benefits
- Provide stability and predictability in administrative processes

Given the growing importance of healthcare issues among policymakers and the public, HFMA believes that doing our utmost to develop a rational pricing system not only will improve patients’ experience as they take more charge of their healthcare purchasing decisions, but also will contribute comparable, meaningful cost and price information to the broader national payment and financing debate.

WHY PRICING REFORM IS CRITICAL

Confusing, opaque, secretive, and convoluted. These are some the adjectives used in both healthcare and consumer publications to describe the current system for pricing healthcare services in U.S. hospitals. Consumers complain that it is virtually impossible to determine what their financial obligations will be for services; hospital executives struggle to explain the complex mechanisms that link healthcare financing and pricing, rendering the prices hospitals charge various purchasers both incomprehensible and sometimes troublesome.¹

Cracks in the healthcare financing system are deepening, exacerbating the pricing challenge. The interrelated dynamics are generally understood by healthcare providers and payers, but this most often is not the case with consumers in the communities served by the nation's hospitals.

It's important to caution readers that the healthcare market is inherently imperfect and will always operate differently from other industries. Due to the urgent nature of health care and the degree of highly specialized knowledge required for many hospital services, it's unrealistic to expect healthcare consumers to immediately comprehend and make informed decisions about complex medical issues using detailed information about price and quality before they may obtain medical services.

That said, a more rational pricing system, combined with improved price reporting methods, is still the first step in getting consumers to think about what they are spending for care.

Uncompensated Care: Shuffling Deck Chairs

Nearly half of hospital revenues derive from Medicare, Medicaid, and other government health programs. Due to federal and state budget constraints, government payment is falling increasingly short of covering hospitals' costs. According to data published in 2005, for every dollar of allocated cost, Medicare and Medicaid paid hospitals 95 cents and 92 cents respectively.²

As in other business environments, to maintain a positive margin, the cost of such shortfalls must be passed through to customers. In fact, private payers paid \$1.22 for every dollar of hospital costs as a result of this "cost-shift hydraulic" (sometimes described as a hidden tax on healthcare purchasers).

However, the uncompensated care costs don't stop at government shortfalls. Hospitals also resort to cost shifting to cover the costs of the increasing number of uninsured and underinsured Americans, as well as the costs of essential but unprofitable, mission-related services (such as burn units, inpatient psychiatric units, or neonatal intensive care units).

The scope of all this uncompensated care combined is a national policy issue that hopefully will continue to gain traction both in Congress and state legislatures across the country.

Complex Payment = Complex Pricing

Depending on the size of the hospital or health system, a central business office may deal with anywhere from 20 to 100 different payers, in addition to Medicare and Medicaid. Each payer's contracting requirements and basis for payments is different—sometimes slightly, sometimes significantly—but it's up to the hospital to adapt to each one.

“U.S. hospital pricing is not entirely of hospitals’ own making. [Hospitals] are part of a wider system of healthcare financing,” notes health economist Uwe E. Reinhardt, PhD, of Princeton University.³ Given this reality, finding a solution to meet today’s pricing challenge has become a national imperative, requiring collaboration among government, provider, payer, employer, and consumer stakeholders alike.

Consumerism

As healthcare costs escalate, many employers are responding by eliminating employee health benefits or shifting more of the burden of payment to consumers in the form of higher deductibles and copayments. This trend is contributing to the mounting number of both uninsured and underinsured individuals in the United States, the former of which increased to nearly 16 percent of the population in 2005. It is also contributing to a rising level of bad debt as this population struggles to cover growing out-of-pocket costs.

The trend is also contributing to increasing price sensitivity among consumers of healthcare services. Consumers responsible for high-deductible and coinsurance payments have economic incentives to shop for the best possible value related to quality and cost.⁴ They expect to find price and quality information for medical services in a format similar to what they are familiar with for consumer products and services in retail markets. High-deductible and consumer-driven health plans, such as health savings accounts and health reimbursement accounts, are on the rise, ensuring that the prices hospitals charge will remain an issue into the future.

A Growing Imperative for Price Transparency

The push for hospitals to make their prices public is widespread and growing, and effective transparency efforts depend on a rational pricing system. In the



summer of 2006, Medicare began publishing information on what the agency pays for common inpatient and outpatient procedures and services. As of April 2007, 32 state legislatures require hospitals to report pricing information; six additional states have voluntary price reporting systems.

To support the value-comparison goals of health services purchasers—whether individuals, employers, or government programs—hospitals are heeding the call to make their prices more available to the public. Many hospitals and health plans have already posted price and quality information on their web sites, or have cooperated with state hospital association initiatives to consolidate this information. And the American Hospital Association voiced strong support for legislation that would require insurers to provide information about an enrollee’s out-of-pocket expenses and require the Agency for Healthcare Research and Quality to conduct a study on what consumers want to know about pricing information.



Shining a Bright Light on the Current Pricing System

An “under the hood” look at the hospital pricing system reveals what some health policy experts have called a Byzantine array of pricing structures: “They range from the infamous chargemaster or fee-for-service price list to bundled payment systems such as diagnosis-related groups, with various forms of ‘discounts off charges’ and ‘per diems’ somewhere in between.”⁵ A description of the key characteristics of the current U.S. pricing system follows.

Wholesale-based prices. Since 1983 when Medicare switched from a retrospective, cost-based payment system to a prospective, case-based system, hospitals have functioned in the pricing domain like a wholesaler. Medicare, Medicaid, and private insurance payers (which followed the government’s lead) set the prices they pay for services independently of individual hospital prices.

The legislated government rates and commercial insurance rates that dominated the payment landscape in the 1980s were based on the average of hospital charges as established by hospitals. By the early 1990s, private payers were paying hospitals according to contracts with lower fee schedules or negotiated discounted rates. Christopher P. Tompkins of Brandeis University and colleagues comment: “Accordingly, billed charges defined prices for a shrinking proportion of patients. Hospitals responded by marking up billed charges even faster than the costs of care for such patients. This scenario resulted in an increasing gap between billed charges and the prices paid by most payers.”⁶ Continuing into the present, this system is characterized by the fact that the bulk of payers never pay full charges as they would do in a retail market. Hospitals accept wholesale prices.

Diverse pricing methodologies. Pricing methodologies vary by organization and are highly complex. For example, gross charges may be based on a combination of factors including the highest allowable charge for a particular service in payer contracts, cost (which may or may not include various indirect expenses), and marketplace considerations, such as being in the 50th percentile (in the state, by bed size, or in the market area).

The approach used to adjust prices also varies widely. Some hospitals increase their prices on an across-the-board basis. Others adjust prices based on departmental cost-to-charge ratios. Still others use market rate information, rate optimization, or other methods to selectively increase prices for services with high costs or low price sensitivity.⁷ Approaches are used singly or in combination. Issues that affect pricing calculations include average costs, discounts to commercial insurers, losses on patients whose cost of care is not covered, and hospital margins needed to sustain continued viability and growth.⁸ The hospital's payer mix in particular often has a great influence on prices.

Hospital-specific chargemasters. Traditionally developed by each hospital or health system over the past several decades, a chargemaster or charge description master is a list of thousands of itemized prices for specific services and procedures performed in the hospital and the supply items used during such services and procedures. Chargemaster format and content varies by organization, and a chargemaster often contains between 12,000 and 45,000 individual charge items as defined by each hospital.⁹ According to a recent study for the Medicare Payment Advisory Commission prepared by the Lewin Group, chargemasters may increasingly reflect hospital budgetary and competitive considerations rather than relative costs or resource consumption.¹⁰

In addition, as noted by Moody's Investors Service, because insurers typically negotiate set prices, the relationship between the chargemaster's "gross price" and the actual amount paid by a patient's insurer has become "essentially arbitrary."¹¹

Organization-specific strategies. Shaped by each provider's unique payer mix of health insurers and government reimbursement systems, which combined pay the vast majority of healthcare bills, current pricing strategies are as complex and varied as the hospitals that employ them. In developing a pricing strategy, organizations must consider a series of competing objectives: meeting mission and providing community benefit, balancing budgets while remaining competitive, and complying with relevant laws and regulatory standards. Definitive resources to guide hospitals with their pricing strategies and best practice approaches to price setting are appearing more frequently in the healthcare literature.¹²

The characteristics of today's hospital pricing system described here—wholesale-based pricing, diverse pricing methodologies, hospital-specific chargemasters, and organization-specific pricing strategies—create a nonlinear relationship between chargemaster prices, government and private payer payments, and other measures. Resulting distortions make it very challenging for hospitals to provide transparent, comparable pricing information, which is now expected by healthcare purchasers. Pricing reform is clearly critical if policy-makers, payers, and the public want hospitals to operate with the price transparency characteristic of a retail environment.

COMMON THEMES FOR A BETTER PRICING SYSTEM

Common Themes

So what might be the guiding characteristics of a national effort toward such reform? The following are experts' consensus views of what a better pricing system might look like—the common themes to consider when shaping a rational and transparent pricing system.

Meaningful, timely, and relevant information.

Healthcare consumers want to be apprised of their out-of-pocket financial responsibility for the services they receive. In a new system, prior to the provision of nonemergent services, consumers would get this information tailored to their specific condition, treatment, insurance policy, coverage, and benefits level. Having patients receive this information before visits would enable the entire provider-patient encounter to maintain a clinical focus rather than an administrative/clinical mix. With emergent care, consumers and their families would receive this information as soon as possible following service provision.

Simplicity. A simpler pricing system for stakeholders would allow patients and insurers to readily understand the pricing system and what it means to them. For example, the current system with thousands of individual “a la carte” prices for each service component might be replaced in some cases by bundled charges for recognizable procedures or services.

Defensibility. Providers should be able to present and explain their prices based on some meaningful basis such as cost and what competitors are charging. Prices would be reasonable and consistent with those of peer organizations that have similar characteristics and provide similar services within the hospital's market. A hospital's prices would be able to withstand scrutiny by healthcare consumers, payers, and state and federal policymakers.

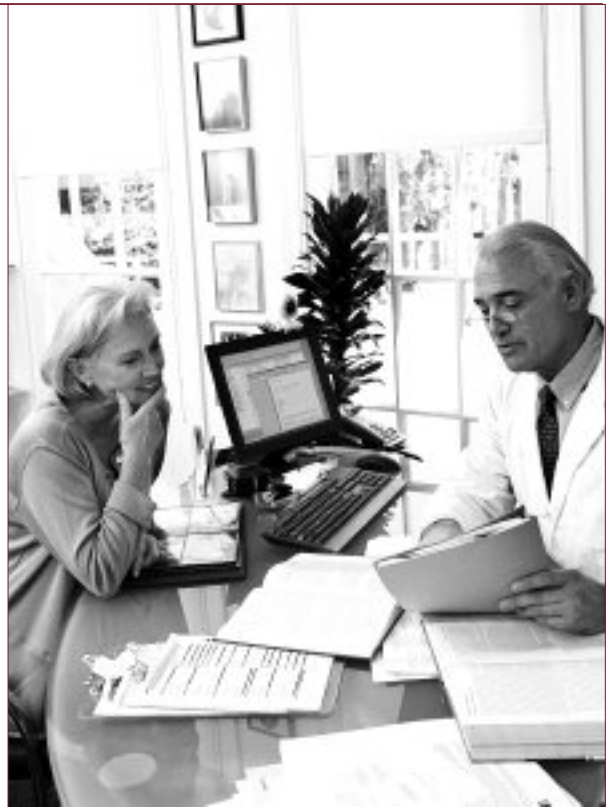
Fairness to consumers. Providers should adopt a pricing strategy that does not result in excessive charges to any one population, particularly self-pay patients.¹³ A new pricing system would provide uninsured and underinsured patients with fair out-of-pocket financial responsibility based on ability to pay. The definition of “fair” might be determined using such measures as proportion of annual household income spending on health care, for example.

Comparability of price and quality. The pricing system should provide consumers and payers with both price and quality information that can be easily compared across providers, allowing an assessment of relative healthcare value. It would encourage providers to enhance quality of care and align price and service quality. Comparability would better align financial incentives with quality of care goals.

Ease and equity of administration. Streamlined administrative processes would benefit all stakeholders. Therefore, a new pricing system’s administrative development and maintenance costs should be shared fairly among all stakeholders.

Equity for providers. The pricing system should ensure providers can address the health needs of their communities and meet the financial requirements needed to maintain their long-term viability. Thus, payments would be sufficient to cover hospitals’ reasonable costs and provide an ROI that enables their continued operation. Government payment would cover cost of Medicare and Medicaid services, including capital costs. In the absence of a national policy to resolve the problem of the uninsured, the costs of their care would be equitably distributed among all stakeholders in the system.

Protection of community benefit activities. A new pricing system should not put certain healthcare providers, such as teaching hospitals and not-for-profit facilities that provide a large proportion of charity care, or important but unprofitable services, at a competitive disadvantage because of their need to spread those costs among all healthcare purchasers.



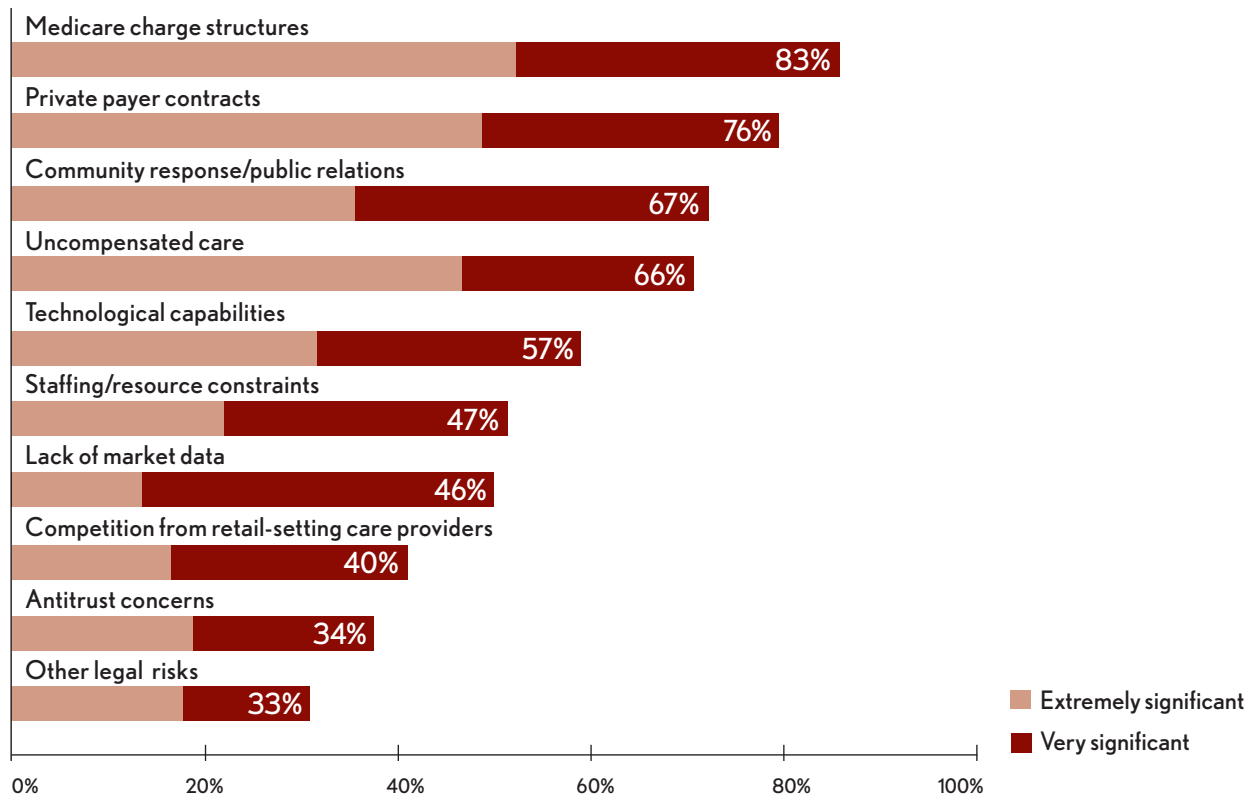
Efficiency. The pricing system should reflect fair prices for high-quality care provided at a reasonable cost. Providers would be responsible—and rewarded—for delivering optimal service in a cost-efficient manner.

BARRIERS TO CHANGE: THE CFO'S PERSPECTIVE

The sheer complexities of the current payment and pricing systems make stakeholders on all sides of the healthcare equation reluctant to start tackling the issue. The spotlight often focuses on hospitals as the expected architect of a new system though they do not have unilateral control of their pricing decisions. Having not created the system on their own, they certainly cannot solve it on their own.¹⁴

So what do hospital financial executives see as the major hurdles to improving the pricing system? In March 2007, the Patient Friendly Billing project e-mailed a survey to a sample of hospital and health system financial leaders and received 161 responses. These respondents most frequently cited Medicare charge structures, private payer contracts, community response, and uncompensated care as top barriers or challenges to improving the rationality of their pricing system.

SIGNIFICANCE OF INDUSTRY BARRIERS



Source: Patient Friendly Billing Survey, HFMA, March 2007.

However, it is important to note that survey respondents also see significant progress toward improved pricing, despite these barriers.

Concerns and Actions

A review of key concerns and the actions that providers and other stakeholders will need to take to address them when redesigning the pricing system follows.

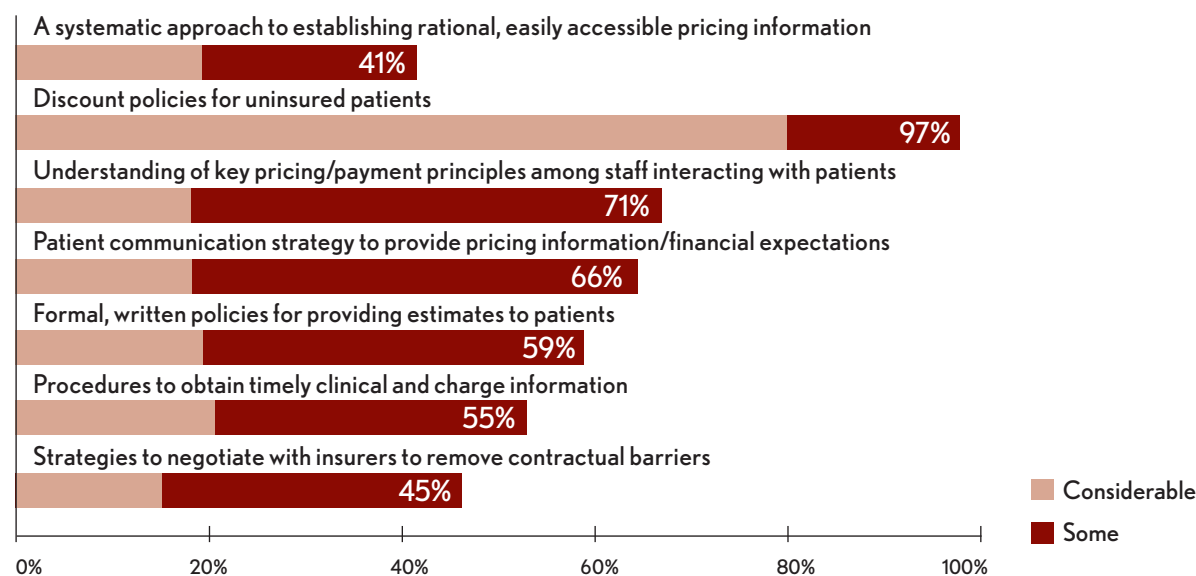
Concern: Rebasing charges could lead to reductions in Medicare payments for outliers. In most cases, improving the rationality of a pricing system will likely lead to the lowering of charges. However, certain Medicare payment rules use the previous year’s ratio of cost to charges as a basis of payment. This is the case for

Medicare outlier payments, which help offset the losses hospitals incur when the costs for treating a patient are much higher than the Medicare diagnosis-related group payment for that case payment. Critical access hospitals, also, still have cost-based Medicare payments.

If hospitals drop their charges, their cost-to-charge ratio will increase, reducing the likelihood of triggering the threshold for outlier payments. The same principle applies to stop-loss thresholds used by commercial payers for high-cost cases.

Hospitals thus have been reluctant to reduce their charges significantly, believing that such changes could decrease or eliminate payments for high-cost outliers.

PROGRESS TOWARD RATIONAL, TRANSPARENT PRICING



Source: Patient Friendly Billing Survey, HFMA, March 2007.

Take Action! Rebasing could present a financial risk to some cost-based Medicare payments, but there are steps you can take to greatly minimize the risk. The Centers for Medicare and Medicaid Services provides hospitals with a means to request a different cost-to-charge ratio if a hospital believes that the current ratio is inaccurate (see sidebar). Hospitals may wish to consider requesting a new ratio when charges are reduced or when costs for new technologies are not adequately reflected. CMS will make the change within 60 days after the appropriate data are submitted.

The caution here is to have a clear action plan in place with CMS *before* making radical changes to gross charges. Start meeting with your fiscal intermediary early in the planning stages to discuss how to minimize

that risk and make the process of changing the cost-to-charge ratio as smooth as possible. The same strategy can be applied to commercial contracts that include outlier or stop-loss provisions.

Providers should also be sure to check Medicaid rules regarding applying a lower cost or charge limitation. In some high-cost areas, charges set at market may be below cost and may result in reduced Medicaid payments if there is a lesser cost or charge limitation applied by the state.

Medicare has demonstrated a willingness to work through these issues, which should help ease concerns that Medicare rules are a barrier to rebasing charges.

CMS GUIDANCE ON DETERMINING COST-TO-CHARGE RATIOS

The Centers for Medicare and Medicaid Services has provided extensive written guidance on how fiscal intermediaries update cost-to-charge ratios to reflect cost and charge information. Intermediaries must recalculate the provider's cost-to-charge ratio on an ongoing basis whenever a more recent full-year cost report is available.

According to such guidance, a hospital may request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital that the cost-to-charge ratio being applied is inaccurate. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office must approve any such request after evaluation by the fiscal intermediary of the evidence presented by the hospital.

Relevant resources include:

- Program Memorandum Intermediaries: Transmittal A-03-004, Calculating Provider-Specific Medicare Outpatient Cost-to-Charge Ratios and Instructions on Cost Report Treatment of Hospital Outpatient Services Paid on a Reasonable Cost Basis, Jan. 17, 2003. www.cms.hhs.gov/transmittals/downloads/A03004.pdf.
- Program Memorandum Intermediaries: Transmittal A-03-058, Change in Methodology for Determining Payment for Outliers Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems, July 3, 2003. www.cms.hhs.gov/Transmittals/Downloads/A03058.pdf.
- Inpatient Prospective Payment System (IPPS) Outlier Reconciliation, MLN Matters (MM3966), Effective Date: Nov. 7, 2005. www.cms.hhs.gov/MLNMattersArticles/downloads/mm3966.pdf.

Concern: Taking a loss on percentage-of-charge contracts. The Patient Friendly Billing survey shows that despite the prevalence of case-based payment methods, many providers still have a large portion of charge-based revenue from private payers. If price changes are made before the provider renegotiates these contracts, the provider will suffer financially. A fear is that payers will not be willing to change their percentage-of-charge contracts if the provider seeks to alter its rate structure. This is essentially virgin territory in contract negotiations, since few hospitals have had discussions about decreasing charges.

CHARGE-BASED REVENUES

Considering the basis of payment, approximately how much of your revenue is charge-based?

Percentage of Responding Hospitals	Charged-Based Revenues
13% of hospitals	Greater than 50%
21% of hospitals	Between 25% and 50%
43% of hospitals	5% and 25%
24% of hospitals	Less than 5%

Source: Patient Friendly Billing Survey, HFMA, March 2007.

Many providers have no burning desire to renegotiate these contracts, because they have already spent months negotiating them in the first place. What's more, the contracts come up for renewal at different times, making implementation of price changes that much more difficult.

Take Action! If a significant portion of your private-payer contracts is charge-based, and renegotiation is just not feasible, the most direct, short-term workaround is to leave charges where they are and simply discount charges to self-pay patients to the level that would be achieved through rebasing. As with all discount policies, you'll need to carefully check payer contracts for "most favored nation" clauses that require a provider to give the lowest price it has offered to anyone else automatically to the private insurance company, regardless of what the insurer would otherwise pay.

Over the longer term, pricing and contracting strategies go hand-in-hand, so simplifying the plethora of contract payment systems—while often difficult—is highly desirable. Although it may be difficult for some hospitals to achieve significantly different payment terms with certain payers, all hospitals can inform payers of overall simplification goals and work toward achieving contracts that are simpler and easier to administer.

Providers are advised to lay the groundwork for improvement by talking with their health plans as they start to develop a more rational pricing structure. Many CFOs meet monthly with their major payers to discuss ongoing claims issues. These meetings provide an opportunity to sound payers out on possible changes and seek ways such changes can be mutually beneficial.

Before talks about renegotiation can begin, the organization should have a plan for how to prepare for and approach each payer. When forming this plan, carefully consider the changes from the payer's perspective. Obviously, an improved pricing structure will benefit patients. But even if the changes are budget-neutral, some payers may offer resistance if the changes affect things like how they advertise their networks to employers. On the other hand, managed care organizations will likely welcome changes that give them greater certainty

when they are pricing premiums and making financial forecasts for the coming year, which in turn gives them a better opportunity to manage their business.¹⁵

Also, a hospital should be prepared to work with insurers who take a "component pricing" approach to negotiations rather than looking at the entire price for the service. That is, the insurer may look at a hospital bill line by line and pick out the items believed to be unreasonable. Understandably, the insurer will view expensive supplies, like implants or other high-tech cardiology devices, as starting points for bargaining better prices. Thus, the hospital should have a plan for how it will bring the insurer back to the overall price for the procedure, if that is the basis of the rebased charges.

Some hospitals may not have enough bargaining clout to be able to renegotiate their contracts, but smaller or rural hospitals can create this clout by working with and educating the business community about these issues. Business leaders are influential stakeholders who can be a significant ally in encouraging insurers to find a way to make pricing system improvements work.

People are clamoring for different and more rational pricing. If a managed care payer won't negotiate when the hospital is making reasonable attempts to create a more rational pricing structure, consideration should be given to making this information public. Communities often will stand behind the hospital.

One consideration at the time of contract renegotiation is whether any "do not disclose" language in the contract impedes the provider's ability to be transparent about prices. Some payers feel that the negotiated rates for services are proprietary information, and they prohibit providers from revealing them. However, such provisions may inhibit consumers' ability to compare prices and providers' ability to relate their prices to the marketplace, so it's advisable to eliminate such



contractual restraints. As with all issues regarding pricing, hospitals should work with their legal counsel to ensure their efforts comply with antitrust laws.

Concern: Community reactions and public relations challenges. Providers traditionally have not shared pricing information, but this situation is changing as demands for price transparency increase. According to one rating agency, hospitals will experience the most significant impact from increased transparency because of the administrative and public relations challenges associated with educating consumers and regulators and the need to develop strategies to respond to pricing disclosure.¹⁶

One frequent point of patient frustration is providers' reluctance to commit to a price because of a lack of access to sufficient clinical information. The need to adjust treatment to address unique patient needs does make preservice estimates difficult; however, many

scheduled, nonemergent services are predictable enough that providers can make reasonable estimates to cover costs. So, for example, estimates for a relatively discrete test, such as a mammogram, would be easier to provide than estimates for a complex procedure, such as a mastectomy. To deal with this margin of uncertainty for more complicated procedures, some providers opt to express the estimate as a price range.

Take Action! One of the best courses of action a healthcare provider can take is to establish a frank and ongoing dialogue with its community about pricing systems and the steps the provider is taking to make the situation better. Talking with community stakeholders early and often can help in fostering trust and arriving at win-win solutions. Even if the organization hasn't made substantial pricing changes yet, it's worthwhile to educate various constituents, including consumers, board members, physicians, employees, media, and legislators, about some of the complexities that affect the healthcare financial experience.

The public relations challenge involved in new approaches to pricing must be properly estimated, planned for, and addressed. "Hospitals will need to dedicate time and resources toward educating the community and regulators on pricing and reimbursement and toward developing strategies to comply with and respond to new pricing disclosure and/or regulation," comments Moody's Investors Service.¹⁷

Simple communications initiatives can focus on the following:

- Cost differences in relation to nearby facilities
- Charity care policies and discounts for the uninsured and underinsured
- How healthcare financing works

-
- The “hidden tax” or cost shift that results from Medicare/Medicaid and self-pay shortfalls and its effects on hospital prices
 - The different ways prices are reported (chargemaster, list price, individual estimate) and what can/cannot be learned from them

Early involvement of stakeholders, such as physicians and trustees, as “sounding boards” or sources for information and ideas can be very helpful.

Regardless of whether a hospital has already been able to make improvements to its pricing system, price disclosure is an important way to build community trust. As an illustration, one executive observed that the ways hospitals set prices were much less of a hot-button issue in the community once the state hospital association organized a uniform price reporting mechanism for all hospitals in the state.

While healthcare organizations work to find the best way to present consumers with the most meaningful estimates of financial obligation, another important area of communication concerns providing patients with clear language that explains what a hospital bill does and does not cover. Hospitals whose physicians are independent can provide a price quote only for hospital services. These providers must make it very clear that the bill is for the hospital component only, and that patients will be getting additional bills from other clinicians who participated in the patient’s care.

Health systems with staff physicians often provide convenient, comprehensive bills for all components of the hospital stay, including physician services.

To be effective in communicating value, bundled pricing must include explanatory language so that patients may appropriately compare the bundled price with the lower prices of hospitals that do not include the physician component.

Another way to involve the public in the pricing dialogue is to review proposed price changes with community stakeholders. Again, hospitals should seek input from their legal counsel to ensure these activities comply with antitrust laws. For tips on working with community-based focus groups, see the *Moderator’s Guide for Focus Groups* on the Patient Friendly Billing web site (www.patientfriendlybilling.org). The site also includes tools hospitals can use for communicating pricing and examples of successful pricing communications from other hospitals.

Concern: Coverage of uncompensated care costs.

One thing that distorts charges is the growing proportion of costs for uncompensated care (charity care, bad debt, and government payment shortfalls) that providers try to spread among other healthcare purchasers. As stakeholders strive for more rational pricing systems, hospitals that bear a high proportion of costs associated with providing services chiefly for community benefit may worry that volume will migrate away from the facilities that most need the commercial business to offset mission-related costs.

The urgent issue for federal and state policymakers is to ensure that important but unprofitable services are paid for as prices become more transparent and as informed consumers balk at substantial add-ons to their bills to cover costs not paid by others in the system.

Take Action! While hospitals don't have direct control over adequate government payment and the growing number of uninsured, they still have options:

- Develop a uniform way to calculate the impact of uncompensated costs on individual patient bills as well as payer outlays, so you can express it succinctly both to payers and to policymakers. The more specific you can be about the size of the financing shortfall, the more it will play an important role in the public debate on what should be covered. It's up to the provider community to ensure that any policies that emerge are based on accurate information about these costs. Useful guidance on how to measure and report these numbers is available in HFMA's *Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers*, available at www.hfma.org/ppb15.
- On a similar note, address uncompensated costs specifically in your pricing policy.
- Take advantage of any available state funding pools for uncompensated care, which can reduce the need for cost shifting.
- Seek philanthropic support, such as specific endowment funds, to reduce the impact of uncompensated care.
- Step up efforts to ensure your uninsured patients are enrolled in all available public support programs.

Concern: Technological capabilities and lack of standardization. There are several concerns among healthcare finance executives about technological capabilities. In general, providers and payers use a wide range of IT systems, with differing functionality, data formats, and interoperability. This lack of standardization makes it very difficult to provide healthcare consumers with comparable pricing information.

The most common concern related to IT is about gaining access to real-time insurance eligibility data, which is necessary to equip patients with information related to their financial obligations. Providers need to verify not just insurance coverage, but benefit levels, noncovered services, and responsibility for copayments and deductibles. Obtaining this information electronically from the various payers is often not possible. Even inquiries by telephone may not yield the desired information. For example, although providers may be able to verify that a patient has a deductible at time of service, they often cannot access the data needed to determine the degree to which that deductible has been satisfied.

For consumers to receive real-time information about their financial obligations, insurers must be willing to provide complete information electronically, and provider and payer systems must be compatible. Increased collaboration among providers, insurers, and IT vendors will be needed to ensure full interoperability. Some progress is being made through efforts such as the Council for Affordable Quality Health Care Committee on Operating Rules for Information Exchange, an industrywide initiative to develop operating rules for transmitting eligibility and benefits information, and enactment of administrative simplification requirements of the Health Insurance Portability and Accountability Act of 1996. However, much more work needs to be done to sufficiently align incentives among payers and providers to make standardization a reality.

Another concern is whether systems can change quickly enough. Existing healthcare IT infrastructure has built up over the past three decades based on business-to-business methodologies. Healthcare electronic systems are not adapting as fast as the industry is changing. In other words, figuring out how to fix healthcare pricing systems is just one part of the problem; building the functionality is another huge issue.

AN EXAMPLE OF SUCCESSFUL PRESERVICE ESTIMATES

As 2002 got under way, patient satisfaction scores for Geisinger Health System in central Pennsylvania were below peer norms. Revenues could have been better. Payers were requiring more and more documentation to justify patient services. Where others might have seen cause for discouragement, Geisinger saw opportunity.

“We recognized that we could improve the patient experience while enhancing revenues by reengineering the patient access process,” explains Gregory Snow, Geisinger’s vice president for the revenue cycle. “We saw that we could eliminate the gaps that existed in the financial clearance process, with specific focus on pre-certification and referrals, patient benefit levels, and communication of the patient obligation amount.”

When it comes to estimating patients’ out-of-pocket costs in advance of services, Geisinger has gone about as far as any hospital or health system in the country today. Geisinger’s preservice program, MyVisit,SM with a dedicated staff of 100, serves all inpatients at the health system’s three hospitals, about 80 percent of scheduled outpatients, and 30 percent of patients making office

visits to the system’s 700 physicians. In the first nine months of FY06, Geisinger financially cleared about \$420 million in net revenues, resulting in nearly \$6.7 million in losses avoided or net revenues increased.

Geisinger achieved these results by performing in advance—before patients receive services—functions that historically came at the point of service or later in the revenue cycle, including:

- Registration
- Insurance eligibility checking
- Verification of patient insurance benefit levels
- Precertification
- Medical necessity checking
- Referral authorizations
- Identification and communication of each patient’s out-of-pocket obligation (copayment and deductibles)
- Financial counseling, including payment plans and alternate payment arrangements
- “Special handling” accounts (package pricing)

Source: Rappuhn, T.A., “Advance Estimates: 4 Approaches to Price Transparency in Health Care,” *hfm*, August 2006, pp. 70-78.

STEPS TOWARD A NEW PRICING SYSTEM

The previous section provided steps CFOs can take to mitigate specific barriers that impede changes to the pricing system. Clearly, however, organization-level actions also are important.

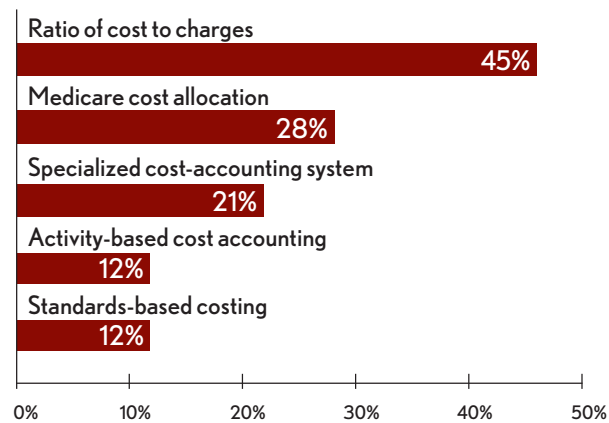
What Can Hospitals Do?

The following are steps that hospitals can take independently to move toward a better pricing system.

Understand cost. Even if a facility predominantly uses market-based methods of price-setting, rational price-setting will require a sound foundation of cost data to ensure prices cover the cost of services rendered.

Some organizations use cost-accounting systems to run detailed information related to actual and incremental costs of each service; other organizations use estimates based on relationships of charges to cost or based on cost proxies, such as an ambulatory payment classification system or relative value unit. According to HFMA research, two cost-accounting methods—ratio of cost to charges and Medicare cost allocation—are used in 73 percent of surveyed organizations.

CURRENT METHODS OF COST ACCOUNTING USED BY HOSPITALS



Source: Patient Friendly Billing Survey, HFMA, March 2007.

Cost per procedure by unit of measure, such as DRG code or APC code, is critical information for a successful pricing strategy. Therefore, hospitals without the current ability to capture and track such information might consider developing and maintaining accurate data on labor, supplies, and other expenses. Hospitals need to know the relationship of cost to charge at the procedure level. "Investment in good cost information can shed insights into how providers can reduce costs, transfer risk, and create more value for the same or even a higher price," suggests one healthcare consultant.¹⁸

Some medical product vendors include strict confidentiality clauses about negotiated prices. Providers are advised to check their purchasing contracts carefully and eliminate such language whenever possible, as such clauses can impede the organization's ability to discuss costs with its physicians and others seeking cost-related information.

Note that caution is needed when making comparisons between hospitals and other industries in terms of the level of sophistication in cost-accounting systems. The level of costing is much more complex in hospitals than it is in most other industries. So, when comparing a \$50 million-a-year hospital with a \$50 million-a-year service firm, one must recognize that the hospital produces literally thousands of different intermediate services, whereas a service firm produces only a limited number of services. In that light, hospitals do a better job of costing than often may appear, given the nature and complexity of their business.

AN EXAMPLE OF SUCCESSFUL PRICE BENCHMARKING

Compare current prices with peers. Healthcare markets are regional, so hospital executives should review competitors' prices using commercially or publicly available databases. Hospitals need to understand how their prices currently compare in the market.

MedPAR discharge data available from CMS include total charges by state and DRG. Medicare cost reports enable hospitals to compare their ratios of charges to cost or cost to charges at a departmental level by state and DRG. Some states offer data sets that enable hospitals to benchmark with competitors individually or by region.

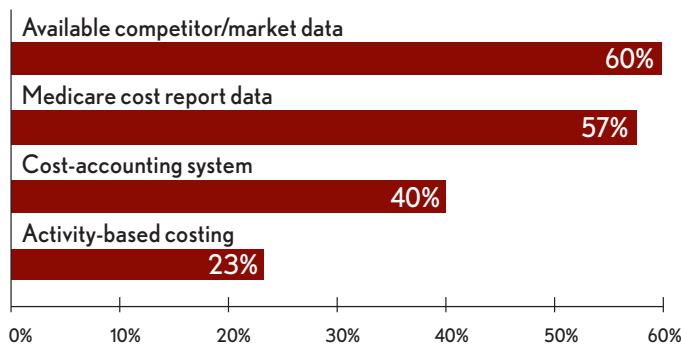
Hospitals responding to the recent Patient Friendly Billing survey cited "available competitor/market data" and "Medicare cost report data" as the most frequently used methods to establish prices. Interestingly, those respondents who indicated they had made "considerable" or "some" progress toward rational, transparent pricing were more likely than others to also include the use of a cost-accounting system or activity-based costing among their most frequently used methods to set prices.

Price modeling at Washoe Health Systems (now Renown Health), Reno, Nev., includes a combination of benchmarking and cost-based analysis, according to Catherine Harris, director, revenue cycle. The benchmarking, which includes MedPAR data, serves to identify areas where the health system may be out of line, either above or below the market average, which then allows the organization to evaluate what charges are appropriate.

"We have looked at certain areas where we might not be capturing all the charges we can to see what kinds of improvements we might be able to make," she explains. "That probably has been a big area of focus for us—going through certain departments and making sure that we're capturing all the charges that are appropriate to bill."

Harris adds that it's difficult to gauge whether the organization's prices are vastly different from those of other hospitals in the market, because the benchmarking data are collective, and individual hospitals don't have access to other hospitals' chargemasters. "I think the real value for us is keeping up with regulatory changes and making sure that when the codes change for certain procedures everything gets changed in our CDM," she says.

MOST FREQUENTLY USED METHODS TO SET PRICES



Note: This figure indicates the most frequently mentioned methods used to set prices by surveyed organizations.

Source: Patient Friendly Billing Survey, HFMA, March 2007.

Source: *Making Prices Make Sense: A Balanced Approach to Defensible Prices*, HFMA educational report, July 2005.

Develop a pricing strategy and structure. Using cost and price data collected, hospitals can determine a rational, competitive pricing structure that will guide redesign and update efforts. Hospital leaders should ask such questions as:

- What are the organization’s overall strategic and financial objectives that will drive the pricing philosophy?
- Where does the organization want to be on the pricing spectrum, both related to individual specialty services and overall in the market? (For example, are you looking to be a high-volume/low-price competitor in X and Y areas in the 50th percentile, or the 80th percentile overall?)
- How should the organization integrate a differential “value pricing” approach, which involves establishing prices based on assessment of the unique value offered by the organization in specific service areas?
- Should the organization consider a “strategic pricing” approach, which involves price increases or decreases for selected services to align rates with both cost and competitive prices?
- What role should cost play in setting prices? When is it appropriate to set a price at, below, or significantly above cost?

- How should the organization implement its approach to pricing? How will the approach be monitored, evaluated, and updated?
- How will the organization spread the costs of uncompensated services, including government shortfalls?

Involving physicians in the development of the pricing philosophy is key. By identifying the required procedures, tests, and supplies, physicians play a significant role in determining the cost of patient care.¹⁹

Plan time to rigorously assess the impact of price changes. Before making major adjustments to prices, hospitals should calculate the impact of various price structure changes, of course. Solid projections using comparative market pricing data and organizational cost data will be needed. Hospitals equipped with high-quality modeling tools will be able to determine where pricing adjustments would—or wouldn’t—be most beneficial, based on payer mix and market constraints. Due to possible effect on volume, price increases cannot be assumed to automatically improve hospital revenue; similarly, price reductions cannot be assumed to automatically reduce hospital revenue.

AN EXAMPLE OF SUCCESSFUL PRICE REBASING

Spectrum Health Hospitals, Grand Rapids, Mich., is passionate about building a better pricing system. As the organization began comparing its prices in the marketplace, leadership discovered that outpatient pricing for things like ambulatory surgery, rehabilitation services, and imaging were significantly above what freestanding peers were charging. Leadership knew it had to lower those prices to be more market-competitive. At the same time, research revealed that room charges to stay in the nursing unit on some floors were not only less than peers, they were less than cost.

Spectrum's finance team began to work on getting the organization's prices in line with costs and the marketplace. "It was a huge effort over months," comments Joseph Fifer, Spectrum's vice president of hospital finance and CFO. "The steps we took were: (1) we made it a priority, (2) we modeled what the impact would be on a pretty specific basis and, (3) we ran model after model until we came up with something that we thought we could live with. Then we implemented it."

When running various pricing models, Spectrum would include market data with its competitors' rates and compare this information with the health system's own cost. Doing so was important to make sure the organization would not lose money if it lowered prices to more competitive rates. If the market rate was less than Spectrum's cost to provide the service, the team considered its options:

- Decide to not price at market
- Change the cost structure
- Accept the shortfall if there were other strategic reasons why these other options weren't acceptable

The payers loved the changes that resulted, since some of their customers had complained about the high prices for outpatient services. The payers also were amenable to raising the inpatient prices to cover costs and mitigate the total impact on the bottom line.

PRICE MODELING TIPS

Ensure patients of limited means are not billed for full charges. In a rational, transparent pricing system, organizations do not expect low-income patients who are uninsured or underinsured to pay more for the cost of care than is paid by commercial insurers or government programs for covered individuals. Best-practice hospitals provide clear, consistent discount policies for this population. Just as with price changes or managed care contracts, these policies must be carefully assessed, and not set arbitrarily, to ensure they are in relation to the actual cost of care and what group purchasers are paying.

In the past, hospitals have expressed concern that discounts for uninsured, self-paying consumers would adversely affect private payer contracts that specified payer rates equal to a hospital's lowest-paying customer.²⁰ Hospitals also have been concerned that such discounts and waiving Medicare copayments for low-income individuals would jeopardize Medicare payments and be judged improper according to fraud and abuse regulations enforced by the Office of the Inspector General. The Department of Health and Human Services has made it clear that hospitals can waive charges and offer discounts to uninsured patients without adversely affecting Medicare payment or violating the rules enforced by the OIG. As a result, according to the recent Patient Friendly Billing survey, 16 percent of hospitals have made "considerable" progress and another 36 percent have made "some" progress in establishing and implementing discount policies for uninsured patients in recent years.

An in-depth discussion of how to develop effective discount policies is featured in the Patient Friendly Billing report *Hospitals Share Insights to Improve Financial Policies for Uninsured and Underinsured Patients* at www.patientfriendlybilling.org.

Modeling techniques vary greatly depending on available resources, the complexity of the organization, and the characteristics of the proposed changes. The following are some key tips to keep in mind:

- Factor in all three components—cost, market data, and payment—when making pricing decisions. Make sure that you are pricing your supplies within a reasonable range of your market.
- Understand your contracts with your managed care payers and how the effect of price changes on those contracts will impact the bottom line.
- Identify your direct costs per procedure in order to know your negotiating points with your managed care contractors.
- Identify market data on a procedural basis, particularly for those procedures that generate 80 percent of revenues.
- Know the relationship of your pricing to your cost to ensure that an item's markup is not out of line, making defense of the price a challenge.
- Perform a market analysis, ideally on an annual basis. Don't let more than two years go by without looking at comparative data.

Even though price modeling is generally done annually, costs for some high-cost medical devices and pharmaceuticals may change much more frequently. So make certain that prices take these frequent (and possibly big) changes into account. Ensure that internal controls can be documented and that compliance issues are covered.

Also, consider technology solutions to the price-modeling scenario. Try to find suppliers that have experience with price modeling in a variety of provider situations and have access to comparative pricing benchmarks.

Source: *Making Prices Make Sense*, HFMA educational report, July 2005.

Simplify and standardize the chargemaster.

A simplified chargemaster will enhance a hospital's ability to post prices and provide patients with accurate and timely information on their financial obligations. Many experts recommend keeping the number of charge codes at a minimum. Steps in ongoing maintenance of chargemasters include:

- Eliminating rarely used or inaccurate codes
- Adding missing charges
- Correcting mismatched current procedural terminology and revenue codes
- Reviewing charges for accurate structure in the ambulatory payment classification environment
- Making sure the chargemaster is compliant with all CMS regulations²¹

While there are no regulations that specifically prohibit having price variances in different departments for the same item, the preferred practice is emerging to standardize pricing throughout the organization. (Note that if a provider's strategy is to price outpatient services lower than comparable inpatient procedures to drive more volume and make the facility more competitive, it is important to model that approach very carefully before implementing. It often doesn't work that way, and the price differentials can cause substantial public relations problems.)

Tools and articles on streamlining the chargemaster are available on HFMA's web site at www.hfma.org/library/revenue/coding/.



A CALL TO ACTION FOR HOSPITAL FINANCIAL LEADERS

Achieving meaningful transformation of the hospital pricing system to facilitate price transparency is a vastly complex endeavor, requiring collaboration among providers, payers, government, employers, and consumers.

Given the complexity of the current hospital pricing system, progress toward a more rational, transparent system may not be as rapid as some stakeholders would wish. However, real progress is being made, and will continue to be made, nationwide in specific improvement initiatives within the hospital's control.

To accelerate this process, providers are encouraged to:

- Act now! Don't wait for others to change—do what you can now to improve your pricing system and patients' ability to understand and compare prices.
- Develop a well-defined, rational, and competitive pricing philosophy, strategy, and structure to guide policy decision-making, redesign, and update efforts.
- Examine approaches that mitigate the impact of pricing changes under Medicare and Medicaid payments and regulations.

- Adopt a pricing strategy or discount policy that makes discounts available for patients of limited means.
- Develop formal, written policies and accountabilities for providing estimates to patients, and be clear about what the estimates do and do not cover.
- Negotiate with insurers to remove contractual barriers to rational pricing methods.
- Simplify and standardize the chargemaster throughout your organization.
- Continually improve your facility's cost-accounting competencies.

As collaborative strategies are identified and implemented to eliminate or reduce the barriers experienced by the relevant stakeholders—providers, payers, employers, government, and consumers—the rate of progress will accelerate. Pricing reform is not negotiable; all stakeholders must make this a priority.

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We provide education, analysis, and guidance; we lead change and innovative thinking; and we create practical tools and solutions that help our members get results. From capital access, to improved patient care, to technology advancement, HFMA is an indispensable resource on healthcare finance issues.

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For more information:

Web: patientfriendlybilling.org

E-mail: info@patientfriendlybilling.org

Phone: (800) 252-4362