As U.S. healthcare providers start to come to terms with the realities of the shift towards pricing transparency, many provider executives—CFOs in particular—are now asking how they can ‘get ahead’ of pricing transparency in order to protect (and possibly even grow) net patient revenues. Those who ignore the influence of pricing transparency on their revenues do so at their own peril.

Pricing transparency matters
When the Centers for Medicare & Medicaid Services (CMS) released the Charge Description Master (CDM) data for the 100 most common Medicare diagnosis-related groups (DRGs) in 2013, it quickly became apparent that there were wide variations in the prices set by providers, even within the same market and catchment area. Many health plans and payers took notice. So did patients.

If this had happened 10 years ago, many providers may not have noticed or, indeed, cared. But since 2006, patient copays and deductibles have skyrocketed from an average of $303 per year to around $1,077 in 2015.1

In part, this is because the so-called “Cadillac Tax” tends to encourage employers to shift more of the cost of insurance to their employees. Medicare patients are also seeing a rise in costs; those using critical access hospitals are expected to pay up to 20 percent of charges in copays.

Patient copays and deductibles have skyrocketed in the last 10 years.

Simply put, price increasingly matters to patients. And the rise in copays and deductibles has led many patients to start to price shop for lower cost (though equal quality) alternatives within their market. It will take some time before the full impact of price shopping on providers’ volumes becomes clear, but anecdotal evidence and our analysis of our clients’ volumes and revenues indicate that the impact is already being felt.

1 Kaiser Family Foundation, 2015
A new market, new challenges

All signs suggest that the shift towards greater pricing transparency is only going to pick up pace. Since CMS’s data release in 2013, more than 17 states have either implemented or proposed their own publicly available databases of prices for the most common in-patient and out-patient procedures.

At the same time, a number of private databases have also popped up. Some, like Aetna’s “Member Payment Estimator” have been available since 2010 and offer details on costs for more than 650 medical tests, procedures, and office visits across the organization’s provider network. The Blues have a universal database that collects data from all Blues plans, allowing members to assess costs across thousands of providers. If you live in a state like Florida, you may have multiple options, including one funded by the state and one provided by the Florida Hospital Association.

The potential impact on patient volumes and revenues should be fairly obvious. Patients are already switching plan providers for better prices—particularly in more commoditized areas such as diagnostic imaging and out-patient procedures—and volumes are dropping as a result. At the same time, health plans and insurers are increasingly using the data to compare pricing in their network ahead of contract negotiations, which, in turn, is putting pressure on charges for services and contract rates.

Patients are already ‘walking across the street’ for better prices – particularly in more commoditized areas such as diagnostic imaging and out-patient procedures.

Go beyond strategic pricing

At KPMG LLP (KPMG), we firmly believe that providers need to reassess their charges and contract rates with an eye on pricing transparency if they hope to remain revenue neutral—or even grow revenues—in the face of increased pricing transparency. This will require providers to go beyond the traditional exercise of Strategic Pricing (a process many providers already conduct annually) to take a more holistic view of their overall pricing strategy that incorporates a much wider set of considerations and variables.

To start, providers will want to identify real trends and changes in their volumes over time, looking at thousands of procedures over a number of years. They should also be looking at past and predicted demographic trends in the catchment area to understand how this is influencing current and future volumes—a drop in the average age within the catchment area, for example, would suggest lower demand for procedures like heart surgery or hip replacements; a shift in the ethnic makeup of a region may portend higher volumes in therapeutic areas such as diabetes or heart disease.

Providers will also want to assess the comparative pricing and claims paid data within their catchment area to assess where the market price sits. There are many available sources that provide charge information, but our experience suggests that the relationship between stated charges and actual claims paid is often tenuous at best, so we often advise providers to focus on claims paid information, which delivers a more realistic view of the actual costs and prices across various types of facilities and procedures.

With all of this information in full view, providers should now be able to start thinking through various charge and contract rate scenarios to ultimately find a balance that protects overall revenues and, where possible, allows for revenue growth. By applying the process to every procedure on the in-patient and out-patient side, providers are then able to develop a CDM that is not only within market on aggregate, but also helps to attract new patients and retain existing volumes.

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3 www.bcbs.com
4 www.floridahealthfinder.gov
**Taking the first steps**

Short of mandating an immediate and wholesome review of the organization’s Strategic Pricing approach, what can provider executives start doing today to prepare for the impact of pricing transparency tomorrow?

First, executives should start familiarizing themselves with their state’s existing pricing transparency rules, and any proposed legislation, to understand how pricing transparency is evolving in their particular markets. Some states have moved slower to legislate databases, so some executives may have a few years before the impacts of pricing transparency fully hit. These organizations would be well served studying the rules in other states (particularly adjacent states) to get ahead of any future legislation in their own markets.

Executives should also be looking at the information that is currently available to patients to assess how they are being portrayed in the market. The reality is that some databases focus on very specific cost and price data but offer little information about the quality of care or recovery times. So a hospital that has exceptional quality and above-market prices will compare unfavorably against a competing facility with low costs but poor outcomes. Understanding how you are being positioned through the databases is key to responding to—or defending—higher than average prices.

Ultimately, however, the best way to start preparing for the impacts of pricing transparency is to integrate it into the Strategic Pricing framework. The bottom line is that Strategic Pricing can no longer be conducted in a vacuum; providers need to also be aware of how their CDMs and contract rates will compare in the eyes of patients and health plans.

The alternative is no alternative at all given falling volumes, pricing pressures from health plans, lower revenues, and growing competition from lower-cost providers. It is essential for those that want to grow their revenues, retain their patients, and enhance their reputations in their markets to start thinking about pricing transparency.

**How KPMG can help**

When we conduct Strategic Pricing exercises for healthcare providers, we always do so with an eye towards pricing transparency. We have the capabilities, the data, and the experience to understand how pricing transparency influences future revenues and our professionals know what it takes to achieve revenue neutrality and—where possible—revenue growth.

Our proprietary Commercial Claims Database, which includes claims information from many of the largest third party payer sources, is one of the three largest sources of claims paid information in the country.

Our process can deliver significant benefits in terms of revenues and competitive positioning. For example, we worked with one large community hospital in the Southeast to help them move their out-patient services from a percent-of-charge reimbursement model to a fixed fee (e.g., grouper) pricing model that included an increase in net patient revenue. Perhaps equally important, the process helped the organization better comply with state pricing transparency regulations, avoid potential losses in patient volume, and align to market pricing.

Our experience suggests that a more robust Strategic Pricing approach with an eye to pricing transparency will also help prepare providers for the introduction of new value-based payment models. Working with a another large Southeast provider, for example, we were able to use the framework to accurately assess potential pricing for a bundled payment approach to major joint repair and compare that against their peers in the market. This allowed them to identify areas for cost management ahead of their eventual switch to value-based payments.

KPMG’s Healthcare and Strategic Pricing professionals go beyond traditional pricing reviews to help clients understand the implications of their decisions and the potential impact of ongoing changes in the marketplace. And that is why leading healthcare providers choose KPMG.
Related links

The Big Data Dividend: Enhancing provider revenues in an era of change – Those providers able to start harnessing the insights from Big Data today will increase their odds of winning population health management contracts with third-party payers in the future.

What Works: Paths to population health – Achieving coordinated and accountable care – Explore the steps health organizations need to consider in order to achieve coordinated care.

A Model for Value: Aligning provider IT organizational models in a value-based world – The most pervasive challenge for providers in the near future may be creating value-based payment models. Beyond ICD-10, Meaningful Use and Electronic Health Record (EHR) integration, all components of a new type of healthcare system, value-based payment is where meaningful, long-term change will be seen.

How does that make you feel? Healthcare providers need new methods to serve empowered consumers and their highly individualized needs – With federal mandates to drive costs down and provide transparency into the connection between services and fees, competition over who will have the opportunity to treat patients is fierce. The simplest way to think about it is that healthcare buyers are now consumers. And consumers are much more powerful than “patients.”

Healthcare 3.0: Prime numbers – Helping organizations unlock the value of big data – Technology will revolutionize healthcare. The question the industry needs to answer is how much of this change is driven by healthcare organizations themselves or other forces.

Gaining an advantage: Joining a Medicare Advantage network may offer providers a stepping stone to risk sharing and value creation – As fee-for-outcomes accelerates, joining Medicare Advantage (MA) networks is one way providers can meet federal mandates. In our newest white paper, Gaining an Advantage, see how MA can help hospitals and individual physicians respond to the “consumerization” of healthcare, improve short- and long-term patient outcomes, and move toward risk-based contracting.

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