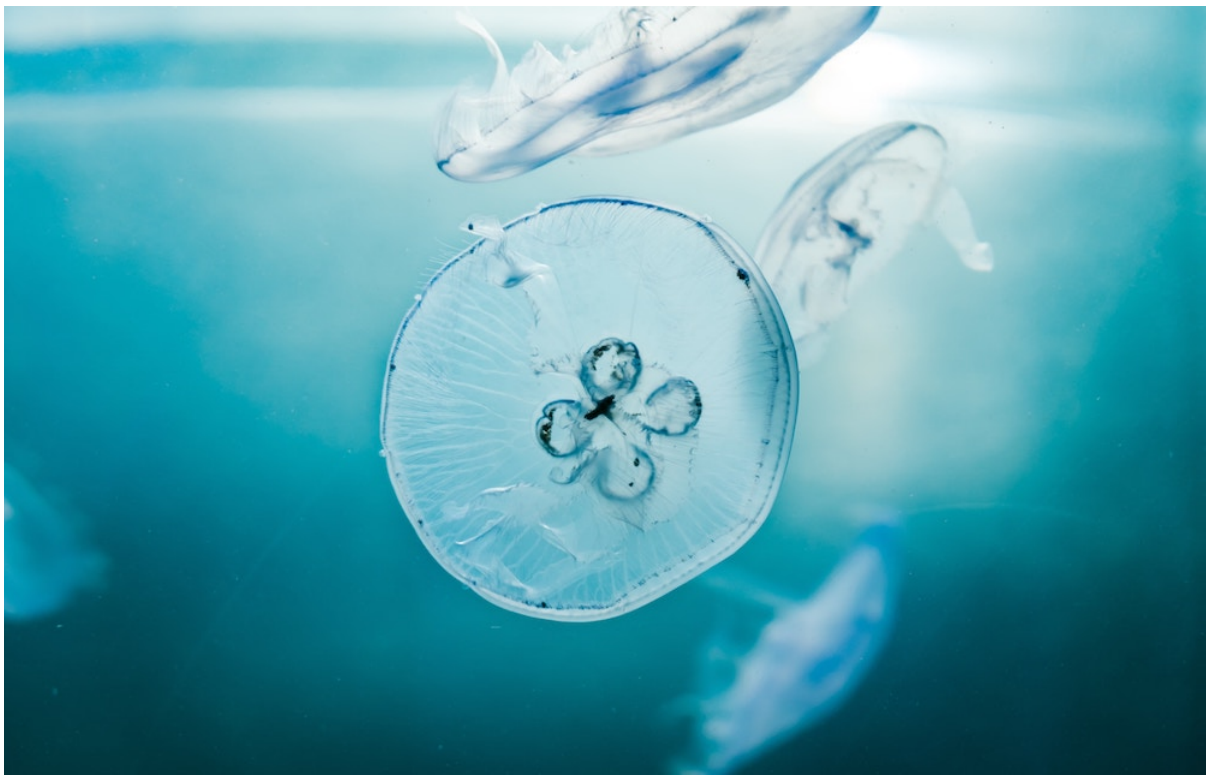
How ACOs Can Leverage Price Transparency To Create Value for Consumers

written by Theresa Hush | August 23, 2018



Health care consumers are being forced to assume a greater

share of costs for treatment. But how can patients determine the value of health care services if they can't compare costs? Lack of price transparency is a major obstacle to value-based medical decisions. In evaluating treatment options or services by different providers, consumers have no reliable means to monetize their choices. They are powerless to do anything about it—as yet. But that may well change as ACOs adapt to downside risk.

Price transparency is a tool that exclusively benefits consumers, because health plans already, obviously, know the prices they negotiated and pay. Now that ACOs are more interested in ensuring market share and patient choice to stay in the network for services, there's an incentive to make real cost information available through cost clarity.

The consumer's relative power is changing because of two current market forces, both of which affect an ACO's total expenses and bottom line. First, the responsibility for health care payment has been shifting increasingly to consumers. Participating providers who don't implement processes to achieve value-based medical decisions for patients may face higher bad debt burdens after they are surprised by costs. Second, as ACOs and other models with financial risk grow—especially in Medicare where patients have free choice of provider—market share will hinge on consumer-focused practices that create trust. Sharing cost information is essential to that concept.

Why Price Transparency Has Been Stymied

Providers have not only failed to supply mechanisms to create cost-awareness; they have also resisted doing so. Why? It's

complicated, as explained below. But the basic truth is that providers are competing and don't want to reveal pricing.

Most providers still consider the health plan, not the consumer, as the purchasing customer. The provider-health plan arrangements create access to patients, and those prices are negotiated individually by insurer and, even, benefit plan. A multi-layered pricing structure combined with the need to protect negotiated prices overwhelms many organizations.

Transparency is also challenging because of multiple billings and providers. It is difficult to always know in advance the consultants, second surgeons and other clinicians who will be required in care. And each of them, in a Fee-for-Service system, may have separate contractual arrangements with health plans that fix their fees. Even if a cost estimate could be made available to patients, the resulting onslaught of multiple bills would be very confusing.

ACOs Are Ripe for Innovative Consumer Initiatives

ACOs will be under more intense pressure to achieve savings, because the alternative—payback of money by providers—will create warfare among participants. ACOs with downside risk will learn quickly to set up plans to lock providers into set-price service packages. Bundled and episodic payments are well suited to this plan, among other changes.

However, the financial model, alone, is not enough to spur change. Clinicians, as well as facilities, are not nimble enough to alter behavior in response to shifting reimbursements, as has been borne out recently.

An ACO will need to create a distinct personality and operational presence to take advantage of the opportunity of market growth. Consumer discovery of a “hidden” ACO identity under which patients are attributed to ACOs without explicit choice, the *modus operandi* of many Medicare ACOs, would create righteous distrust among seniors, and the plan could boomerang.

Providers who lead and form the ACO must facilitate a transition from Fee-for-Service to financial risk *that translates into how both providers and patients experience the health care process.* For providers, ACOs must temper the incentives that value volume of clinical services and their revenue, and increase the value of patient tenure, clinical and patient-reported outcomes, and affordable cost. For patients, this means improving communication and care delivery to meet patient preferences and implementing value-based medical decision processes under guidance by clinicians.

Cost and Expected Outcomes Are the Holy Grail for Patients—But How?

We know that patients want answers, but we aren’t sure exactly what kind. While providers often insist that patients “ask for” services, this could stem from a belief in medical science generally or specific solutions suggested by a provider. We have never studied how and under what conditions patients will decide value.

We do know, however, that three pieces of information determine value of medical services for the purposes of providers, specialty associations and payers. These include (1) effectiveness (i.e., results of effectiveness from randomized trials, which should be expressed in absolute numbers versus

percentage variation; (2) risks of harms, side effects and death; and (3) cost. We can't answer how important it is that these three are connected in a single discussion about the relative merits of various treatment options, but it makes sense to assume that isolating these individual components is not a good basis for medical decisions.

We also see that consumers do not seem to make decisions based on cost alone. That makes sense. Cost of health care is not akin to retail pricing. Consumers know that there is the relationship between who does a procedure, the outcome and the cost. The formula, however, is a mystery. We also know that in the U.S., medical interventions cost more than in other countries, clarifying that one of our problems is, simply, what providers charge.

Providers cite anecdotal cases that consumers do not act according to evidence. But these are headline cases, not proof. Some research has revealed, on the other hand, that patients will cut back on health care based on patient payment responsibility—including much-needed but costly medical treatments. The fact is we lack a reliable process for evaluating clinical effectiveness, risk and cost in a single construct. While cost information is available on some websites, it is independent of discussions with trusted providers.

Guidelines for ACOs to Implement Price Transparency

ACOs are the only provider-led entities charged with simultaneously saving money while providing quality care and good patient experiences. As such, they are uniquely positioned

to experiment to achieve these goals and to include them in a growth initiative. ACOs that can innovate savings through consumer-focused initiatives and decision-making will also build loyalty among patients to ACO providers.

As most ACOs have likely realized, it is not possible to mandate cost reductions in the long run. Any cost savings initiatives must be inspired by collaboration and education, and be of benefit to the participants, whether providers or patients.

Price transparency unlocks the discussion of value with the consumer by acknowledging its importance in the context of effective solutions. A medical treatment of rare effect is less likely to be chosen by someone without means to afford it. While it is possible to make decisions based only on effectiveness and harms, the inability to afford health care is the real reason that many people don't adhere to treatment plans or pursue medical treatment at all.

ACOs intending to implement price transparency for consumers should consider these guidelines:

1. Analyze data to identify your reputational strengths and why patients choose your providers, as well as your cost weaknesses. It will not be possible to create price transparency tools for all services at once. Providers should understand that this is a strategic marketing endeavor, not administrative.

2. Develop your ACO market strategy and the consumer tools you will use. Price transparency must fit into this, not the other

way around. You will then find a pathway to creating the essential group of episodes that will attract consumers. This gives you the means to engage providers in the effort and build the cost distribution formula for bundled services.

3. Choose one of two basic cost basis options for estimates:

   a. Produce estimates based on average Fee-for-Service *totals* for professional, facility and ancillary costs, or use a standardized fee schedule like Medicare to create such total costs; or

   b. Produce estimates based on established episodic payments for all involved providers.

   Using the latter approach requires that ACOs are able to establish episode groups and negotiate episodic payments with insurers, in addition to organizing such terms with groups of providers. The estimates, therefore, reflect such pre-determined charges.

   The episodic payment approach could be extremely attractive to consumers, because it provides a mechanism for comparisons. But that is only if other ACOs or groups provide similar packages. As financial risk moves forward and Medicare implements more episodic payments, we expect such arrangements to become more common.

4. Make prices transparent based on a package of fees that is all-inclusive, and therefore captures all payments. Providers must appreciate the need to facilitate consumers' ability to see full cost without having to anticipate or navigate the

separate clinician services and charges.

5. Carefully construct packages to ensure that consumers understand the limits of estimated costs. If outliers must be specified, they should fall into unusual circumstances, not excessive charges for ordinary or typical services that vary by small degree.

6. Educate providers on what price transparency means, and how you will go about it. They should be able to pull information easily to discuss cost with patients when needed.

7. Market and message price transparency in conjunction with other consumer-focused initiatives. Don’t make consumers ask—broadcast the initiative.

8. Support cost as a component of determining value, not an independent factor, by creating processes for medical decision-making that also focus on benefits and risks or harms to treatments. Patients need standardized informational materials, and clinicians need education—and your organization also needs a process for collecting patient preferences, establishing and choosing among treatments, and capturing results in the EMR.

Price transparency can be a powerful ingredient for building trust with patients, as long as providers are on the same page. For an ACO fighting to distinguish its unique personality, implementing consumer-focused initiatives generally, and price transparency in particular, can be very successful. Perhaps not for the weak-hearted, these initiatives push change in health care beyond comfort levels for some providers. But enrichment of the trust between providers and consumers—including those

who are not yet patients—will create a robust pathway to success.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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