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Crowe RCA benchmarking analysis

Price transparency in healthcare: It won't help hospitals

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Recently enacted price transparency legislation will provide healthcare consumers greater visibility into the actual out-of-pocket costs for their selected treatments. Theoretically, having pricing as a key determinant of a consumer's decision will create broader competition among hospitals – therefore driving down prices in the same way that retail companies compete to attract customers (the "shopping effect"). The federal government's role in this process has been to require hospitals to publish their managed care rates; that is, hospitals must share the actual negotiated reimbursement rate versus their gross charges for a service (which very rarely reflect what is actually paid). What isn't widely discussed is that while price points driving consumer decisions might apply some pressure on healthcare prices, other systemic forces are at play. One less commonly discussed factor in price volatility is the effect of Medicaid reimbursement variability across states.

To further study this topic, Crowe used its proprietary Crowe Revenue Cycle Analytics (Crowe RCA) solution, which captures every patient transaction for nearly 1,500 hospitals and more than 100,000 physicians nationally for purposes of automating hindsight, accounts receivable valuation, and net revenue analyses. Within its benchmarking database, Crowe analyzed a portfolio including 45 states and comprising 707 hospitals within Medicaid-expansion states and 445 hospitals in nonexpansion states, as of 2019. Crowe combines financial transaction information with 835/837 account-level data to produce comparative metrics.

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The real story is cost shifting

Crowe research has found significant variability in outpatient net (per patient) payments that hospitals receive from Medicaid payers across states. In a broad sampling of states, the variability was striking, with payment discrepancies ranging from $200 to $650 per patient in certain outpatient settings. Several factors affect these payment amounts, including acuity, locality adjustments, and types of programs, but one thing is clear: State-run Medicaid programs are not uniform across the country, in process or payment. As such, hospitals in lower-paying Medicaid states must find alternative methods to sustain their financial margin, and one of those options is cost shifting – that is, garnering higher reimbursement from other payers, such as employer-based managed care plans, to offset lower-paying Medicaid rates.

57%

The national average reimbursement of select Medicaid outpatient services, expressed as a percentage of Medicare reimbursement for the same services

240%

The national average reimbursement of select managed care outpatient services, expressed as a percentage of Medicare reimbursement for the same services

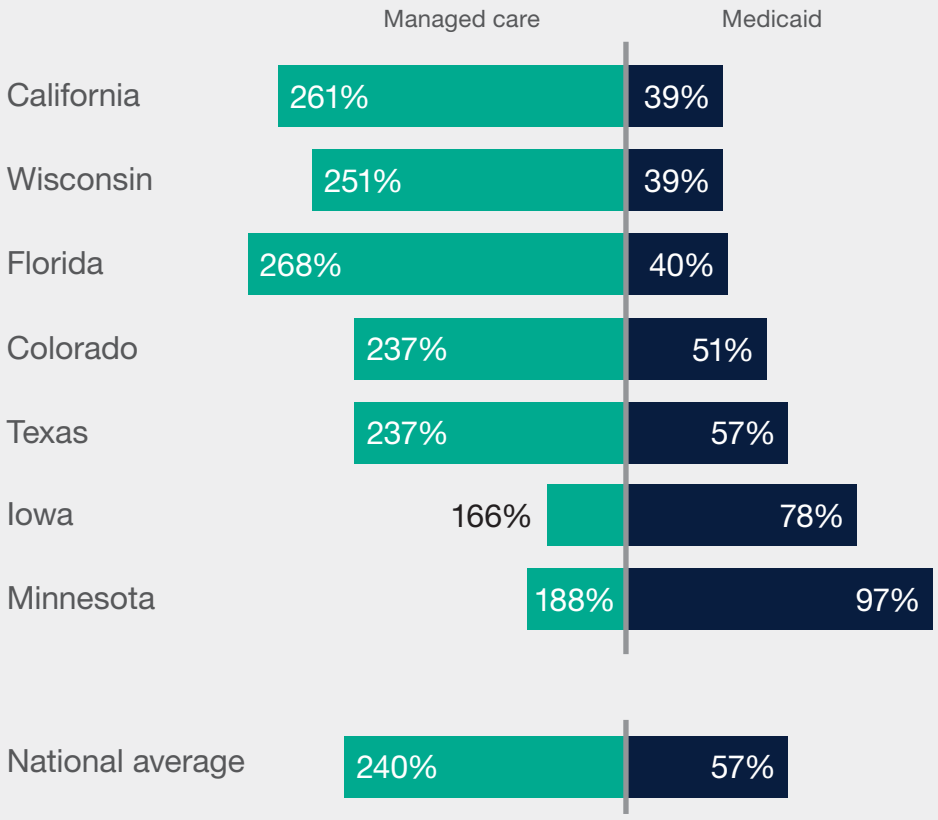
Crowe research revealed a correlation between lower Medicaid per patient rates and higher commercial and managed care per patient rates.

In order to better compare managed care to Medicaid reimbursement across sites in different localities with varied cost of living and other factors that can affect reimbursement, Crowe analyzed average managed care and Medicaid reimbursement by state as a percent of Medicare. These ratios were assessed to determine relative reimbursement differences across the country in our sample.

Overall, Crowe research revealed a correlation between lower state-specific Medicaid reimbursement and higher managed care rates within outpatient services. Based on net revenue information received by Crowe for 2019 dates of service, the average national Medicaid reimbursement for outpatient services is 57% of Medicare rates, and the average managed care reimbursement for outpatient services is 240% of Medicare rates.

The following exhibit shows examples of the state inconsistencies:

Outpatient payment rates as a percentage of Medicare rates



The challenge for hospitals

Cost shifting likely is a tenuous strategy. Price transparency has led to increased precision (and attention) related to every hospital's market position on price. This reduces leverage that some preferred providers might have in managed care negotiations. In addition, as benefit plan designs continue to move to higher out-of-pocket consumer costs, much of the former "shifted" costs have become a patient responsibility, which has been challenging for many hospitals to fully collect. In fact, some hospitals are seeing 10% to 20% increases in bad debt as a likely result of pandemic employment issues.

Price transparency has effectively amplified the discussion on consumer prices and might create some of the desired shopping effect for a limited grouping of outpatient services – although hospital price "shaming" – in which the media calls out hospitals whose pricing appears to be disparate, predatory, or unsupportable – might have a more immediate and negative impact.

10-20%

increases in bad debt as a likely result of pandemic employment issues

Nevertheless, pricing is only one element of a complicated healthcare decision. Other factors include the following:

- **Other consumer considerations.** Quality of care, convenient access to facilities, in-network or out-of-network restrictions, and emergency clinical situations have been traditional determinants of selecting a provider.
- **Other reimbursement methods.** Bundled payment programs and at-risk (for example, capitation or value-based) contracts add layers of price complexity that might not easily be understood by consumers. More hospitals are moving to these models as they further integrate with physicians and ancillary providers.

As managed care reimbursement rates become more available for review, hospitals will need to better explain their rationales for market disparity – and that might reduce their negotiating power with insurance payers. But that doesn't solve for the problem that created cost shifting – that low reimbursement from government programs might not cover the cost of care. Rather than focus primarily on price, we envision a future with a Consumer Reports-style car-buying-guide kind of comparison for hospitals, where many parameters of a decision are graded, and the pricing therefore seems more logical. For example, a luxury SUV costs more than a no-frills sedan model – but differences in factors such as reliability and safety features might support choosing the more expensive option.

Learn more

For more information on the Crowe RCA benchmarking program, please visit crowe.com/benchmarking or contact:

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