

Jamie Cleverley

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closing the price gap for commodity services

The competitive pricing offered by freestanding clinics has many hospitals looking to lower their own prices.

Many hospital administrators are strongly attracted to the idea of lowering prices to compete with freestanding providers, but most have not done so out of a concern for the associated net revenue loss. Although it has been said that the presence of “fixed” payment terms makes pricing a nonissue, the reality is that a significant connection between pricing and payment persists today and would be costly to ignore. To be sure, it’s the reason health care has not seen a wide-spread slashing of prices for hospital-based services across the country.

Nowhere is this connection more evident for administrators than in the area of “commodity” services (e.g., imaging, laboratory, therapy, and surgical service), where freestanding competitors have established lower rates and where patients have increasingly more choices. As patients are

opting for these freestanding facilities for such services, hospital leaders are seeking to respond without incurring a significant financial loss.

A Case for Lower Prices

Although the exact reasons for lowering prices may differ by hospital, many of the driving factors fall into a few key categories.

Volume protection/growth. The exodus of patients in commodity service areas can be very costly, particularly because many of these lost patients have good insurance coverage that helps the hospital offset losses in other service areas. Although some of the volume shift to freestanding providers likely is driven by convenience or physician referral patterns, a number of hospitals report that price also is a significant factor. Because lowering the “list” price (gross charges) helps lower the “net” price (payment) for many patients—especially those with certain types of high-deductible plans—there is a sense that becoming more competitive in pricing will help protect current volume or even permit growth.

Optics. Many administrators express a desire to lower prices to ease the number of questions they encounter regarding list prices. Certainly patients are a significant source of these questions, but

AT A GLANCE

For hospitals seeking to lower prices to compete with freestanding clinics, four steps are imperative to achieving success:

- > Commit to a strategy.
- > Assess pricing relationships.
- > Model the new strategy.
- > Mitigate the financial risks.

physicians increasingly are becoming frustrated with a pricing system that is so disparate from actual payment levels that it has changed referral patterns.

Financial reporting. The growing disparity between list price and net price has reached a critical point for many hospitals. The current deductions percentage (contractual allowances/gross patient revenue) for the hospital industry is 68.6 percent, which means hospitals are collecting in payment about 31 percent of what they charge. Fifteen years ago, each side stood at about 50 percent. There is a growing call to action for many to help

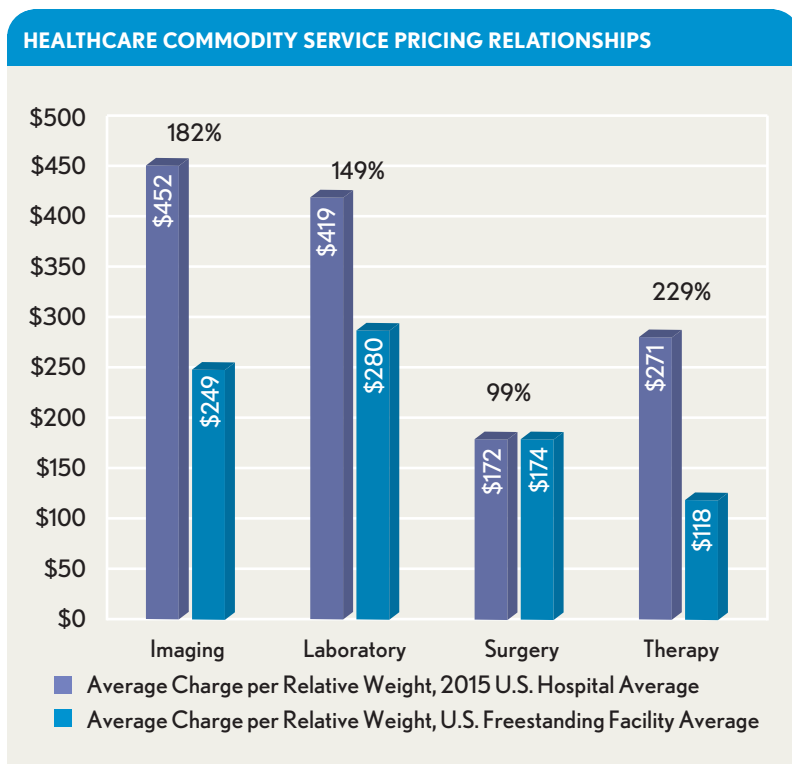
tighten this relationship as there is concern that continued disparity will only add more fuel to the fire for the optics and volume issues.

Regardless of the exact driving factor, responding effectively requires an overall approach perhaps best characterized by four essential actions: commit, assess, model, and mitigate.

Commit

Successful strategies must begin with commitment. If the organization is not fully behind a strategy to lower prices, it simply will not happen. With regard to commodity services, there is clear evidence that a great number of organizations want to change pricing structures in response to the challenges of volume loss and/or patient pushback because of higher rates. In a 2015 survey of 58 hospital executives representing 156 hospitals and health systems, 83 percent of respondents stated that addressing these commodity service pricing issues is of moderate to high concern.³ However, in most organizations, the desire to change confronts obstacles.

A lack of cross-department communication is one such obstacle. Efforts to reduce prices significantly likely will require collaboration among groups that might not have formally defined or well-established relationships. For instance, if contracts must be modified to create desired pricing structures, then the chargemaster team will need to work closely with the managed care team on the impact of term changes to pricing. These conversations can be complicated when the thoughts and terminology of one group do not translate well for the other group. Understanding the need for collaboration and having leadership squarely behind the effort will help the process move forward productively.



Source: Cleverley + Associates

This exhibit shows a comparison of pricing information for key service areas in hospitals versus freestanding facilities using real Medicare claims from 2015. The percentages represent the proportion of the average charge per hospital relative to that for freestanding facilities. From these claims, a charge per ambulatory payment classification (APC) paid weight of 1.0 for each relevant HCPCS code was created, and then related HCPCS codes were grouped together into charge “families.”

a. Houk, S., and Gardner, S., “Insights Into Hospital Retail Pricing Strategies,” *Strategic Financial Planning*, Summer 2015.

SIGNIFICANT SERVICE PRICING CHANGES, 2012-15

	U.S. Hospitals by Rate of Charge Growth				Freestanding Centers
	Lowest Charge Growth	Lower Charge Growth	Higher Charge Growth	Highest Charge Growth	
Emergency Department	-11%	-5%	1%	11%	N/A
Surgical Procedures	-11%	-3%	2%	16%	-9%
Imaging	-13%	-3%	2%	12%	-3%
Laboratory	-10%	-2%	2%	12%	14%
Therapy	-9%	-3%	3%	9%	-4%
Routine Room Rates	-9%	-3%	1%	8%	N/A

Source: Cleverley + Associates

The percentage changes shown in this exhibit are relative to U.S. average. Calculations were performed through an analysis of Medicare claims data from 2012 to 2015. From those years, all U.S. hospitals (excluding critical access facilities) were grouped into quartiles based on their three-year growth rates.

Unrealistic expectations also can stand in the way of progress. The pricing gap between hospitals and freestanding providers did not occur overnight, and it likely will not be resolved quickly either. Hospitals should set realistic goals and allow themselves adequate time to accomplish them.

Assess

After committing to an effort to reduce prices, an organization is ready to determine what prices are appropriate and competitive. A hospital may choose to perform a cost analysis to ensure that pricing and payment structures are appropriate to cover costs of care. The competitiveness question can be addressed through direct comparisons with freestanding providers. Such pricing information for freestanding facilities is not always readily available, but it can be accessed publicly and can provide significant insight into relative price positions. The exhibit on page 2 shows such a comparison, using actual Medicare patient claims from 2015.

What's telling about the information in the exhibit is how close or far current hospital prices are from freestanding facility prices depending on the area of focus. For instance, hospital pricing for therapy services is about 130 percent higher than freestanding facility pricing for such services, whereas pricing for surgery appears to be similar between the two organization types. It should be noted, however, that the surgery comparison could be skewed because many ambulatory surgery centers employ packaged pricing, so the gap is likely larger than these numbers suggest. Laboratory and imaging—among the most important pricing areas for most hospitals—are priced 50 percent and 80 percent higher by hospitals than by freestanding counterparts, respectively. For these two areas, the study presented the following additional interesting highlights.

The difference between hospitals' higher prices and freestanding facilities' lower prices appears to be greater with standard imaging services such as X-rays than with advanced imaging services

such as computed tomography (CT) and magnetic resonance imaging (MRI). One possible explanation could be that the proliferation of outlets—including physician offices—for less complex imaging tests has driven the price lower relative to average hospital rates. And hospitals, with net revenue sensitivity in this area, have been unable to reduce prices without sacrificing payment.

Hospital laboratory rates, in general, appear to be lower than hospital imaging rates in relation to the corresponding rates among freestanding centers. These lower relative rates could be due to payment provisions. If the laboratory is typically paid on a fee schedule (as is the case for many commercial health plans), then rates could be lowered without as much net revenue sensitivity, or they may not have increased as significantly over time because yields were lower. Laboratory prices could be further reduced if commercial health plans were to follow Medicare's payment approach to eliminate separate payment for tests performed with other primary courses of care. Fee-schedule pricing, or pricing that is significantly reduced by packaging, can present *lesser-of* exposure, though, which is discussed below.

growth in charges increased by 12 percent over the national average in the same period. Interestingly, charges for imaging services among freestanding centers decreased by 3 percent—the same percentage change experienced by the quartile of hospitals designated to have lower charge growth. These adjustments mean that half of the hospitals in the United States were able to change prices by at least the same percentage as did freestanding imaging centers, and one-quarter were able to make a significant dent in the price gap.

In the laboratory category, freestanding centers increased their prices significantly relative to the hospital industry average. If this trend continues, there could be a rapid tightening of price differentials between hospitals and freestanding laboratory providers.

The largest area of improvement for hospitals was the aforementioned 13 percent reduction in imaging charges in the quartile with the lowest charge growth. Meanwhile, the highest increase in charges relative to the U.S. average occurred, as one might expect, among hospitals in the quartile with highest charge growth, with a 16 percent increase in charges for surgical procedures.

The landscape is changing, and quickly. In creating price strategy, it's important to recognize where those changes are taking place to ensure the hospital's pricing structure is keeping pace with market dynamics.

Model

Having completed the benchmarking assessment, hospitals next should determine the financial impact from hitting certain price points for commodity services by modeling pricing changes against a detailed claims data set and payment terms. This can be an intricate and challenging process, however, and it presents the following key considerations.

Whatever the solution, the organization must ensure that the billing system can support it.

Trends in pricing also are a key element to research and understand. The exhibit on page 41 represents a summary of pricing changes relative to the U.S. hospital average by key service area. To illustrate, the imaging price position for the hospital quartile with the lowest charge growth declined by 13 percent relative to the U.S. average for imaging services during the period of study. Conversely, imaging rates in the quartile with the highest

Claim payment status changes. Payment can change at different levels of pricing because of factors related to *outlier* status (claim charges exceed a threshold amount set by a health plan, creating a situation where the claim is paid based on charges rather than a fixed rate) and *lesser-of* status (claim charges are below a threshold amount set by a health plan, creating a situation where the claim is paid on charges rather than a fixed rate).

An outlier claim could be paid at a percentage of charge and then shift to fixed payment rates with a reduction in pricing. Moreover, most contracts have lesser-of provisions, which can have a significant impact on price reduction strategies. In fact, many providers try vigorously to avoid situations where pricing changes could result in lost revenue through lesser-of provisions.^b

However, finding the threshold where lesser-of loss can be avoided is not easy because under most contracts, lesser-of situations are evaluated on an aggregate basis, where claim charges are summed and compared against the sum of all claim payment. This practice creates a situation where each lesser-of claim is unique in the combination of codes exposed. Consider a health plan that has an established case rate for emergency visits with an aggregate lesser-of provision. In one example, a patient could receive some imaging and surgical services in conjunction with the emergency visit, where another primarily has lab tests performed. Clearly, a focus on pricing reduction to laboratory or imaging could alter payment if the reduction causes those claims to fall below the emergency case payment amount. In a lesser-of environment, it may be necessary to shift charges to balance reductions in some areas with increases in others to mitigate significant revenue changes.

b. Cleverley, J., and Handlon, L., "The 'Lesser of' Conundrum: Solving the Puzzle Through Payment Terms and the Chargemas-ter," *Strategic Financial Planning*, Fall 2015.

Measured action in assessing price variation and modeling and mitigating payment changes can keep the organization on solid financial ground while enhancing its competitive position in key service areas.

Application of new pricing according to patient type.

Healthcare organizations also should determine which patients should receive the new lower rate—i.e., whether it should be all patients, only outpatients, or possibly the subset of outpatients who are most like the patients visiting the freestanding facilities (typically, nonemergency outpatients). Modeling likely will be needed to support this determination. Whatever the solution, the organization also must ensure that the billing system can support it. Typically, the more granular the application, the more difficult the implementation.

Creating dual-pricing structures introduces compliance risks that have prompted some discussion, as well. Specifically, healthcare finance experts point to two sections of the Medicare Provider Reimbursement Manual (Pub-15) as offering reasons to avoid separate pricing structures based on patient type: Section 2202.4 (i.e., that charges should be related to cost and applied uniformly to inpatients and outpatients) and Section 2203 (i.e., that Medicare charges should be the same as charges to non-Medicare patients).

For organizations that adopt such a structure, however, two primary factors are referenced that

CASE STUDY: ADVANCED IMAGING PRICE REDUCTION MODELING

Service (Code Group)	Recovery Percentage	Original Charges	Scenario 1			Scenario 2		
			Percentage Change	Incremental Charges	Incremental Profit	Percentage Change	Incremental Charges	Incremental Profit
Advanced Imaging: CT/CTA Scan, Brain/Head/Neck	8.26%	\$29,913,063	-12.00%	-\$3,589,568	-\$296,558	-20.00%	-\$5,982,613	-\$494,264
Advanced Imaging: CT/CTA Scan, Other	9.94%	\$117,267,416	-12.00%	-\$14,072,090	-\$1,398,466	-20.00%	-\$23,453,483	-\$2,330,776
Advanced Imaging: MRI/MRA, Brain/Head/Neck	11.95%	\$52,189,512	-5.00%	-\$2,609,476	-\$311,899	0.00%	0	0
Advanced Imaging: MRI/MRA, Other	12.18%	\$84,098,870	-5.00%	-\$4,204,944	-\$512,073	0.00%	0	0
Emergency Department	10.27%	\$90,018,779	5.00%	\$4,500,939	462,246	5.00%	\$4,500,939	\$462,246
Surgery	11.31%	\$443,820,389	5.00%	\$22,191,019	\$2,508,899	5.00%	\$22,191,019	\$2,508,899
Total		\$817,308,029	0.27%	\$2,215,882	\$452,149	-0.34%	-\$2,744,137	\$146,105

allow for the possibility of compliant dual pricing. The first is that there is a cost difference to provide services to inpatients and outpatients. That lower cost structure of outpatient services can be passed on to those patients through reduced prices. Second, so long as all patients receive the lower outpatient price, regardless of health plan or government payer, an organization should not have a compliance issue. Although each organization should closely review this matter, many organizations already seem to have concluded that it does not raise any compliance concerns. Further, such structures have been in place for some time at many organizations without recourse or official comment from the Centers for Medicare & Medicaid Services.

The exhibit above presents a case study analysis in which an organization sought to reduce charges in advanced imaging areas while offsetting the changes to ensure its gross charges would remain unaffected. Reductions in imaging charges were backfilled with increases to charges for emergency and surgical services. The organization did not want to create a dual-pricing structure, so imaging charge reductions were applied to both inpatient and outpatient areas.

Management focused on two key scenarios: a reduction in CT and MRI charges, and no change to MRI charges with a more significant reduction to CT charges. Under both scenarios, the hospital would be able to keep its gross charges relatively

neutral, while producing a small amount of additional net revenue from the higher rates of recovery in the emergency department and surgical units compared with CT.^c Armed with information along the lines of what is shown in the exhibit, management was able to select the scenario that best fit the organization's needs.

For many that set out on a path to reduce commodity service pricing, the solution found through modeling results in a phased approach, where pricing changes are projected to be implemented over several years. In the case example, even a 20 percent reduction would not lower gross charges to freestanding levels but certainly would help close the gap. Selecting a service line to focus on can minimize the impact and allow the organization to measure whether the lowered pricing structure is helping with patient volume trends.

Mitigate

The final point of consideration is financial mitigation. In the case example, the management team had two options to neutralize the impact of reductions to advanced imaging charges. However, both options included charge-shifting to surgery and emergency services. As a counter approach to charge-shifting, however, the team might have considered payment-term-shifting, where the effects of the net revenue loss would be diminished by changing payment terms. The information in the exhibit on page 6 can be

c. Recovery here refers to the change in net revenue that results from a change in gross charges based on the payer mix and payer terms for those services. Health plans that have terms that are charge-based—either through straight discount percentages or outlier/lesser-of provisions—will have positive recovery. The higher the recovery, the greater the net revenue sensitivity to making pricing changes. In the example, MRI has the highest recovery rates among the areas listed because of the payment provisions (more charge-based terms for this area) and payer mix (less government patients where rates are fixed).

separated into government payer and health plan categories to determine which are the biggest contributors to the net revenue impact. These areas then can be pinpointed in health plan negotiations to mitigate the impact of the price change. A combination of redistributing charges and payment terms might be necessary to accommodate the charge strategy's objectives; however, the right data can provide the path to success.

Certainly, the task of closing the pricing gap with freestanding providers can seem daunting. National data suggest, however, that many hospitals are committing to more competitive pricing structures in commodity areas. And as more hospitals evaluate these decisions, the need for a strategy to address the issue of pricing becomes imperative. Although a hospital may not be able to close the price gap quickly, measured action in assessing price variation and modeling and mitigating payment changes can keep the organization on solid financial ground while enhancing its competitive position in key service areas.

Armed with better pricing and mindful of net revenue, hospitals electing to develop and implement such strategies could very well emerge as market leaders in a changing competitive landscape. ■

About the author



Jamie Cleverley, MHA, is president, Cleverley + Associates, Worthington, Ohio. (jcleverley@cleverleyassociates.com)