FEATURE STORY

REPRINT October 2015

hfm
healthcare financial management association hfma.org

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pricing commodity outpatient procedures
assessing the impact

Hospital executives are facing unrelenting pressure to reduce prices and payments for outpatient services, which have begun to be viewed as commodities. Here are five components of a thoughtful strategy.

AT A GLANCE

Hospitals should carefully consider all relevant factors before choosing to lower prices and payments for certain outpatient commodity services in an effort to remain competitive in their market. Key steps to take in the evaluation process include:

- Determining current profitability
- Assessing profitability by payer class
- Understanding overall cost positions
- Assessing the relative payment terms of current commercial contracts
- Determining the net revenue effect of proposed changes

In the past five years, managed care payers have been pressuring urban and many rural hospitals to lower outpatient prices by threatening to divert their beneficiaries to lower-cost freestanding providers. These efforts have mostly focused on three types of outpatient services or products that are beginning to be perceived as commodities: surgery, imaging, and lab. With commodity products, each unit is perceived to be identical, regardless of who produces it. In the absence of product differentiation, providers of commodity products are usually "price takers," meaning they have little control over their pricing.

A dilemma facing many hospitals is the level of profitability in the delivery of outpatient services. Commercial margins for outpatient procedures are usually substantially higher in many of these commodity service areas, and reductions in profit may create significant financial pressure on hospitals where overall margins are usually razor thin. Medicare payment is an exception to this rule because margins for outpatient services are usually lower than for inpatient service margins. The Medicare Payment Advisory Commission estimated that the Medicare outpatient margin was −11.2 percent in 2012, compared with an inpatient margin of −4.4 percent.

Hospitals have a limited number of strategies for dealing with increasing price pressure in outpatient commodity areas. One approach is to exit the market completely and leave the business to the remaining providers. Many hospitals have abandoned minor outpatient surgery departments to physician-owned surgery centers, for example. Alternatively, hospitals can try to establish enhanced product differentiation (e.g., higher perceived quality) that may enable them to maintain higher pricing.

Finally, as illustrated by the following case study, hospitals can consider lowering their prices and payments for selected outpatient commodity services to levels at which they can remain competitive and retain market share.

Case Hospital: Background

"Case Hospital" is an actual, medium-size acute care hospital operating in a midsized combined statistical area (CSA). The economy in the area is healthy, with a blend of manufacturing and service industries. The hospital is smaller than several others in the CSA but has been able to retain market share for most inpatient acute care services.

Case Hospital has experienced market-share erosion for many of its outpatient procedures, however. Operating margins have been falling during the last four years, which management believes is caused by declining volume in ambulatory procedures—especially surgery, imaging, and laboratory.

Hospital leaders have a fairly simple objective: They would like to dramatically reduce prices and payment terms for many of the ambulatory products that they believe have become commodities. However, they also need to maintain their operating margins. They realize achieving both of these goals may not be feasible in the short term, and instead may require several years and significant revisions to payer contracts.

Five Steps to an Informed Decision

To make informed decisions with respect to price/payment changes, Case Hospital leaders take the following five steps.

Determine current profitability. Before considering any specific actions with respect to price changes or contract revisions, it is important to have a clear understanding of the current levels and sources of profitability. Hospitals with low or negative margins may not be in a position to absorb major reductions in prices or payment without a clear expectation of increased volumes. Conversely, hospitals with above-average margins may be able to operate with sizable reductions in price or payment for a prolonged period of time, enabling them to drive some freestanding providers out of the market.

As shown in the exhibit at left, Case Hospital is experiencing a sizable loss on inpatient care (–29.2 percent operating margin). Outpatient operations have a positive operating margin, but that level of profitability is not enough to offset the large inpatient operating loss.

The major takeaway from this initial analysis is that any reduction in outpatient margins resulting from price or contract changes could be catastrophic unless sizable improvement in inpatient operating margins can be realized or a large increase in outpatient volume occurs. Improvement in inpatient margins is possible only if a

A SNAPSHOT OF CASE HOSPITAL'S PROFITABILITY

	Inpatient	Outpatient	Total
Gross revenues	$168,284	$193,975	$362,258
Less allowances	$113,717	$145,413	$259,129
Payment	$54,567	$48,562	$103,129
Cost	$70,505	$42,152	$112,658
Profit	$(15,938)	$6,410	$(9,529)
Operating margin %	-29.20%	13.20%	-9.20%

Source: Cleverley & Associates. Used with permission. Data from an actual hospital client.

Despite profitable outpatient operations, the hospital is in the red due to a large inpatient operating loss.

reduction in cost or a change in contract payment terms can be made.

Assess profitability by payer class. The second step is to analyze the specific sources of loss or profit by payer. If a hospital is realizing positive margins from its government payers—such as Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services—price reductions should not affect margins in these areas and could provide a cushion of profit stability. Conversely, low margins in existing commercial business could prevent a hospital from making further price or payment reductions in commercial lines because there is no cushion of existing profitability.

The exhibit at right shows Case Hospital's losses and profits by payer. In addition to large losses in charity and self-pay care, the hospital is losing $9.8 million on inpatient care for Medicare and Medicaid patients. Plus, inpatient commercial margins are very small, at 4.3 percent, possibly because of unfavorable commercial payment terms for inpatient care, very high costs, or some combination of both. Because the margin on Medicare inpatient business is so negative (–23.5 percent, compared with the U.S. norm of –4.4 percent), higher costs may be a key factor.

The largest source of Case Hospital's profit is derived from commercial outpatient areas ($14.8 million), which have a very high margin of 51.2 percent. Commercial outpatient payments are most likely very favorable, and making payment reductions in these areas would be costly. However, there is a positive margin to absorb some reductions.

Understand overall cost positions. Before making price or payment reductions, a clear understanding of the hospital's cost structure must be known. Price or payment reductions in areas where costs already are low may not be a wise strategic move because sizable profit losses may result. Conversely, price or payment reductions in areas where costs are high may be made with less negative impact if cost reductions are possible.

CASE HOSPITAL'S LOSSES AND PROFITS BY PAYER

		Payment	Cost	Profit	Margin
Commercial	Inpatient	$14,174	$13,564	$610	4.3%
	Outpatient	$28,807	$14,053	$14,754	51.2%
	Total	$42,981	$27,617	$15,364	35.7%
Medicare	Inpatient	$29,748	$36,742	$(6,995)	–23.5%
	Outpatient	$9,277	$12,138	$(2,860)	–30.8%
	Total	$39,025	$48,880	$(9,855)	–25.3%
Medicaid	Inpatient	$7,652	$10,478	$(2,826)	–36.9%
	Outpatient	$5,932	$5,418	$513	8.7%
	Total	$13,584	$15,897	$(2,313)	–17.0%
Charity/ self-pay	Inpatient	$16	$6,025	$(6,009)	–37,145.5%
	Outpatient	$292	$5,482	$(5,190)	–1,778.0%
	Total	$308	$11,507	$(11,199)	–3,635.3%
Workers compensation	Inpatient	$359	$245	$113	31.6%
	Outpatient	$440	$407	$33	7.4%
	Total	$798	$652	$146	18.3%
CHAMPUS/ Tricare/VA	Inpatient	$2,618	$3,450	$(832)	–31.8%
	Outpatient	$3,815	$4,655	$(841)	–22.0%
	Total	$6,432	$8,105	$(1,673)	–26.0%
Total		**$103,129**	**$112,658**	**$(9,529)**	**–9.2%**

Source: Cleverley & Associates. Used with permission. Data from an actual hospital client.

Commercial payments for outpatient services bring in the most profit for Case Hospital, while government payments for all services represent a loss.

We used the Hospital Cost Index® metric to assess overall cost positions at Case Hospital (see the exhibit below). This analysis shows that Case Hospital's inpatient cost structure is high

CASE HOSPITAL'S COST POSITION

Measure	Case Hospital	Local Peer A	U.S. Average
Inpatient Cost Index	112.51	82.39	100.00
Outpatient Cost Index	86.46	84.41	100.04
Hospital Cost Index®	99.02	83.16	101.13

Source: Cleverley & Associates. Used with permission. Data from an actual hospital client.

Case Hospital's inpatient cost structure is 12.5 percent above the U.S. average and 30 percent above its primary local peer.

CASE HOSPITAL'S TOP 5 PROFITABLE APCs

Ambulatory Payment Classification (APC) Title	Dollars in Thousands			Margin %
	Costs	Payment	Profit	
Lower gastrointestinal (GI) endoscopy	$1,960.9	$4,273.0	$2,312.1	54.1%
Combined abdomen and pelvis CT with contrast	$771.8	$1,550.9	$779.1	50.2%
Level III nerve injections	$302.8	$737.6	$434.8	58.9%
Combined abdomen and pelvis CT without contrast	$572.4	$962.6	$390.2	40.5%
Level I upper GI procedures	$563.4	$950.5	$387.2	40.7%
Total top five outpatient procedures	$4,171.3	$8,475.6	$4,303.4	50.8%
Total all outpatient procedures	$42,152.4	$48,562.2	$6,409.8	13.2%

Source: Cleverley & Associates. Used with permission. Data from an actual hospital client.

Together the top five profitable APCs account for 67 percent of all outpatient profit, but only 17.5 percent of total payment.

compared with the U.S. average and its primary local peer, while its outpatient cost structure is competitive. If Case Hospital had an inpatient cost structure similar to its local peer, it would have shown a small but positive margin on inpatient business.

The major takeaway from this analysis is that Case Hospital should explore the reasons why its inpatient costs are so high, relatively speaking. Much of this cost difference may be related to intensity-of-service issues (e.g., longer lengths of stay and greater use of ancillary services, high-cost supplies, and pharmacy).

Assess the relative payment terms of current commercial contracts. The last step before committing to make price or payment reductions is to analyze specific payment terms in existing commercial contracts. This is an important prelude to identifying specific price or contract changes.

Case Hospital's 10 major commercial contracts have widely varying payment terms. On the inpatient side, eight of the 10 plans pay on an MS-DRG base case rate. The range of payment runs from $5,500 to $12,000 for an MS-DRG base weight of 1.0. The two other plans pay on a percent-of-charge basis at either 90 or 92 percent.

As expected, higher payment rates drive inpatient profit. There are separate, per diem-based payment rates for psychiatric and rehab care and a separate case rate for obstetric care. We noticed that the two largest MS-DRG loss areas were psychoses and alcohol and drug abuse. These two areas together lost $4.1 million, with much of the loss related to Medicaid and indigent care.

With respect to outpatient payment terms, there was a larger presence of percentage-of-charge payment, but most of the larger plans still paid on a fee basis. All fee-based contracts had "lesser-than" provisions, which specify that if actual charges are below fee-based payment schedules, the actual charges will be paid (and not the fee schedule). These provisions became a serious problem when specific price reductions were tested.

To review outpatient product profitability, we used a grouping methodology and identified the five most profitable ambulatory payment classifications (APCs) for Case Hospital (see the exhibit above). The hospital has large volumes and high existing margins in endoscopic and imaging services. Yet competitive pricing pressure is most acute from freestanding endoscopy surgery centers and CT/MRI imaging centers.

Determine the net revenue effect of proposed changes. The initial proposal called for the creation of separate outpatient charge codes that would be used in all "scheduled" outpatient procedures. The initial price strategy was simple to understand: Reduce outpatient surgery rates by 50 percent, and set all imaging and lab procedures at three times the current Medicare fee or APC schedule where a fee could be identified. If no fee existed, then reduce the price for the outpatient procedure by 50 percent.

The initial impact resulted in an $81.5 million reduction in gross charges, a 22.6 percent drop. A key question remained regarding the expected impact on net revenues, given the large percentage of business that was fee-based and not percentage-of-charge paid.

Initial projections showed a net revenue reduction of $7.3 million. Without any cost reduction, operating losses would increase from $9.5 million to a projected $16.8 million. The loss was entirely concentrated in outpatient procedures because inpatient prices were not changed.

The five APCs with the largest reduction in payment and, therefore, the largest reduction in profit are shown in the exhibit below. Approximately 45 percent of the reduction in payment was concentrated in five procedures.

Also shown is the ratio of the change in profit to the change in charges. Larger values imply greater sensitivity to price change. The unusually large values for gastrointestinal (GI) procedures (31 percent for lower GI endoscopy) indicated that a large amount of the decrease in payment revenue was related to price.

At first glance, this seemed unusual because only two relatively small commercial payers have percentage-of-charge payment arrangements for outpatient surgery. A review of the individual payer/APC profiles showed that 70 percent of the $1.3 million reduction in payment was associated with one payer. That payer had a fee schedule for outpatient surgery, and most GI procedures had a current fee of $3,875, with a lesser-than provision.

The initial average charge for a lower GI endoscopy was $4,191, which was slightly above the fee schedule. But that charge fell to $2,251 with the proposed price change, making most of the claims for this payer subject to the lesser-than provision. Lesser-than provision impacts were experienced in other areas and for other payers—and accounted for more than 50 percent of the total decrease in payment revenue.

The magnitude of the projected loss was too large, and Case Hospital leaders did not anticipate being able to offset much of the loss with volume increases. Leaders decided to test smaller reductions in outpatient prices while increasing their focus on inpatient cost reduction.

NET EFFECT OF PROPOSED CHANGES TO CASE HOSPITAL'S CHARGES/PAYMENTS

	Dollars in Thousands				
Ambulatory Payment Classification (APC) Title	**Change in Charges**	**Change in Payment**	**Total Proposed Profit**	**Original Profit**	**Profit Change to Charge Change**
Lower gastrointestinal endoscopy	$(4,179)	$(1,315)	$997	$2,312	31%
Level 3 type A emergency visits	$(8,226)	$(849)	$(563)	$286	10%
Combined abdomen and pelvis CT with contrast	$(7,715)	$(528)	$251	$779	7%
Level 4 type A emergency visits	$(6,011)	$(334)	$(504)	$(170)	6%
Combined abdomen and pelvis CT without contrast	$(5,678)	$(304)	$87	$390	5%
Five largest loss changes	$(31,809)	$(3,330)	$267	$3,597	10%
Total	$(81,448)	$(7,323)	$(913)	$6,410	9%

Source: Cleverley & Associates. Used with permission. Data from an actual hospital client.

Case Hospital leaders wanted to dramatically reduce charges and payment terms for commodity outpatient products. An analysis showed that approximately 45 percent of the payment reduction would be concentrated in five procedures.

The Impact of Lesser-Than

Increasingly, many hospitals are considering either lowering their prices for outpatient procedures or negotiating contract changes to reduce payment levels to enhance their competitive position relative to freestanding providers. Price reduction has been viewed by many as a no-consequence strategy because only a small percentage of the payers make payment on a percentage-of-charge basis.

The case example demonstrates that a sizable negative impact can still result because of lesser-than provisions, which are present in many commercial contracts. Hospitals exploring price reductions for outpatient commodity services should proceed carefully and use the five analytical steps identified in this article to ensure they make sound strategic decisions. ■

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