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Identifying the Gap Between Hospital and Free-Standing Prices

By Jamie Cleverley

Commodity services such as imaging and lab work are often considered for reduced pricing.

Do you have special “retail” prices for certain procedures that help you compete with free-standing providers? If you do, you have lots of company. In our firm’s recent survey answered by 58 healthcare financial executives representing 150 hospitals and health systems, approximately one-third of respondents have created separate pricing structures in their chargemasters to compete with free-standing providers. Those “retail” or outpatient-oriented rates are intended to be much lower than the standard or inpatient rate to mitigate volume migration from the hospital.

Most hospital executives experimenting with this strategy have two questions: “How much lower do I need to go to be competitive?” and “How much will it cost me?” We researched these questions and provide our approach and findings below.

The Pricing Gap

Although lower prices for all services are a goal for many hospital executives, when pressed for specific areas of concern, most point to services that are deemed to be more of a commodity. Typically, those services fall into two primary areas: imaging and lab. The commodity designation has evolved as free-standing providers—those facilities that are typically not a part of a hospital-anchored health system and that focus on a specific service—have emerged.



With lower costs and different payment terms, these providers have been able to establish reduced prices that have lured many patients away from the hospital. The idea among many hospital providers has been to create retail-oriented rates specifically for these commodity services to help bring patients back—or keep them from going if they haven’t already left.

Compliance Considerations

There has been some discussion of the “compliance” risks of lower pricing for outpatient services versus inpatient services. Specifically, individuals point to Medicare Provider Reimbursement Manual (Pub-15), section 2202.4, which defines charges as “the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.”

Price structure appropriateness may be determined by cost analysis, and competitiveness typically is determined by direct comparisons to free-standing providers.

Furthermore, Section 2203 describes the consistency of pricing across settings for the hospital and associated sub-providers, while 2204 specifies that “the Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS [Civilian Health and Medical Program of the Uniformed Services], private insurance, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service.” These provisions have caused many to steer clear of creating separate pricing structures based on patient type.

Hospital Prices as a Percentage of Free-Standing Imaging Prices

National average hospital charges for imaging services outpace those charged by free-standing providers.

Standard imaging – nuclear medicine	308%
Standard imaging – breast/chest	202%
Standard imaging – musculoskeletal	298%
Standard imaging – other	185%
Advanced imaging – CT/CTA scan brain/head/neck	249%
Advanced imaging – CT/CTA scan other	235%
Advanced imaging – MRI/MRA brain/head/neck	180%
Advanced imaging – MRI/MRA other	170%
Echography/ultrasonography – cardiac/carotid arteries	292%
Echography/ultrasonography – other	256%

Note: A value of 100 percent signifies that the prices are equivalent, while a value of 200 percent would imply that the average hospital price is twice as high.

Key:
 CT = Computed tomography
 CTA = Computed tomography angiography
 MRA = Magnetic resonance angiogram
 MRI = Magnetic resonance imaging

Source: Cleverley + Associates, Worthington, Ohio. Used with permission.

However, hospital executives who choose to create separate prices point to two primary elements that they believe make dual pricing compliant. The first is that there is a cost difference to provide services to inpatients versus outpatients. That lower outpatient cost structure can be passed on to those patients through the form of reduced prices. Furthermore, so long as that lower outpatient price is charged to all patients (e.g., Medicare, commercial) there is no issue.

While this matter should be reviewed by each organization, many hospitals and health systems are concluding that creating separate prices is compliant. In addition, these different structures have been in place for quite some time at many organizations without recourse or official comment from the Centers for Medicare and Medicaid Services.

Pricing Comparisons

After deciding to evaluate or implement an outpatient pricing structure, the

natural next step is to determine what price is appropriate and competitive. Appropriateness may be determined by cost analysis, and “competitiveness” typically is determined by direct comparisons to free-standing providers. For this article, we used Medicare patient claims from 2015 to evaluate the pricing differences between hospitals and free-standing providers. From these claims, we created a charge per ambulatory payment classification (APC) paid weight of 1.0 for each relevant HCPCS code and then grouped related HCPCS codes together into charge “families” to evaluate pricing comparisons for key service areas. Because the primary focus in the commodity area is imaging and lab, we focused our attention on the pricing gaps for these areas.

We created two primary charts—one for imaging areas (see the exhibit above) and one for lab (see the exhibit on page 3)—that show the national average hospital charge per relative weight stated as a percentage of the national average free-standing

provider charge per relative weight. A value of 100 percent would imply that the prices are equivalent, while a value of 200 percent would imply that the average hospital price is twice as high.

The imaging results show that average hospital prices range from 70 percent higher (magnetic resonance imaging [MRI]/magnetic resonance angiogram [MRA] other) to 208 percent higher (nuclear medicine) than the average prices at free-standing imaging centers. Lab prices are from 12 percent higher (pathology) to 285 percent higher (transfusion) than free-standing laboratory centers.

The data present some interesting results.

For advanced imaging services, hospital prices are much higher than free-standing facilities' prices for all imaging types. However, the variance between hospitals' and free-standing facilities' computed tomography (CT) scan pricing is much greater than the variance for MRI/MRA service pricing. Standard imaging prices are also higher at hospitals versus free-standing facilities and, as a whole, have a greater variance compared to the prices of advanced imaging services at free-standing facilities. One possible explanation for this could be that the proliferation of outlets—including physician offices—that offer less complex imaging has driven the price lower. In short, increased supply has driven pricing lower. And hospitals, with greater net revenue sensitivity, have been unable to reduce prices to remain competitive with free-standing centers.

For labs, the average difference in rates between hospitals and free-standing centers is not as great as for imaging. One possible explanation could be related to payment provisions. If labs are typically paid on commercial plan fee schedules, rates could be lowered without as much net revenue sensitivity. So, some hospitals may have had the opportunity to decrease rates without losing much revenue. Or, they may not have increased them as much as imaging over the years as the returns were not as substantial.

We might see further reduction of lab prices if other commercial payers follow

Medicare's payment approach to eliminate separate payment for tests performed with other primary courses of care. In addition, fee schedule pricing, or significantly reduced pricing as a result of packaging, can present "lesser-of" exposure, which should be measured. The price could fall below the negotiated rate in a "line-level" lesser-of example, or, the elimination of lab charges could cause claim-level lesser-of provisions to be triggered in the "packaged" example. We'll come back to this point in the next section.

The Cost of Lower Prices

In some cases, hospitals can price certain services closer to free-standing averages with varying effects on charge impact. An evaluation of a specific hospital's position relative to specific free-standing centers would determine the precise levels needed to be competitive. However, the gross charge impact is not the only consideration when hospitals create alternate price points for commodity services—more important

is the net impact. If payers have fixed fee terms, the impact could be smaller. It is critical, though, to not assume it will be nothing. Most contracts have lesser-of provisions—the payer will pay the contracted rate or the hospital's chargemaster rate for a service, whichever is lower—that can have a significant impact on price reduction strategies. In fact, many providers try vigorously to avoid these situations (Cleverley, J. and Handlon, L., "The 'Lesser of' Conundrum: Solving the Puzzle Through Payment Terms and the Chargemaster," *Strategic Financial Planning*, HFMA, Fall 2015).

There are two keys to determining the cost of making reductions.

The first key is determining the net revenue sensitivity for the charge codes of interest. The net revenue sensitivity will result from an analysis of payer mix and payer terms for claims that contain the codes of interest. It is critical to remember that typically codes are not paid—entire claims are. In a predominantly fixed-fee environment, certain claims will be

Hospital Prices as a Percentage of Free-Standing Lab Prices

National average hospital charges for lab services outpace those charged by free-standing providers.

Lab tests - chemistry	177%
Lab tests - drug testing	153%
Lab tests - hematology and coagulation	257%
Lab tests - immunology	122%
Lab tests - microbiology	194%
Lab tests - organ or disease-oriented panels	298%
Lab tests - pathology	112%
Lab tests - reproductive medicine procedures	136%
Lab tests - routine venipuncture	151%
Lab tests - therapeutic drug assays	201%
Lab tests - transfusion medicine	385%
Lab tests - urinalysis	222%
Lab tests - other procedures	136%

Note: A value of 100 percent signifies that the prices are equivalent, while a value of 200 percent would imply that the average hospital price is twice as high.

Source: Cleverley + Associates, Worthington, Ohio. Used with permission.

exposed to stop-loss, lesser-of, and/or carve-out provisions that create revenue sensitivity. In these instances, revenue from the codes of interest may be impacted if rates are reduced. And, reimbursement from certain payer types—namely non-contracted commercial payers or payers with percent-of-charge term structures—can be significantly impacted by chargemaster rate reductions. The key is to perform a detailed payment term and claim-history modeling to determine the net revenue sensitivity.

Aside from the list price of the service, considerations such as net rates, convenience, and physician referrals are significant determinants in patient decisions.

The second key is modeling the application of the new rate structure. Will the alternative prices be provided to all outpatients or a subset? For some hospitals, emergency visits pose similar cost

structures as inpatients, so they do not apply reduced prices to all emergency department patients. Rather, they apply them only to those patients who are more similar in nature to those seen at free-standing centers—those making an appointment and coming in primarily for the test or service.

Some even become more granular in the application of reduced rates. This granularity can mitigate net revenue loss, but it can be problematic for administration. Namely, can the billing system implement the structure being modeled? Typically, the more granular the application, the more difficult the implementation—especially implementation free of unintended issues or financial impact.

Keys to Success

In a fiercely competitive market, some hospitals are making the choice to create alternative pricing structures that more closely mirror rates at free-standing providers. We've seen that average hospital prices are still significantly above free-standing centers, although there are some areas—certain lab areas, in particular—that appear to be closer than others.

The key to successfully implementing these new structures is to determine the

precise variances between appropriate free-standing market peers, adjust pricing, and then model the resulting net revenue impacts with thorough claim payment assessments. The larger question, though, will be whether these changes are enough. Aside from the list price of the service, considerations such as net rates, convenience, and physician referrals are significant determinants in patient decisions. However, for many providers, this strategy is better than doing nothing, because doing nothing only perpetuates the current environment—and results. //

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