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11 Metrics Reveal the Best Strategies For Cutting Outpatient Prices

By William O. Cleverley

Health systems must decide which hospitals should be targeted and how quickly price reductions can be implemented.

Hospitals have been feeling increasing pressure in the past five years to create lower prices for “shoppable” services, such as lab, computed tomography (CT)/magnetic resonance (MR), and mammography. Pressures for outpatient rate reductions have come from different sources and often vary by market, but in general, patients and managed care payers have been the most vocal in seeking reductions. These parties point to lower procedure prices in freestanding providers.

Health systems are beginning to establish strategic pricing directives that deal explicitly with outpatient pricing at their individual hospitals. These systems have two critical decisions: which hospitals should be targeted and how quickly price reductions can be implemented.

Our scoring matrix creates two category scores—one that measures the need to perform outpatient price reductions and the second to assess the hospital’s ability to implement those price reductions (see the exhibit on page 2).

We use six metrics to assess hospitals’ need to make significant outpatient price changes. The metrics can be derived from public data sources, which permits a relatively quick and cost-effective analysis. For each of the metrics, we calculate a “standardized” value by dividing the hospital’s actual value for the metric by the state average.

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For example, the value of 1.18 for Hospital A's Gross Patient Revenue per Equivalent Discharge means that Hospital A's value is 18 percent above the state average.

Gross patient revenue per equivalent discharge. Hospitals with high values for this metric have higher overall prices than their peers and are more likely to be targets for patients and payers seeking price concessions. In our weighting system, this metric received 10 percent of the total need for price reductions.

Markup (charges/costs). The second metric is markup; it also received a 10 percent weighting. We have included this metric because it has been used by policy analysts and journalists to point out hospital pricing practices that may be unfair to patients (Bai, G. and Anderson, G., "U.S. Hospitals Are Still Using Chargemaster Markups to Maximize Revenue," *Journal of Health*

Affairs, September 2016). Higher markups indicate a greater separation between prices and costs.

Outpatient surgery freestanding ratio. The third metric quantifies the relationship between the hospital's outpatient surgery prices and the outpatient surgery prices that exist in ambulatory surgery centers (ASC) in the state. The metric is derived by summing the hospital's outpatient surgery procedure charges and then dividing by the sum of the Medicare-assigned Ambulatory Patient Classification (APC) weights. For example, a colonoscopy with biopsy (CPT 44389) that had a charge of \$4,800 would be divided by the APC weight of 11.69 to produce a value of \$410.61. This same method is applied to all outpatient procedures performed in the hospital, and then an average charge per APC weight of 1.0 is computed. The median value for all ASCs

in the state would also be calculated and the hospital's value divided by that amount.

In our case example, the state average value for outpatient surgery was \$414.42. Hospital E had an outpatient surgery value of \$554.61, which would yield a ratio of 1.34 ($\$554.61/\414.42), indicating that the hospital's prices would be 34 percent above the state ASC average. It is important to remember that hospital outpatient surgery prices often reflect other charges in addition to the procedures, such as anesthesia and supplies, while ASCs usually only bill for procedures and therefore do not include additional charges in their prices.

To illustrate, note that Hospitals B and C in the exhibit below have outpatient surgery prices that appear to be more than 30 percent below the state ASC average. Most likely, their prices are not below the average ASC price, but they are well below their system hospital peers. Prices for lab, imaging, and therapy procedures do not experience

The Need to Make Outpatient Price Reductions								
		Standardized Values for Hospitals						
Need For Price Reductions	Weight %	Hosp A	Hosp B	Hosp C	Hosp D	Hosp E	Hosp F	Hosp G
Gross Patient Revenue Per Equivalent Discharge™	10%	1.18	1.10	1.01	1.63	1.48	1.42	1.13
Markup (Charges/Cost)	10%	1.35	1.07	1.13	1.21	1.23	1.42	0.81
OP Surgery Free Standing Ratio	15%	1.08	0.64	0.65	1.15	1.34	1.06	0.72
OP Imaging Free Standing Ratio	25%	1.26	1.67	1.58	2.51	1.65	1.23	1.70
OP Lab Free Standing Ratio	25%	1.15	1.27	1.58	1.57	1.54	1.04	1.32
OP Therapy Free Standing Ratio	15%	1.68	2.09	2.30	2.75	1.76	1.90	3.30
Weighted Need Score	100%	1.27	1.36	1.44	1.89	1.53	1.30	1.55
Ability to Reduce Prices								
Net Patient Revenue per Equivalent Discharge™	30%	1.09	1.09	0.93	1.38	1.22	1.18	1.00
Total Margin	25%	4.31	1.32	0.50	(0.31)	(0.22)	2.57	3.68
Equivalent Discharges™	15%	0.50	1.04	1.34	0.13	0.41	0.89	0.69
Uncompensated Care %	15%	9.41	1.54	0.68	0.46	0.68	1.39	0.72
Cost Per Equivalent Discharge	15%	0.93	1.10	0.95	1.43	1.28	1.05	0.88
Weighted Ability Score	100%	3.03	1.21	0.85	0.64	0.67	1.50	1.56

Source: Cleverley & Associates. Used with permission.

the same degree of additional charging, and therefore the ASC-to-hospital values are more comparable. The outpatient surgery freestanding ratio is assigned a 15 percent weighting.

Outpatient imaging freestanding ratio.

The fourth metric is defined in a similar manner to the outpatient surgery metric, except the state average would be derived from independent imaging centers. The state average for this metric is \$440.32; this becomes the denominator in the ratio for each hospital in the system. Hospital B has a value of \$734.26, which yields the ratio value of 1.67 ($\$734.26/\440.32). The value indicates that Hospital B's prices would be 67 percent above freestanding imaging centers in the state. The weight for the imaging variable is 25 percent. The higher weighting reflects the greater perceived importance of outpatient imaging relative to outpatient surgery.

Outpatient lab freestanding ratio. The fifth metric assesses the relative pricing differential between hospitals and independent labs. Lab procedures are not assigned APC weights, but they do have Medicare assigned fee amounts per the Clinical Lab Fee Schedule. For example, an assay of calcium test (CPT 82330) has a fee of \$16.88, which could be converted to an APC weight by dividing the fee by the average payment per APC weight of 1.0 ($\$70.00$) to yield an imputed APC weight of 0.241. The outpatient lab metric was also assigned a 25 percent weight because of its higher perceived importance.

Outpatient therapy freestanding ratio.

The sixth and final need-assessment metric assesses the relationship between independent providers of therapy procedures—primarily physical and speech—and hospitals. The therapy services also are paid by Medicare under a fee-schedule basis, so, as with lab procedures, they need to be converted to an APC weight. Therapy procedures are accorded a 15 percent weight, which is below lab and imaging because therapy procedures are deemed

to be a lower priority for outpatient price reduction.

Ability to Reduce Prices

All hospitals within a system may need to reduce their outpatient pricing, but there may be wide variation in the abilities of individual hospitals to actually do so. To help provide initial assessment, we use five metrics to determine implementation ability. All five of the metrics are standardized around the mean value for that metric in the hospital system.

Net Patient Revenue per Equivalent Discharge™.

This metric receives the highest total weight, 30 percent. Hospitals that are currently receiving more revenue per equivalent discharge should have a greater ability to implement outpatient price reductions because they can absorb them. Higher values for this metric usually indicate a better payer mix (e.g., less governmental payers, better contract terms with commercial payers, or a mixture of both). It is important to use an Equivalent Discharge™ measure for volume because it is not affected by price changes, as measures of adjusted discharges would be. Hospitals making outpatient price reductions will see an artificial decline in their level of adjusted discharges, affecting any revenue or cost targets that use the adjusted discharge measure. Reduced outpatient prices will lower adjusted discharges because the ratio of outpatient charges to inpatient charges will drop even though there was no actual reduction in volume.

Total margin. Total margin includes profits from both operations and non-operating sources of income. Hospitals with higher levels of total margin are more able to sustain revenue reductions resulting from reduced outpatient pricing. The weighting of this metric is the second highest in the ability category, at 25 percent.

Equivalent Discharges™. This metric measures total volume of services provided at the hospital. Hospitals with higher levels of volume are often able to shift pricing

to other areas where they may be able to recoup some lost revenues resulting from outpatient price reductions. The weighting for this metric was set at 15 percent, significantly lower than the first two metrics.

Uncompensated care percentage. Uncompensated care represents unpaid costs of care, provided primarily to Medicaid and charity patients. The value is taken from line 30 of Worksheet S-10 in the Medicare Cost Report and is divided by net patient revenue. High values indicate that hospitals will need to cost shift to patients covered by commercial plans because the losses are not likely to be covered by governmental payers.

Because outpatient payment is more likely to have percent of charge payment than inpatient procedures in commercial plans, cutting prices in the outpatient arena is likely to create the largest negative revenue impact.

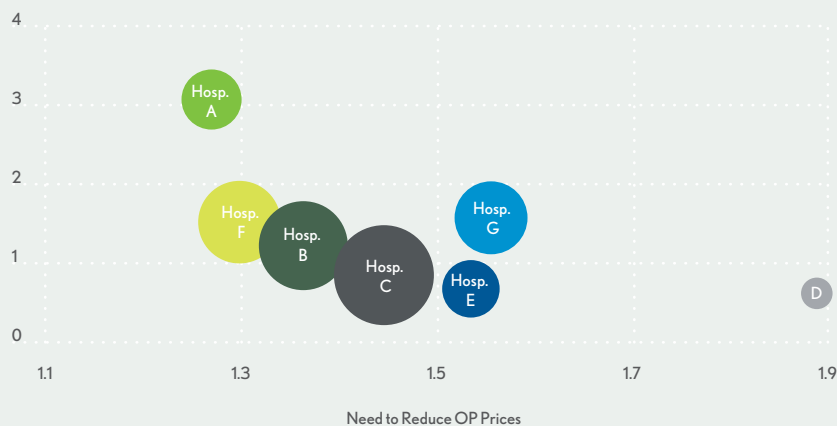
To standardize this metric, we divide the mean health system value by the individual hospital value, which will produce higher values in hospitals with lower uncompensated care. This metric is also weighted 15 percent.

Cost per Equivalent Discharge™. High values for this metric indicate that there are possible cost savings that could offset the revenue reductions resulting from lower outpatient prices. Low-cost hospitals may have little additional room to cut costs further without sacrificing quality or service capabilities. Outpatient revenue reductions would therefore have to be shifted to other service areas or absorbed through reductions in profitability.

We emphasize again that a cost-per-adjusted-discharge metric can be highly misleading if measured after an outpatient price reduction because that would reduce the number of adjusted discharges and therefore artificially increase cost per adjusted discharge. This metric is also weighted 15 percent.

Hospital Scoring for Outpatient Price Reductions

A visual can help isolate hospitals with the best and worst likelihood for immediate outpatient price reductions.



Source: Cleverley & Associates. Used with permission.

Case Illustration to Identify Hospitals for Price Reductions

The exhibit above summarizes values for a seven-hospital system that is in a single state and presents a visual to help isolate hospitals with the best and worst likelihood for immediate implementation of outpatient price reductions. Standardized values for each of the need and ability metrics are presented.

For example, Hospital D has the greatest need for outpatient price reduction because its weighted need score is 1.89 $[(.1*1.63) + (.1*1.21) + (.15*1.15) + (.25*2.51) + (.25*1.57) + (.15*2.75)]$. This value is 22 percent above the second-highest-need hospital (Hospital G), which has a value of 1.55. Hospital D has the highest need score because its values for existing outpatient

prices relative to freestanding state averages are the highest in the system.

At the same time, hospital D has the lowest ability to reduce its outpatient prices with an ability score of 0.64. A review of the scoring sheet shows the underlying causes for the low value. Hospital D has the lowest standardized values for total margin and has the highest levels of uncompensated care. It is also the smallest hospital in the system (the size of each bubble represents the relative values for Equivalent Discharges™).

On a positive note, Hospital D has the highest level of net patient revenue and cost per equivalent discharge. Cost reduction appears to be the primary factor that could help Hospital D lower its outpatient prices,

but its small size may be preventing the realization of some economies of scale that are possible in larger hospitals.

At the other end of the spectrum, Hospital A has the greatest ability to realize outpatient price reductions but the lowest level of need to do so. Its outpatient lab prices are only 15 percent above the freestanding state average, and its imaging prices are only 26 percent above the state average.

Price Reductions Without Sacrificing Financial Viability

Many hospital systems in the United States are considering dramatic outpatient price reductions to either stem bad public relations exposure or to reduce the flight of patients to freestanding centers where prices are often considerably lower. While most hospital revenue is fee based and is not directly affected by chargemaster pricing, there is a significant amount of revenue that is adversely affected by outpatient price reductions.

Corporate strategy in the outpatient pricing area is dictated by the pressure to reduce outpatient prices balanced by the ability of a specific hospital to implement outpatient price reductions without sacrificing financial viability. We have presented a scoring methodology that we believe can be a useful first step in evaluating the desirability of initiating outpatient price reductions. //

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