Smart approaches to top-level decision making

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Pricing Commodity Outpatient Procedures: Assessing the Impact

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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 steps to a thoughtful analysis.

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 free-standing 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. A commodity product is one where all units are perceived to be identical, regardless of who produces them. Without product differentiation, providers of commodity products are usually "price takers," which simply means that they have little control over their pricing.

A dilemma that faces many hospitals is the current 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 sizable 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 inpatient service margins. The Medicare Payment Advisory Commission (MedPAC) estimated that the Medicare outpatient margin

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.

was -11.2 percent and the inpatient margin was -4.4 percent in 2012.

Hospitals have a limited number of strategies for dealing with increasing price pressure in outpatient commodity areas. One approach: They can choose to exit the area completely and leave the business to the remaining providers. Many hospitals have abandoned minor outpatient surgery departments to physician-owned surgery centers. Alternatively, hospitals can try to establish some 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 lower their prices and payments for selected outpatient commodity services to levels where they can remain competitive and retain market share.

Case Hospital: Background

The 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 both manufacturing and service industries. The hospital is smaller than several of the other hospitals in the CSA but has been able to retain market share for most inpatient acute care services.

Case Hospital has, however, experienced an erosion in market share for many of its outpatient procedures. 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. They also need to maintain their operating margins. They realize that this may not be an attainable short-term goal but may require several years and some significant payer contract revisions.

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 on page 1, 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.

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.

The major take-away from this initial analysis is that any reduction in outpatient margins resulting from price or contract changes could be catastrophic unless some 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 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 CHAMPUS, 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/payment reductions in commercial lines because there is no cushion of existing profitability.

The exhibit on page 2 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. This may imply that commercial payment terms for inpatient care are not favorable, costs are very high, or some combination of both. Because the margin on Medicare inpatient business is so negative (23.5 percent compared to 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), and the margins are very high at 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 are already 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 can be made.

We used the Hospital Cost Index® metric to assess overall cost positions at Case Hospital (see the top exhibit on this page). This analysis shows that Case Hospital has an inpatient cost structure that is above the U.S. average and its primary local peer. In contrast, Case Hospital has a competitive outpatient cost structure. 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 needs to explore the reasons why its inpatient costs are so high relative to the U.S. average and its local peer. Most likely, much of this cost difference may be related to intensity of service issues (e.g., longer lengths of stay, greater use of ancillary

Case Hospital's Cost Position

Measure	Case Hospital	Local Peer A	All U.S. Group
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 Five 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 accounted for 67 percent of all outpatient profit, but only 17.5 percent of total payment.

services, or high-cost supply and pharmacy usage).

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

Case Hospital has 10 major commercial contracts that 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 other two 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 payment rates for psychiatric and rehab care that are per-diem based and a separate case rate for obstetrical 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. Much of the loss in these two MS-DRGs was related to Medicaid and indigent care.

With respect to outpatient payment terms, there was a larger presence of percent-of-charge payment, but most of the larger plans still paid on a fee basis. All of the fee-based contracts had "lesser-than provisions." These contract provisions specify that if actual charges are below fee-based payment schedules, then 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 identified the five most profitable ambulatory payment classifications (APCs) for Case Hospital (see the bottom exhibit on page 3). 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 dollar reduction in gross charges, a 22.6 percent drop. A key question still remained: What is the expected impact on net revenues given the large percentage of business that is fee-based and not percent-of-charge paid?

Initial projections showed a net revenue reduction of $7.3 million. This would mean that without any cost reduction, operating losses would increase from an initial loss of $9.5 million to a projected loss of $16.8 million. All of the loss was 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 on page 4. Approximately 45 percent of the reduction in payment was concentrated in five procedures.

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%
Largest five 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.

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

At first glance, this seemed unusual since only two relatively small commercial payers have percent-of-charge payments 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, 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 change in payment.

The magnitude of the projected loss was too large, and Case Hospital leaders did not expect that much of the loss could be offset with volume increases. Smaller reductions in outpatient prices were then tested, and renewed attention to inpatient cost reduction was made.

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 with freestanding providers. Price reduction has been viewed by many as a no-consequence strategy because a small percentage of the payers pay on a percent-of-charge basis.

The case example demonstrates that 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 that sound strategic decisions will be made.

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