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time for a price check?

Market trends are leading some acute care hospitals to examine their managed care payments and adopt a protective strategy: price shifting.

General acute care hospitals' revenues are under attack as inpatient and outpatient niche providers continue to sap profitable business. Although the Centers for Medicare and Medicaid Services has issued a temporary moratorium on licensing new niche inpatient service providers, competition from existing competitors and those focused on outpatient areas—typically the hospital's most profitable source of business—only grows.

The situation is compounded by the fact that specialty competitors not only are targeting lucrative services, but also are known to take care of fewer severely ill patients than are full-service hospitals. They frequently take the less sick patients within a diagnosis-related group, leaving the sicker—and costlier to treat—patients for the general acute care hospital. With fixed-priced payers, hospitals are paid the same for a given DRG

regardless of a patient's acuity, creating a financial burden for the general hospital.

What can providers do to maintain their margins when faced with such market challenges?

Price Shifting Model

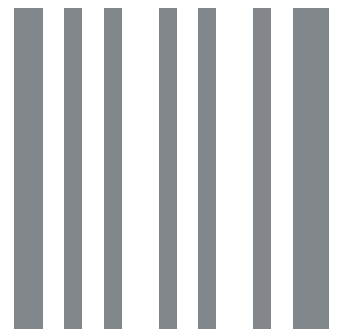
Some hospitals are adopting a progressive strategy based on price shifting. Under this pricing model, hospitals move commercial payers' payments away from commodity services and focus on the hospital's "proprietary" services.

Proprietary services are those areas where the hospital excels in the market. For an acute care, tertiary hospital, proprietary services involve taking care of very sick patients who would not be appropriately served at a less sophisticated facility. These patients frequently require advanced technology, high levels of monitoring, and access to a full range of medical services. At the extreme, this group would include patients receiving organ transplants, trauma services, or neonatal intensive care unit services.

At the same time, payments are shifted away from the hospital's commodity services—those services that almost anyone can offer. Examples of commodity services include outpatient laboratory tests and imaging because they have minimal barriers to entry and do not require a physician in the room when the service is being performed. In most states, outpatient surgery also would be

AT A GLANCE

- > General acute care hospitals often are losing out to niche providers.
- > By focusing commercial payment on proprietary and commodity services and away from noncore services, these hospitals can help guard against the competitive threat.
- > Transitioning to the price shifting model requires distinct and careful actions.



considered a commodity service because it is offered by multiple providers and has few barriers to entry (especially in states that do not require a certificate of need).

Between these two extremes are noncore services. These services typically require some investment in bricks and mortar, but not the same level of technology, monitoring, and medical backup. Low-risk obstetrics, cardiovascular procedures on otherwise healthy people, and general medical/surgical services are examples of noncore services. These are services that increasingly are being provided in freestanding facilities.

The concept behind price shifting is that general acute hospitals are best served by focusing commercial payments on areas that have the greatest barriers to entry and the fewest providers and by reducing reliance on services where the market is flooded.

Historical Pricing

Traditionally, general acute hospitals have not priced their services on the principles of supply and demand. Services have been priced either on cost (as best as could be guessed) or what Medicare mandated. Managed care contracts were negotiated based on inpatient per diems and outpatient services as a percentage of charges, if possible, with little thought given to the margin they provided.

As a result, hospitals have dramatically underpriced key inpatient services for which they have

Ultimately, the viability of the acute care hospital is more important to payers than the duplication of services.

product differentiation, barriers to entry, and scale, and they have overpriced outpatient services—providing an artificially inflated revenue stream. In the authors' experience, general acute care hospitals typically derive their greatest commercial profit margins (and frequently greatest profit) from outpatient services, while inpatient services run a poor second.

This current pricing approach conflicts with the fact that general acute hospitals have a substantial competitive advantage and market protection in acute, complex inpatient services, while they are exposed to significant competitive pressures on the outpatient side. The result of this pricing strategy has been significant market distortions that have helped create both "niches" and vulnerability for hospitals.

Economic theory suggests that general acute hospitals should price based on market factors, including product differentiation and capacity, barriers to entry, level of existing competition, and perceived value to the customer. The strategy of increasing the price for proprietary services while lowering the price for commodity services should have little short-term effect on a hospital's revenues, but it can help protect future revenues. By simultaneously raising and lowering prices, price shifting does not have an adverse effect on commercial payers. In most respects,

General acute hospitals typically derive their greatest profit margin from outpatient services.

PROFITABILITY OF COMMERCIAL PATIENTS

	\$ Profit		Profit Margin	
	Inpatient	Outpatient	Inpatient	Outpatient
Hospital A	\$669,517	\$3,278,946	7.7%	35.1%
Hospital B	\$1,741,555	\$9,036,110	9.1%	34.3%
Hospital C	\$1,944,589	\$10,841,218	4.4%	37.1%
Hospital D	\$21,025,140	\$6,748,792	40.0%	42.6%
Hospital E	\$21,719,079	\$14,519,686	26.8%	38.4%

SHIFTING PAYMENTS AND PROFITABILITY FROM COMMODITIES TO CORE SERVICES

Category	Service	Current Profit per Case	Current Profit Margin	New Profit per Case	New Profit Margin	% Change
Proprietary services	390 - Newborn	\$649	32.4%	\$2,512	65.0%	100.4%
	209 - Orthopedic surgery	\$8,883	48.0%	\$17,854	65.0%	35.3%
	98 - Pulmonary medicine	\$2,142	35.2%	\$7,317	65.0%	84.5%
	1 - Neurosurgery	\$11,419	43.3%	\$27,762	65.0%	50.1%
	148 - Surgery	\$12,642	49.9%	\$23,552	65.0%	30.2%
	Total top 5	\$5,207	45.0%	\$11,806	65.0%	44.3%
	Total core services	\$1,532	48.0%	\$2,852	63.2%	31.7%
Noncore services	373 - Obstetrics	\$1,179	33.1%	\$1,548	39.4%	19.0%
	494 - Surgery	\$4,345	52.9%	\$2,520	39.4%	225.5%
	183 - Gastroenterology	\$3,195	53.5%	\$1,808	39.4%	226.3%
	500 - Neurosurgery	\$3,024	43.5%	\$2,554	39.4%	29.4%
	143 - Cardiology	\$3,797	58.2%	\$1,776	39.4%	232.3%
	Total top 5	\$1,543	37.9%	\$1,645	39.4%	4.0%
	Total noncore services	\$1,872	41.3%	\$1,632	38.1%	28.0%
Commodities	Day surgery	\$1,428	52.0%	2 \$495	259.9%	2215.2%
	Minor emergency	\$135	47.6%	2 \$59	266.3%	2239.5%
	Infirmary	\$2,282	60.2%	2 \$314	226.3%	2143.7%
	OP testing	\$304	56.7%	2 \$63	237.2%	2165.6%
	Cardiac clinic	\$101	29.4%	2 \$62	234.5%	2217.5%
	Total top 5	\$1,045	54.2%	2 \$287	248.1%	2188.8%
	Total commodities	\$873	55.3%	2 \$224	244.4%	2180.3%
Total		\$1,256	48.8%	\$1,256	48.8%	0.0%

it asks them to look more like most hospitals' largest payer, Medicare.

How to Implement Price Shifting

Developing a basic pricing system that focuses commercial revenues on core services is not a difficult process. However, it does involve multiple parts of the hospital, including the managed care contracting, finance, and planning departments. To implement price shifting, the following actions are recommended.

Determine your current contracting structure (case rates, per diems, or DRGs) and the structure you want to put in place. Most payers are not yet able to handle billing based on acuity scores. However, case rates based on DRGs, per diems based on service lines or bed types, or percentage of charge programs can serve as an intermediate step.

Classify those services on a scale from commodities to core services based on the desired contracting system.

As an example, if using case rates based on DRGs to contract, DRG 484 (craniotomy for trauma) would be classified as a core service, while DRG 391 (normal newborn) would be classified as a noncore or, potentially, commodity service.

Look for opportunities. Identify those services with especially limited capacity (both at the hospital and in the marketplace), services in which you have a dominant market share, and areas in which you want to affect market share. Reclassify any services that deserve to be moved.

Using existing cost-accounting systems (or a home-grown approach), determine current profits for each unit. Set a goal for the profit margin for core services and for noncore services. (This goal should

The table shows the effect of shifting payments and profitability from commodities to proprietary services for one commercial payer. Note that commodities still have a positive contribution margin, but lose money on a fully allocated basis.



be no more than 50 percent to 75 percent of the core service rate.) Once you have determined how much of an increase in payments you need to achieve these margins, calculate the impact of taking these revenues out of your commodity services. Make sure that even commodity services have a positive contribution margin, but at a rate that reflects the availability of the service.

Model, model, model. Look at every angle and scenario to fully understand the risks and rewards that may result. When your hospital is a market leader, a change in pricing strategy could cause

some temporary instability in the market for which you need to be prepared.

Develop a communications plan. If you are planning dramatic and immediate changes to payment schedules, be prepared to respond to upset employees and physicians. Some hospitals believe it is best to inform interested parties before the change while others would rather answer questions after the fact. The authors believe that well-thought-out, proactive communication is best. Assurances, if possible, that managers' bonuses and capital spending plans will not be upset in the coming year will be helpful.

PRICE SHIFTING CASE STUDIES

The following case studies are based on actual experiences with price shifting. Names have been withheld to protect competitive interests.

Hospital: Small Fish in a Big Market

This 200-bed, medically advanced, community hospital is based in a subcommunity of a major metropolitan city.

Previous pricing strategy: Focus revenues on growing outpatient services while letting inpatient rates fall.

Problem: The rise of freestanding outpatient providers. From 1971 to 2000, licenses for medical imaging had been issued at an average rate of 25 per year. Since 2000, this rate increased to 80 licenses per year.

Solution: Shift payments away from outpatient services to inpatient services. Initially targeted an even profit margin (10 percent to 15 percent) for all commercial patients, but eventually decided to focus even more heavily on inpatient services, with a small premium on some specific service lines.

Roadblock 1: Getting the managed care payers to negotiate the large increases (mid-double-digit percentages) on inpatient rates despite the equivalent decreases on the outpatient side.

Solution 1: Pleading and threats. "The MCOs have to understand that the outpatient niche providers threaten the viability of the hospitals. If we leave the marketplace, then competition on the most needed services will drop, and then the prices will really rise."

Roadblock 2: Communicating with the governing board. The board was not typically involved in contract negotiation, but complaints from business leaders about the rapid increases in inpatient rates caused concerns.

Solution 2: Increased communication far beyond what the hospital had traditionally done. "Our CEO was never a fan of disclosing too much about specific contract negotiations, but in this case, we had little choice. The board needed to understand what we were doing, and why it wasn't a bad thing for area employers."

Outcome: Success thus far, as rate changes have been completed with the major payers and revenues are beginning to stabilize.

The next problem: Rumor that physicians are seeing the profitability of outpatient niche services disappearing and contemplating owning general, acute care hospitals, without costly emergency services.

Of course, communicating with the payers is of great importance. Ultimately, the viability of the acute care hospital is more important to them than the duplication of services and, sometimes, the increased utilization that freestanding providers represent. Building a strong case of how these changes will not affect the total dollars paid to the hospital (unless a rate increase is to be part of the adjustment) and how this can be represented to the payers' customers is important.

Set your new rates and work with the managed care organizations to implement. In many cases, the managed care organizations will tolerate the rate

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change because it is a zero-sum game to them, since any increased payments on the inpatient side are offset by declines in the commodity services. However, some may offer resistance,

System: Large Fish in a Mid-Size Market

This Southeastern healthcare system consists of three hospitals and provides tertiary services. In the growing community where it is located, another healthcare system and six hospitals also operate.

Previous pricing strategy: Dictate rates to commercial payers, staying on a percentage of charge basis.

Problem: Within five years, multiple inpatient niche hospitals appeared as well as growth of freestanding surgical centers. Inpatient niches were taking less acutely ill patients (within the same DRG) and leaving for the healthcare systems the truly sick, who require more resources but garner the same payment.

Solution: Fully implement price shifting, including creation of new revenue codes to better capture patient acuity and investments in technology for modeling rates.

Roadblock 1: Internal strife as employees and physicians in some very profitable departments (such as radiology) discovered their projected revenues would be drastically cut. Fears of reduced importance and resources reduced support for the program.

Solution 1: Communication. "We have to show staff and physicians the big picture and help them understand that it is a whole new day in pricing.

Ultimately, as a system, we will have to rethink how we view each of our departments and services and to what financial standards we hold them."

Roadblock 2: Understanding the implications and impact on the system's market placement and strategic plan, which had been focused on direct competition for the commodity services rather than the proprietary programs.

Solution 2: By adopting a "retail mentality" on outpatient services, the system is changing how it views its business model. Most outpatient services are now seen as commodities, and the revenues they generate, especially for new programs built away from the hospital, are essentially "incremental" to the proprietary services. That mind-set has broadened the range of joint ventures and partnerships that the hospital is willing to consider.

Outcome: Payers are receptive thus far, but wary of a never-before-seen pricing strategy. A director-level position has been created to manage the pricing and to continue communicating with internal stakeholders as the implementation moves forward.

The next problem: Watching the reaction of the other major system in town and modulating the changes to make sure no market share is lost.



Depending on the change in contract structure, managed care organizations may welcome the change.

especially if the change affects how they advertise their networks to employers.

Depending on the change in contract structure, managed care organizations may welcome the change. Moving from a contract based on percentage of charge to one based on per diem or from a per diem structure to one based on case rate gives payers greater certainty when they are pricing premiums and making financial forecasts for the coming year, which in turn gives them a better opportunity to manage their business. Monitor the new system and determine the

WHAT ARE PRICE SHIFTERS SAYING?

- > "Other industries focus on pricing. Why can't we?"
- > "The trick is to not create new niches and vulnerabilities. We have to be rational in how we approach the pricing."
- > "The biggest problems we face are internal—payers and physicians have been receptive, but our own staff is so scared of the new model that they create barriers."
- > "The more we dig into this, the more areas of opportunity we start to see. Initially we thought that it was as simple as shifting pricing to the inpatient side. Now we see that we have a lot of levers that we can pull."
- > "As other providers catch on, it will be easier to convince payers that this isn't a trick—it is what hospitals need to do to remain viable."

impact on your profitability. Make sure prices have not been set so drastically that you are influencing market share (except in the areas you want to affect it). Lowering outpatient prices to the point that you are receiving more (low-paying) business while increasing inpatient prices to the point that payers are directing patients elsewhere can have a negative financial impact. After a couple of months, compare what you were paid under the new system with what you would have been paid under the old system and then calculate the impact of changing volumes.

Protecting Core Services

General acute care hospitals cannot ignore a significant revenue drain. They must continue to examine new ways to combat niche competitors and protect core services.

Although some hospitals have begun implementing price shifting and are enjoying some of its successes, there are still issues and roadblocks for hospitals to work through. Each hospital needs to evaluate its own situation and determine to what degree it is capable of implementing a program amidst the prevailing economic, market, and legal issues. ●

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