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Strategic Pricing: Hospitals' Key to Combating Niche Providers?

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Recently, there has been much discussion about the deleterious effect that niche providers (such as specialty hospitals with physicians as investors or other outpatient service providers) are having on the finances of general, acute care hospitals across the country.

Lawmakers, advocacy groups, and others have voiced concern that these niche providers are taking profitable services such as cardiac, orthopedic, and surgical care away from general hospitals, leaving them with money-losing services such as the emergency department (ED) and intensive care units. Not only are niche hospitals targeting profitable services, but also, the GAO published a report this past April saying that specialty hospitals take care of fewer severely ill patients than do full-service hospitals. In other words, specialty hospitals take the less sick patients within a DRG, leaving the sicker patients for the general-acute hospital.

Under fixed-priced payers, hospitals are paid the same for a given DRG, regardless

of the patient's acuity. Therefore, the hospital that is treating the sicker patients (and therefore incurring more costs) is economically disadvantaged. Although it may be clinically appropriate for physicians to send the sicker patients to the facility that has the clinical backup to treat them, it is not appropriate that general-acute hospitals are financially burdened.

The question then becomes, what can general-acute hospitals do to improve profitability for those services that only they provide and for taking care of truly sick patients?

Many providers are pursuing traditional tactics against niche providers, such as requiring physicians to sign noncompete contracts, removing investing physicians from the ED, and pressuring managed care companies. Recently, some providers have begun investigating a new approach known as "strategic pricing." This concept is still largely untested, with only a few markets (those where niche providers have already become a large problem) in

the early stages of implementation. However, the authors believe that the move to protect core revenues is worth the risk for some hospitals.

Strategic Pricing

Strategic pricing simply means shifting commercial payers' payments away from the "commodities" that hospitals offer and toward the hospital's "core competencies," the services the hospital is best at doing. For an acute care, tertiary hospital, core competencies would be taking care of very sick people. These patients require the best technology, high levels of monitoring, and access to a full range of medical services. At the extreme, this group would include organ transplant patients, trauma patients, or neonatal intensive care unit patients.

In contrast, commodity services are those that almost anyone can offer. As an example, outpatient laboratory tests and imaging have minimal barriers to entry and do not even require a physician to be present when the service is being performed.

In most markets, outpatient surgery is being offered by multiple providers and has few barriers to entry (especially in states not requiring a certificate of need), making it a commodity product.

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

The concept behind strategic pricing is focusing commercial payments on the core services, which have the greatest barriers to entry and the fewest providers, and taking payments away from the commodities, which anyone can do and where the market is flooded.

Historical Pricing

Traditionally, general-acute hospitals have not priced their services based on the

How to Implement Strategic Pricing

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

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

Classify those services on a scale from commodities to core services based on what sort of contracting system you desire. As an example, if you were 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. Go through the list a second time and identify those services with especially limited capacity (both at your 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 reasonable goal for the profit margin for core services (40 to 65 percent is the typical range the authors see) and for noncore services (this should be no more than 50 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. The goal is to make sure that even commodity services have a contribution margin, but that the prices are well below current market rates.

Set your new rates and work with the MCOs to implement. In most cases, the MCOs will not mind the rate change because it is a

“zero sum” game to them; any increased payments on the inpatient side are offset by declines in the commodity services.

If you are changing your contract structure, MCOs may welcome the change. Moving from a percent of charge contract to a per diem or from a per diem to a 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 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 you shift market share and are receiving more low-paying business while increasing inpatient prices to the point that payers are directing patients elsewhere can have a negative impact on your finances. After a couple of months, compare what you were paid under the new system versus what you would have been paid under the old system and then calculate the impact of changing volumes.

Such a result conflicts with the observation that general-acute hospitals have a substantial competitive advantage and market protection in acute, complex inpatient services, while being exposed to significant competitive pressures on the outpatient side. The result has been significant market distortions that have encouraged niche players to enter the market.

Economic price theory suggests that general-acute hospitals should price based on market factors, including product differentiation, barriers to entry, level of existing competition, and perceived value to the customer.

Shifting pricing to increase payments for the core inpatient services a hospital provides and to lower it for the commodity services that anyone can provide should have no short-term effect on the general-acute hospital's total revenues, but should cause current and proposed niche providers to reconsider their business models. Furthermore, by simultaneously raising and lowering prices, the program does not have an adverse effect on commercial payers.

A Caveat

Strategic pricing is an untested strategy, but one that appears to hold a great deal of promise as both a strategic and defensive tool. However, because the strategy is in its early stages, we do not know all of the implications about shifts in market share, impact on cost reports, or the ability of niche providers to adapt to the new market pressures. We do know, however, that for general-acute hospitals to sit back

economic principles of supply and demand. Services have been priced either on cost or what Medicare mandated, but not on what the market would bear. Managed care contracts were negotiated based on inpatient per diems and outpatient

services as a percent of charges (if possible).

As a result, hospitals have dramatically underpriced core inpatient services for which they have 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 hospitals typically derive their greatest profit margins (and frequently greatest profit) from outpatient services, while inpatient services run a poor second.

Shifting Payments and Profitability from Commodities to Core Services for One Commercial Payer

Category	Service	Current Profit per Case	Current Profit Margin	New Profit per Case	New Profit Margin	% Change
Core 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 Five	\$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%	-25.5%
	183-Gastroenterology	\$3,195	53.5%	\$1,808	39.4%	-26.3%
	500-Neurosurgery	\$3,024	43.5%	\$2,554	39.4%	-9.4%
	143-Cardiology	\$3,797	58.2%	\$1,776	39.4%	-32.3%
	Total Top Five	\$1,543	37.9%	\$1,645	39.4%	4.0%
	Total Noncore Services	\$1,872	41.3%	\$1,632	38.1%	-8.0%
Commodities	Day Surgery	\$1,428	52.0%	-\$495	-59.9%	-215.2%
	Minor Emergency	\$135	47.6%	-\$59	-66.3%	-239.5%
	Infirmery	\$2,282	60.2%	-\$314	-26.3%	-143.7%
	OP Testing	\$304	56.7%	-\$63	-37.2%	-165.6%
	Cardiac Clinic	\$101	29.4%	-\$62	-34.5%	-217.5%
	Total Top Five	\$1,045	54.2%	-\$287	-48.1%	-188.8%
	Total Commodities	\$873	55.3%	-\$224	-44.4%	-180.3%
Total	\$1,256	48.8%	\$1,256	48.8%	0.0%	

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

and to continue to lose their most profitable inpatient and outpatient services to niche providers would ultimately prove detrimental to all the services the hospitals offer.

Hospitals must continue to examine new ways to combat niche providers and protect core services. ■

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