

Strategic Pricing – An Approach to Maximizing Revenues & Combating Niche Providers

HFMA'S WINTER SEMINARS

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- Introduction to Strategic Pricing
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Learning Objectives

- This presentation will show:
 - The concepts behind strategic pricing
 - The evolution of the healthcare payment system
 - How strategic pricing can protect and maximize core revenues
 - How to evaluate and implement strategic pricing
 - The impact of strategic pricing at the Seton Healthcare Network

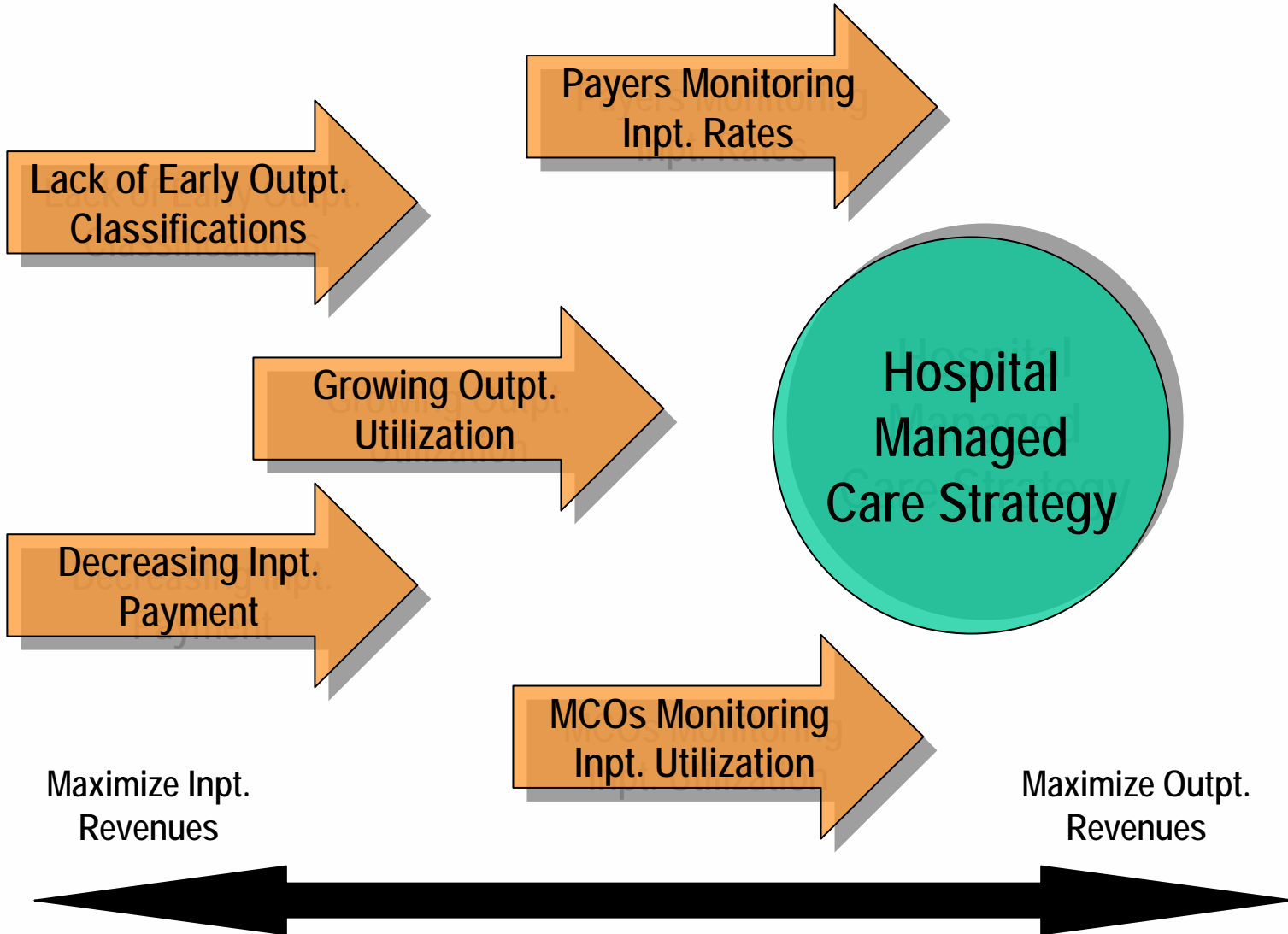
Strategic Pricing – Dictionary

- **To protect and optimize certain revenue streams, hospitals should shift commercial payments from “commodity” to “proprietary” services.**
 - **Commodity** services are those that almost anyone can offer because they have minimal barriers to entry.
 - Laboratory tests
 - Imaging
 - **Proprietary** services are those that hospitals excel at providing, i.e. taking care of acutely sick patients who require advanced technology, high levels of monitoring, and access to a full range of medical services.
 - Trauma services
 - Neonatal intensive care unit
 - **Non-core** services are those between these two extremes and are increasingly being offered in freestanding niche facilities.
 - Low risk obstetrics
 - Low-risk cardiovascular procedures

Strategic Pricing Overview

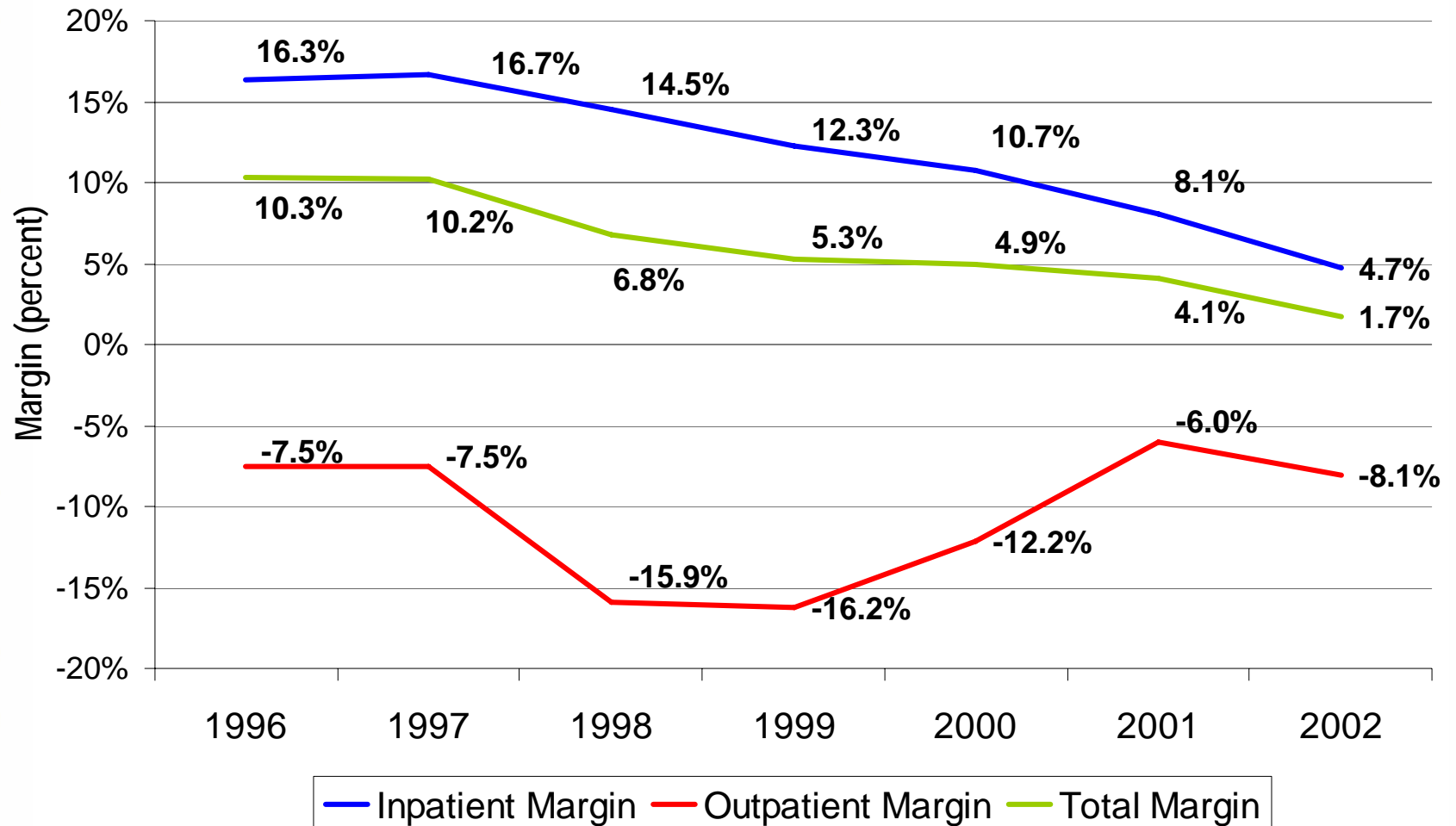
- The goal of strategic pricing is to:
 - Focus commercial revenues on the services least likely to be taken by niche competitors
 - Price commodity services at competitive market rates; price proprietary services at a premium
 - Zero-sum impact on hospitals, unless price increases are included
 - Potential for lowering the market rates and margins, for niched services
 - Potential for moving market share
- In the simplest form, this means moving revenues from outpatient services, which are very vulnerable to niches, to specialized inpatient services, which have higher barriers to entry.
- At the extreme, it involves a highly fluid pricing approach and price shifting based upon market demands and capacity.
- At either extreme, it means protecting hospitals' revenues and profitability as well as potentially taking the niche away from niche providers.

- Drivers in the 1980's, '90's, and Today



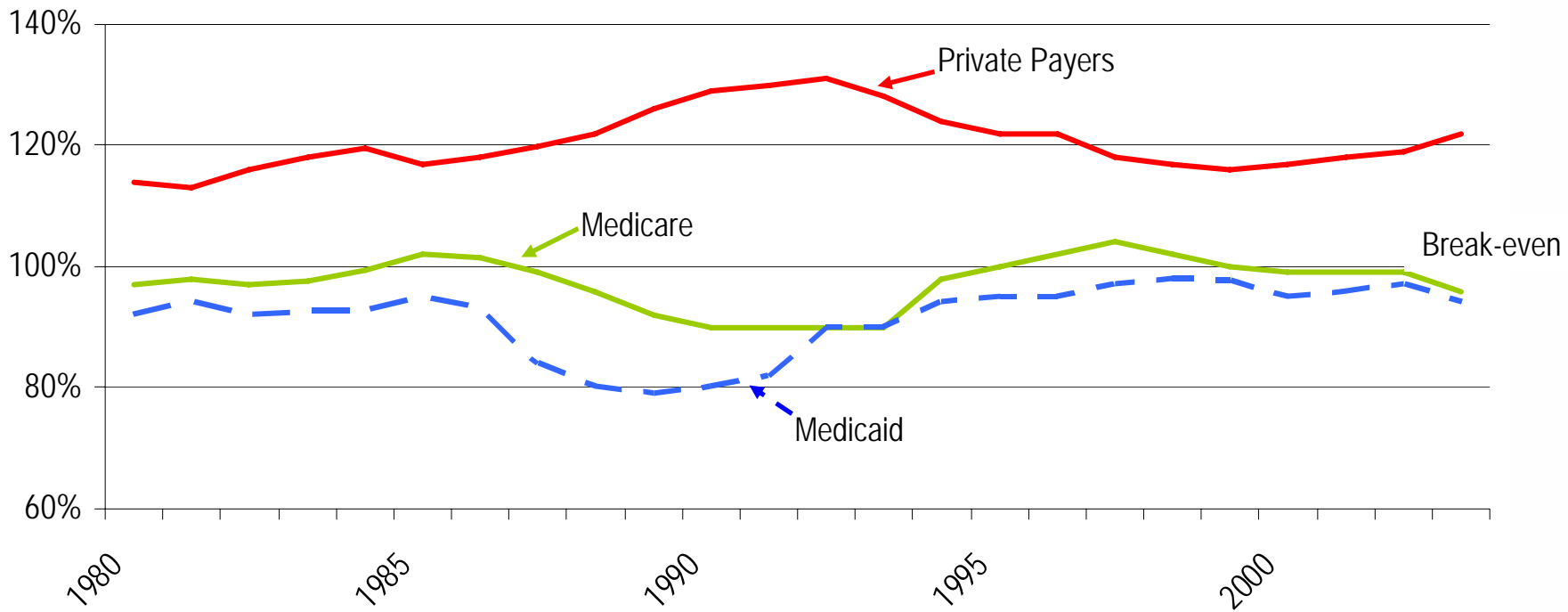
As Medicare Margins Decline...

Medicare Margins for Inpatient and Outpatient Services



Hospitals Shift the Burden to Private Payers

Hospital Payment-To-Cost Ratio, By Type Of Payer, 1980-2003

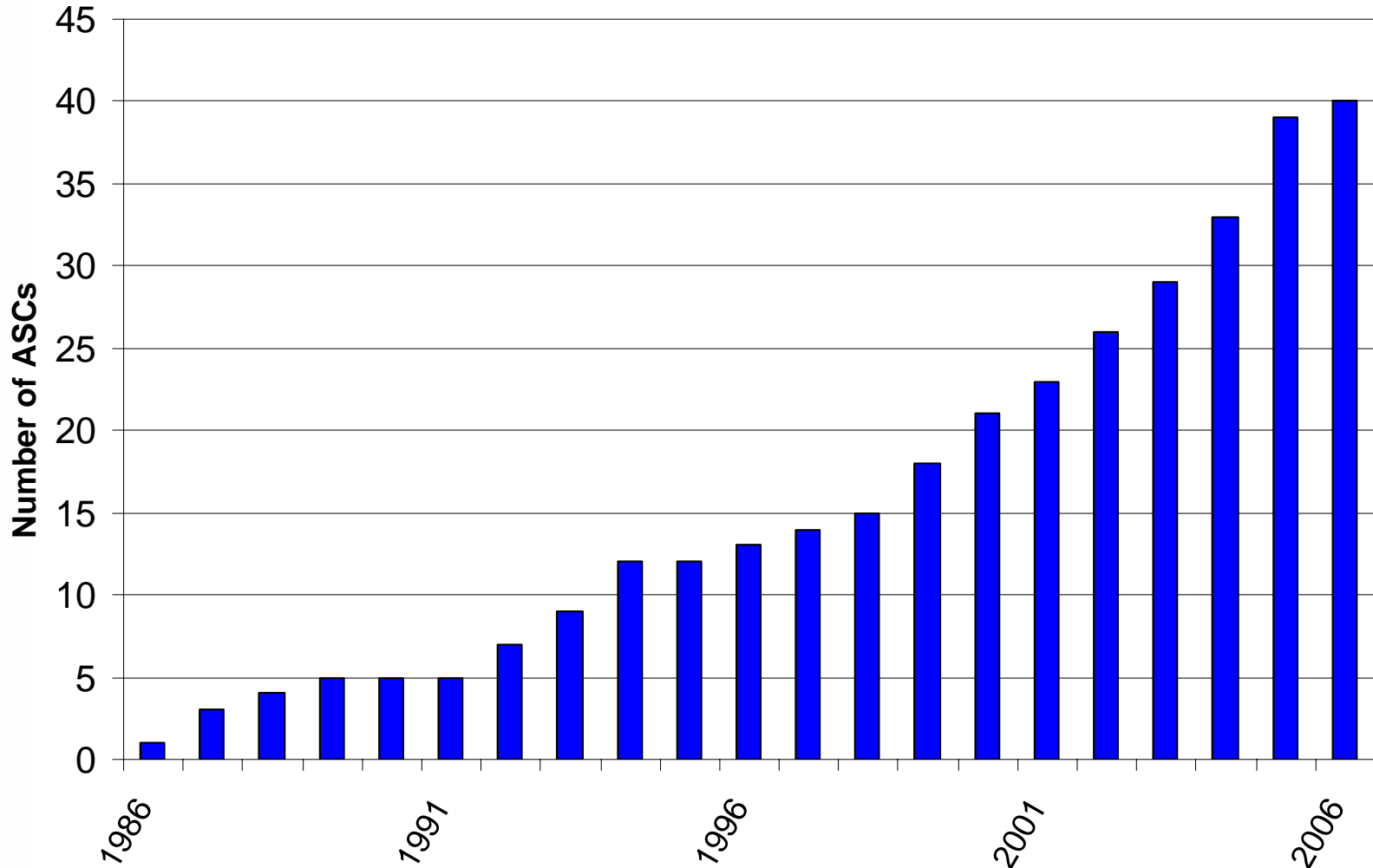


Source:
Christopher P. Tompkins, Stuart H. Altman, and Efrat Eilat,
The Precarious Pricing System For Hospital Services,
Health Affairs, Vol 25, Issue 1, 45-56

Dependence on Commercial Outpatients

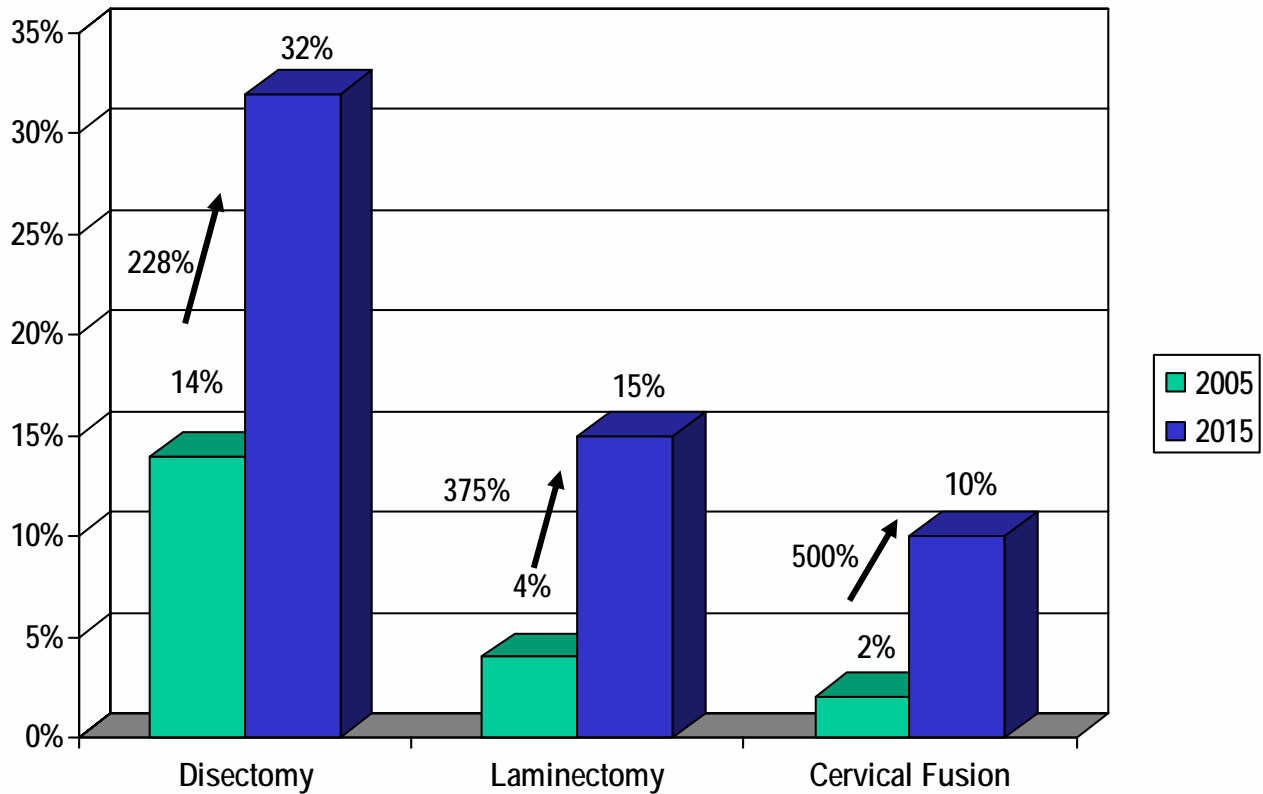
Profitability of Commercial Patients					
	Hospital	\$ Profit		Profit Margin	
		Inpatient	Outpatient	Inpatient	Outpatient
Dependent on Outpt.	GA, rural	\$ 490,524	\$ 958,005	17.8%	38.4%
	TX, suburb	\$ 614,615	\$ 2,180,722	17.9%	57.4%
	SC, urban	\$ 669,517	\$ 3,278,946	7.7%	35.1%
	TX, rural	\$ 1,043,082	\$ 4,436,607	15.2%	39.0%
	IN, urban	\$ 1,741,555	\$ 9,036,110	9.1%	34.3%
	GA, urban	\$ 1,944,589	\$ 10,841,218	4.4%	37.1%
	GA, urban	\$ 4,904,187	\$ 8,830,228	18.6%	31.2%
	CO, urban	\$ 6,912,242	\$ 22,930,179	15.5%	51.1%
	IL, urban	\$ 14,017,691	\$ 29,603,983	26.0%	46.8%
	Average	\$ 3,593,111	\$ 10,232,889	14.7%	41.2%
Depend on Inpt	FL, urban	\$ 21,025,140	\$ 6,748,792	40.0%	42.6%
	TN, urban	\$ 21,719,079	\$ 14,519,686	26.8%	38.4%
	TX, urban	\$ 28,789,298	\$ 19,071,384	26.6%	37.8%
	Average	\$ 23,844,506	\$ 13,446,621	31.1%	39.6%
	Total Avg.	\$ 8,655,960	\$ 11,036,322	18.8%	40.8%

Tapping the Revenues – ASCs Opening Dallas, TX



Targeting the Lucrative Cases

Percentage of Outpatient Cases in ASCs



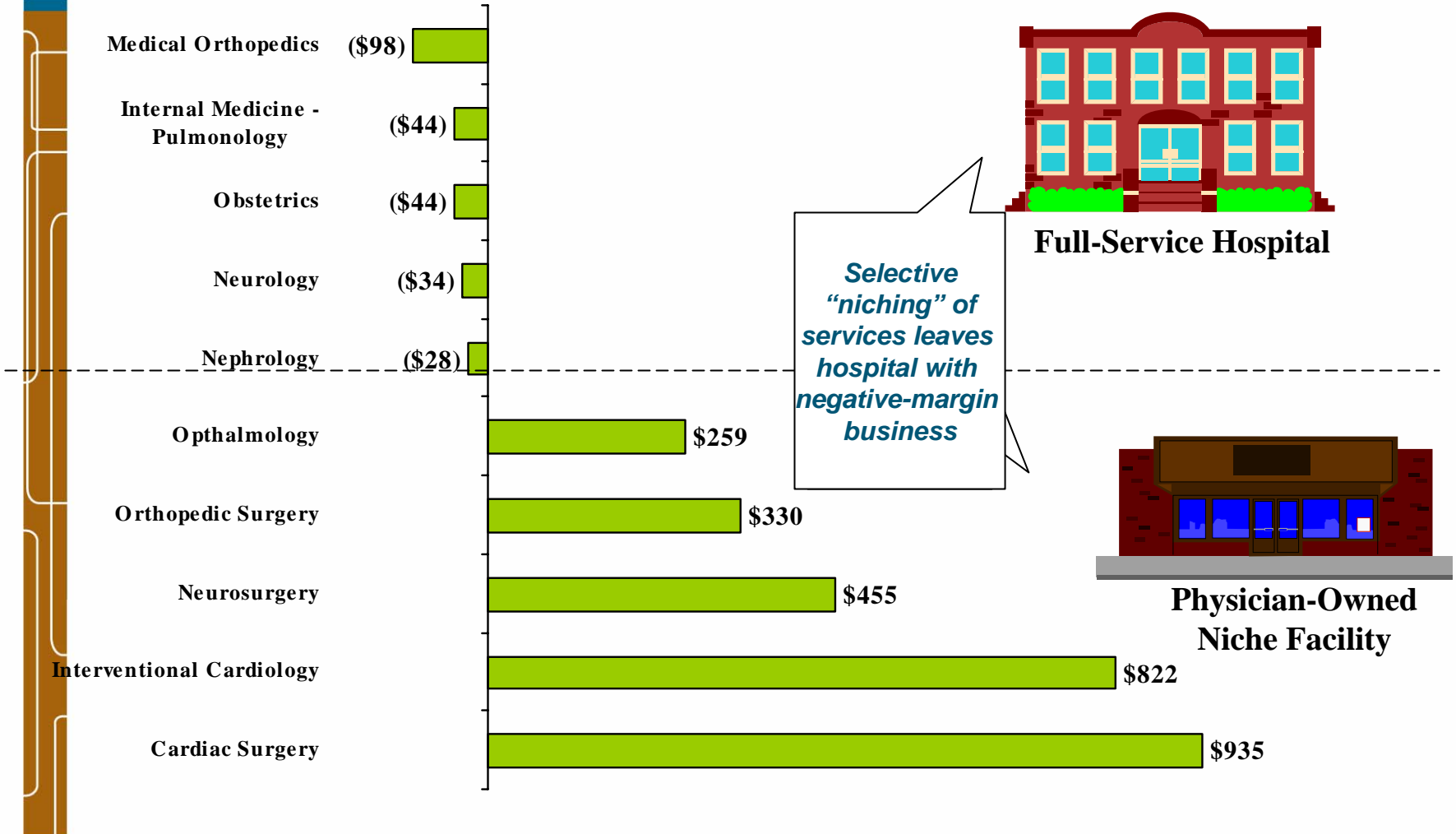
Percentage Commercial: 60%
 ASC Commercial Revenue: \$4,672

64%
 \$5,138

72%
 \$14,031

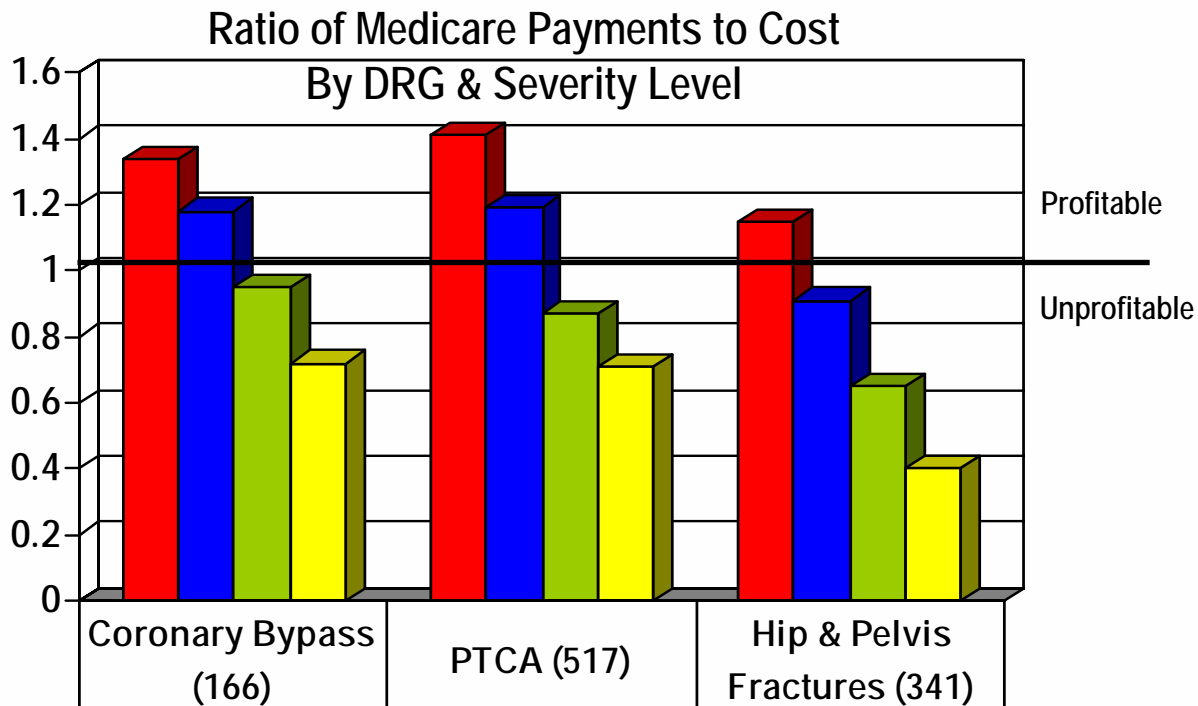
Tapping the Revenues – Inpatient Services

U.S. Hospitals – Profit per Patient Day



Propelling Medicare to Rebase DRG Payments

"... differences in profitability across patients of varying illness severity would give hospitals financial incentives to select the less severely ill (and less costly) patients within DRGs." – MedPAC, 2005



Source: MedPAC analysis of CMS Reports, 2000-2002

■ Least Severe	1.34	1.41	1.15
■ Severity 2	1.18	1.19	0.91
■ Severity 3	0.95	0.87	0.65
■ Most Severe	0.72	0.71	0.4

Patients Becoming More Involved

Patients push for price data

Lawsuits, regulations could cause consumers nationwide to start seeking more transparency from hospitals on outpatient fees By: Cinda Becker, Modern Healthcare, Nov. 2006

DeLois Gibson never paid much attention to her hospital bills until the deductible of the health plan offered by the Seattle law firm where she works was raised to \$1,500 from \$200, and she became responsible for 20% of her medical bills. After the change, she started questioning every charge, she said, a practice that ultimately embroiled her longtime healthcare provider, Virginia Mason Medical Center, in a class-action lawsuit.

"I do pay more attention to how I spend my medical dollars just like I do when I go grocery shopping," Gibson said. "I'm looking for the best deal."

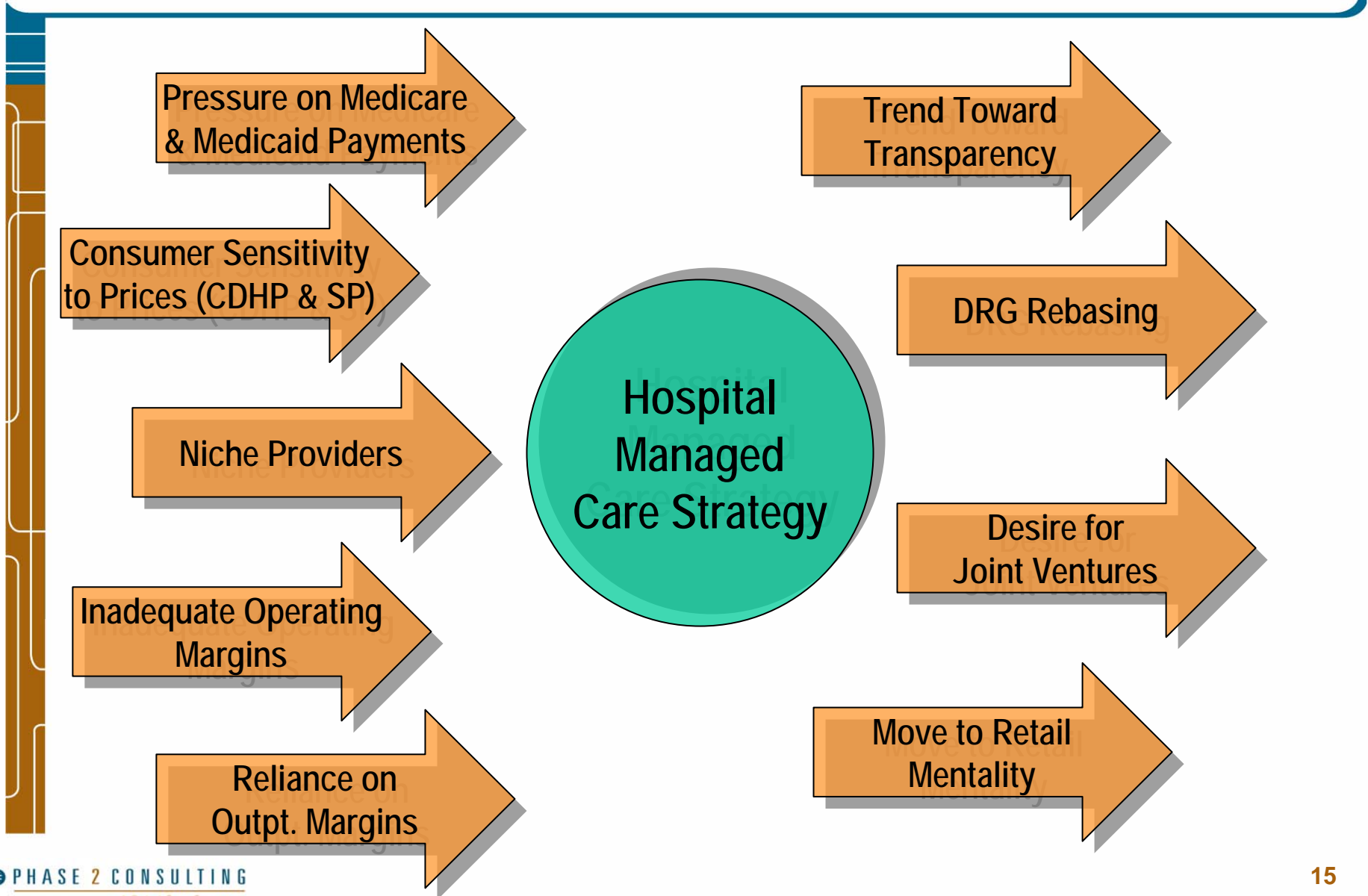
...

"I really do think the industry hasn't really had the opportunity to think through the magnitude of change that transparency of pricing will drive," said Jean Chenoweth, senior vice president for healthcare improvement at healthcare research company Solucient.

...

But indirectly the case potentially affects how hospitals nationwide market their outpatient services to patients. That's a huge financial stake for hospitals, which have long been fiercely defending their turf against the invasion of physician- and corporate-owned outpatient centers, widely regarded as the biggest growth area in healthcare.

New Drivers of Strategy



Current Pricing Approach

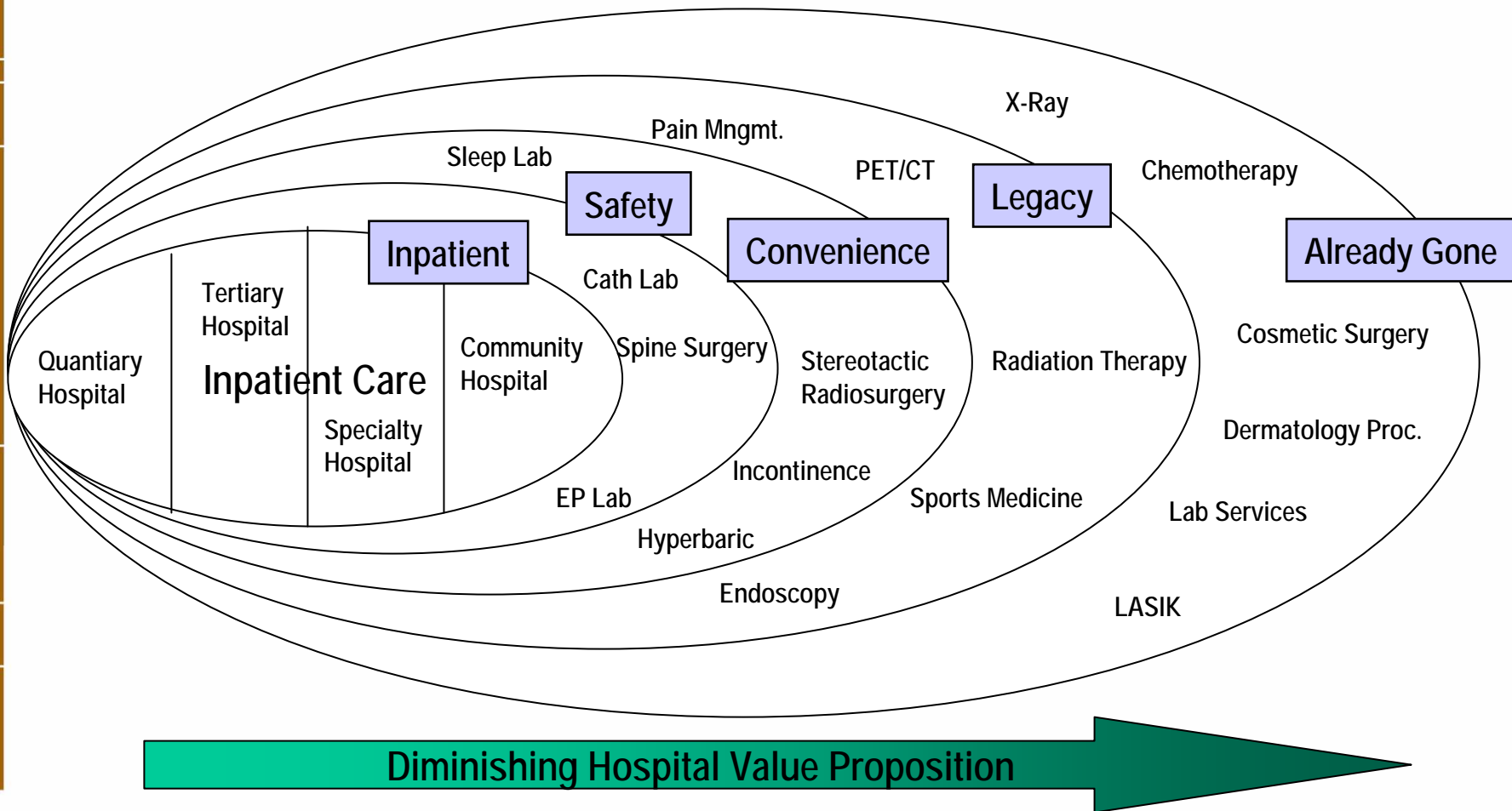
- The current pricing approach conflicts with economic theory. General acute care hospitals:
 - Have a competitive advantage and market protection in acute, complex services.
 - Are exposed to competitive pressures on the outpatient side.
- The result?
 - Significant market distortions
 - created both “niches” and vulnerability for hospitals



Strategic Pricing - A New Approach

- To protect and optimize certain revenue streams, hospitals should shift commercial payments from “commodity” to “proprietary” services.
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 - Laboratory tests
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Focusing Revenues Where Hospital is Valued

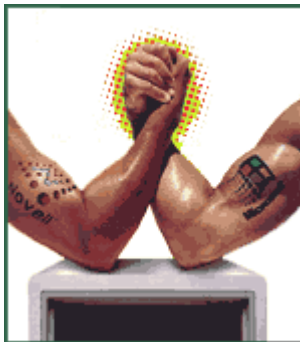


Strategic Price Shifting

- General acute hospitals are best served by:



- Focusing commercial payments on areas that have the greatest barriers to entry and the fewest providers.
- Reducing economic reliance on services where the market is flooded.





- This will help hospitals maximize the revenues that support the rest of the mission.

Economic Theory Perspective

- 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
 - Perceived value to the customer



Strategy Effects

- The strategy of  the price for *proprietary services* while  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 to have an adverse effect on commercial payers.
- Hospitals must decide if they want to use this tool as a way to increase volumes.
- If the hospital is a “rate setter” in its marketplace and has the capacity for additional volumes, managed care organizations can justify lowering the payments to all providers for specified services.



Shifting to Core/Proprietary Services

<u>Service</u>	<u>Current Profit</u> <u>per Case</u>	<u>Current Profit</u> <u>Margin</u>	<u>New Profit per</u> <u>Case</u>	<u>New Profit</u> <u>Margin</u>	<u>% Change</u>
<u>Proprietary Services:</u>					
390 - Newborn	\$649	32.40%	\$2,512	65.0%	100.4%
209 - Orthopedic surgery	\$8,883	48.00%	\$17,854	65.0%	35.3%
1 - Neurosurgery	\$11,419	43.30%	\$27,762	65.0%	50.1%
148 - Surgery	\$12,642	49.90%	\$23,552	65.0%	30.2%
Total core services	\$1,532	48.00%	\$2,852	63.2%	31.7%
<u>Noncore services:</u>					
373- Obstetrics	\$1,179	33.10%	\$1,548	39.4%	19.0%
494 - Surgery	\$4,345	52.90%	\$2,520	39.4%	-25.5%
183 - Gastroenterology	\$3,195	53.50%	\$1,808	39.4%	-26.3%
143 - Cardiology	\$3,797	58.20%	\$1,776	39.4%	-32.3%
Total noncore services	\$1,872	41.30%	\$1,632	38.1%	-8.0%
<u>Commodities:</u>					
Day surgery	\$1,428	52.00%	\$495	-59.9%	-65.3%
Minor emergency	\$135	47.60%	\$59	-66.3%	-56.3%
OP testing	\$304	56.70%	\$63	-37.2%	-79.3%
Cardiac clinic	\$101	29.40%	\$62	-34.5%	-38.6%
Total commodities	\$873	55.30%	\$224	-44.4%	-74.3%
Total (All Service Lines)	\$1,256	48.80%	\$1,256	48.8%	0.0%

Note: All services must maintain a positive Contribution Margin

Source: Phase 2 Consulting Records

Overview of Recommended Actions

1. Determine current contracting structure and the structure you want.
2. Classify services on a scale from commodities to core services.
3. Look for opportunities.
4. Using current cost-accounting system, determine current profits for each unit.
5. Model, model, model.
6. Develop a communication plan with hospital staff and managed care organizations.
7. Set new rates and work with managed care organizations to implement.

Protecting Core Services

- General acute care hospitals cannot ignore a significant revenue drain.
- These hospitals must continue to examine new ways to combat niche competitors and maximize core revenues.
- Each hospital needs to evaluate its own situation to determine to what degree it is capable of implementing a program amidst prevailing economic, market, and legal issues.



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