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A Strategy for Defensible, Sustainable Prices

About HFMA Roundtables

With this article, HFMA continues a series of “virtual” discussions to offer thought leadership and practical perspectives on healthcare financial issues by leading industry professionals. This roundtable offers viewpoints and advice about the challenges of making pricing decisions as part of a hospital’s overall financial strategy. This HFMA Roundtable is made possible through the support of 3M Health Information Systems.

A moment of truth has arrived for planning, finance, and operations. Gone are the days when pricing strategy meant a yearly retooling of the chargemaster. Also on the outs are traditional “strategic pricing” processes that haven’t withstood the scrutiny of hospitals’ many stakeholders. Instead, forward-thinking hospital administrators liken the idea of managing prices to the process of capital allocation. Both should be integral pieces of a hospital’s financial strategy in light of shrinking reimbursement levels.

Often, what makes managing the pricing function difficult for CFOs is their shallow pool of net revenue. When hospitals are ready to dive in and adjust their charges, there is little room for miscalculation. A tiny mistake could spell serious trouble for organizations plagued by slender margins and revenue streams built on the past.

In this article, healthcare providers, consultants, and an attorney peel away at some of the issues that can derail pricing strategies in hospitals and healthcare systems. They also provide practical, thoughtful suggestions on how hospital administrators can implement sound pricing strategies that they can sustain over the long term.

ROUNDTABLE PARTICIPANTS



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David Gladstone, Vice President, TRC Information Management Group, Hartford, Conn.



James L. Heffernan, FHFMA, CFO and Treasurer, Massachusetts General Physicians Organization, Boston. The physicians' organization, which represents more than 1,200 physicians, reported total operating revenues of \$364 million in 2004.



Gregg Johnson, MBA, Project Manager, responsible for managing pricing and chargemaster consulting engagements, 3M Health Information Services, Consulting Services, Atlanta.



Michael Nugent, CHFP, MBA, Senior Manager, Tiber Group, a healthcare strategy consulting organization based in Chicago.



Sydney Rountree, FHFMA, Senior Financial Officer, MedCentral Health System, Mansfield, Ohio. The system includes two general, acute care hospitals with a combined total of 351 beds and 44 bassinets.

ROUNDTABLE DISCUSSION

► **Let's talk about the idea of "defensible" prices. How can organizations develop prices that they are comfortable discussing with patient advocacy groups and civic organizations?**

► **Johnson:** Certainly hospitals need to have pricing and pricing policies they are comfortable discussing with any of their constituents and the public. Many times, hospitals are embarrassed when their prices are depicted by the press as "out of line" with those of the rest of the market. This normally occurs when the hospital is one of the highest if not the highest-priced hospital in its market. Or the hospital may implement a significant price increase that they might see as justified because they haven't raised prices for two or three years. For example, prices may jump 20 percent from one month to the next, because the hospital is trying to "catch up." It is more appropriate to increase prices on a yearly basis in relation to the costs of doing business.

A hospital should evaluate market survey information when setting its prices in order to establish or confirm a competitive price position. Unfortunately, most industry "outsiders" don't realize that payment is significantly lower than price for most payers. I believe government and public pressure will change this in the future. A proactive hospital will need to change its contracts in order to realign prices with payment. This must be done over one or more years since government payments rely on historical costs that sometimes are two or more years old. Strategic pricing currently may have a negative connotation, but any pricing strategy must be performed using good business principles so that a hospital can retain its financial good health.

► **Gladstone:** The whole idea of strategic pricing differs from what I would call *price transformation*. It may be that we are trying to change the meaning of strategic pricing. Most people today would refer to strategic pricing as that mechanism used to maximize net revenue while minimizing increases to gross revenue by trying to determine which services provide the most bang for the buck and raising prices for those services. This type of strategy, however, is no longer valid and its use is coming to an end. Pricing strategy, or pricing

transformation, is a different animal. Our clients tend to use one of those terms because they want a rational, defensible process. Strategic pricing does not resonate with payers, the insured, the press, the board—basically, all of our constituents. *Price transformation*, however, is a process of setting up predictable, affordable, and defensible prices.

► **Nugent:** Ultimately, CFOs need to defend their prices to a wide variety of stakeholders, including patient advocacy groups, civic organizations, boards, physicians, and patients. On the surface, each stakeholder may have a different point of view on prices. Therefore, a key step in managing defensible prices is to define consistent pricing criteria. Criteria I pose to my clients include: Does the price enhance your overall competitive market position service by service? Does the price reflect your organization's intrinsic costs, including capital and ROI? Does the price reflect the relative value patients receive for a particular service (e.g., prescheduled, off-hours MRI vs. MRI as part of an acute, complex medical inpatient stay)?

► **Bookman:** The problem is that prices are a historical development, which makes it very difficult for hospitals to change their charges. Getting back to the issue of public perception and pricing fairness, hospitals shouldn't necessarily put their focus on trying to change prices. Instead, they should develop charity care and indigent care policies that will allow them to take patients' individual factors into account.

► **Heffernan:** I agree that the discussion of pricing goes hand in hand with having a policy for charity care overall. We have had a formal policy in place since our organization was formed in 1994, and our physicians do take charity care. In the state of Massachusetts, we have a free care fund that the hospitals participate in. As a physician organization, we have agreed to follow a policy consistent with our principal hospital's policy. And it makes our pricing strategy appear to be more defensible.

► How should organizations approach pricing strategy?

► **Nugent:** Managing prices is analogous to allocating capital strategically. Organizations need to consider managing prices in the context of their long-term market strategy. "Strategic price management" is

fundamentally different from the traditional chargemaster exercise and is a core competency of the most successful organizations outside of health care, including Southwest and Disney. First, you have to define your pricing intent and understand your competitiveness within specific customer and service segments. Then, you have to leverage forecasting and optimization tools to systematically evaluate pricing opportunities and risks within those segments. Lastly, you have to transform select contracting relationships to penetrate target segments based on value rather than just leverage.

Let me speak on the second component, forecasting and optimization tools, for a moment. Other industries rely on more sophisticated methods and competitive intelligence to forecast future utilization, revenue, and costs under different pricing scenarios. Hospitals are just now beginning to evaluate how patients seek and physicians refer different services under various competitive pricing scenarios.

► Can hospitals take control of pricing strategies in-house?

► **Rountree:** Our organization did. Three years ago, we created an internal chargemaster integrity team, chaired by our compliance officer, to manage prices. This multidisciplinary team includes finance, patient accounting, medical records, material management, and many of our clinical directors. We created the team because we believed that we needed the in-house expertise. We also developed one of our nurse auditors into a certified hospital coder and created a position of chargemaster coordinator. We didn't want a quick fix—we wanted the changes that we made to "stick."

We feel that it is very important to have clinical managers involved. They need to understand that pricing does matter to them. And they need to understand how the organization gets paid—they don't get dollar for dollar on every gross charge that they produce.

► In other words, pricing is not just a finance issue.

► **Rountree:** Yes, in fact, I would say that pricing is really a team effort, including both the financial and clinical aspects of health care. Finance admittedly is at the helm of developing the strategic pricing model for the organization; however, it is best managed through a team approach.

► **How difficult was it to get buy-in from your clinical managers on this process?**

► **Rountree:** I think it's universal that clinical managers feel incredibly overwhelmed. It's not that they don't want to, but they feel they don't have the tools to keep up with the business side of what they do. Getting buy-in was tough, and it still can be a struggle. Adding responsibility for coding knowledge is generally a new concept for them. However, there must be a tight linkage between clinical and finance—otherwise the finance people don't know when something new clinically is being done, and the clinicians don't know when their “new thing” should involve new codes and result in new revenue.

► **Heffernan:** Educating clinicians is a significant part of the process. Four years ago, we developed common fee schedules across our employed group practices. We had found that the same service was charged differently by different specialties, and it was very hard to evaluate contracts. Also, we wanted to make sure that the pricing was consistent as we entered into global pricing for high-end services.

Developing the fee schedules probably took a year. We implemented the process during our budgeting process, so we tried to make sure that we got closer to the charges. Then, we had to educate physicians and clear up some of the misconceptions that were out there. For example, physicians were concerned that moving to a common fee schedule would upset their profile maintained by insurers. And while that may have been true at one point, it was no longer the case.

► **What are the biggest challenges that organizations face when developing a pricing strategy?**

► **Gladstone:** In a broad sense, the biggest challenge is that the net revenue stream has been built on the past. Most healthcare organizations do not have the margins that allow them to slip from that current net revenue stream, so they have a limited margin for error. It is like walking on a tightrope without a net.

Another challenge is the language in some of the contracts. Most contracts have “lower of” language, which means that hospitals get reimbursed according to the “lower of” their charge or the fee schedule. That kind of language forces hospitals to set charges at the highest possible fee schedule. A major contractual

change would be to get rid of the “lower of” language, so that they are paid from the fee schedule.

► **Johnson:** In my view, developing a pricing policy is fairly simple: remain price competitive, be fair to consumers, and obtain enough net revenue to pay your bills and invest for future needs. The challenge is to put this into practice and try to forecast the future competitive and regulatory environment.

No hospital wants to be accused of price fixing, so being competitive requires evaluating *public* price information about your competitors. Evaluating comparative information is always a challenge. The biggest source of market information now is CMS data. The drawback is that the CMS data are usually a year or two old, and may not provide a true picture of the current environment. Commercial data must be at least three months old to alleviate concerns about price fixing and may not even be available.

Fair consumer pricing is difficult since the real issue is fair payment. Some hospitals write off more of the charge than they collect! Laws “requiring” that all patients be charged alike regardless of their insurance or ability to pay may be responsible for the disconnect between charges and payment. Public scrutiny over the financial hardship of self-pay and underinsured patients has further revealed the problem with disconnecting payment from price. The result has been hospitals creating discount policies for these financially abused patients.

► **Heffernan:** One of the challenges we face as a physician organization is determining what is a fair basis for setting charges when you start to go across specialties. A lot of physicians gravitate toward the Medicare Relative Value System. The problem with those weights is that the equity between charges starts to diminish across specialties. And certain specialties don't have a high Medicare penetration, so they don't spend as much time providing data. Two examples are obstetrics and pediatrics. Medicare data is a good place to start, but we need to make some artificial adjustments. For example, take regular delivery services. We believe that the weights in the Medicare Relative Value System are too low for obstetrical delivery services and need to be adjusted.

The other type of adjustment we make is based on our own internal cost. When we first started, we found charges that were either at or below cost. You have to at least be cognizant of where the cost is.

► **Bookman:** If a hospital decides to implement a charity care policy to build more defensible prices, one challenge relates to admissions. There are a number of different entry points into a hospital: admissions, the ER, etc. Yet the people who are responsible for these admissions have different understandings of what the hospital's admissions policies are. Different financial clerks from the same hospital may use different forms and different income screening tools. To overcome this disparity, the hospital needs to develop uniform forms and tools, and then train staff at all points of patient access.

► **What kind of data does an organization need to gather to support a pricing strategy?**

► **Rountree:** There are at least two tools that you have got to have when looking at a pricing strategy: a clean and compliant chargemaster, and marketplace intelligence that helps you price at the procedural level. The latter is particularly difficult to obtain. We are competing against freestanding imaging and other services in the community that do not need to publicly report their pricing.

► **Gladstone:** While it is easy to understand what your sister hospital is doing down the street, it is not easy to understand what's happening at the ambulatory center down the block. It is a competitive disadvantage that hospital information is public.

► **Heffernan:** On the physician side, it is even harder to get pricing information than on the hospital side. We do use regional pricing data. The problem, though, is that a lot of companies that participate are large, national insurance companies. But our local market is dominated by three regional HMOs. So we only can get a piece of it.

► **How can organizations ensure the accuracy of their chargemaster?**

► **Bookman:** The problem we see is that some hospitals have chargemasters with thousands of charges for services they don't even perform. But hospitals can minimize these problems with thorough reviews of their chargemaster.

► **Rountree:** The key to a clean chargemaster is keeping up with the changes. Not only do the services that we offer change periodically, but also myriad

coding and regulatory changes are happening on an ongoing basis, including CPT codes, revenue code regulations, status indicator changes, and the like. That means you have to contract that out or develop the in-house talent. We chose a team approach in-house.

► **Gladstone:** It's also a systems problem. The systems that many hospitals are using now were designed to be used at the department level, and they may not have enough detail for the level of scrutiny that's required. Another challenge is the lack of standardization in our industry. We all have different charges: one hospital may charge for a one-view chest X-ray, another may charge for a two-view chest X-ray. And while CPT codes are all standardized, we all have different chargemasters, even those in the same healthcare system.

► **How should factors such as payer mix and market considerations enter into the equation?**

► **Nugent:** Hospitals tend to overlook these factors when managing prices. Therefore, as finance audits its chargemaster and contract prices, we advise the hospital's planning department to systematically audit its market position and pricing decisions by type of service, geography, competitor, payer, and patient segment. The result is a much more robust set of planning assumptions, which, when integrated into forecasting and optimization models, can yield a competitive contracting advantage.

► **Rountree:** Payer mix is a conundrum. We are 65 percent Medicare and Medicaid, so some people may say that we don't need a pricing strategy because we are so fixed. But we still have commercial pricing. Our basic pricing strategy is that our prices need to be at minimum what the Medicare fee schedule is. And we use a multiplier form so that we make sure that we get at least what we are due from Medicare. The challenge, of course, is that we don't get paid enough because of dwindling government reimbursement.

► **Johnson:** Accurate payer mix for one specific charge is used to evaluate the impact of either increasing or decreasing its price. This must be repeated for all the other charges. Once the relationships are modeled, the impact of price changes on payers and patient segments may be analyzed in at least three ways: 1) maintenance of a competitive market price, 2) quantifying price impact on various payers and net revenue needed

to cover increasing costs, and 3) pricing each service in relation to its value and other similar services. Clearly, payer mix is part of the basic foundation for building a pricing model, which allows a hospital to evaluate multiple price scenarios and their market impact.

Market considerations can mean many things, including examining what the payment impact on each payer may be, what the starting and ending price position in the market will be, or determining whether new pricing will require contract renegotiation.

Many market considerations can and should be modeled as benchmarks or limiting constraints. Understanding the importance and priority of multiple market considerations should be the basis for setting short-term and long-term pricing goals. I believe the larger the gap between price and payment, the larger the risk of negative market reaction.

► **How can you address any risks to your organization's business that might arise because of pricing decisions?**

► **Nugent:** One of the biggest risks is incorrectly anticipating how competitors will react. For example, the price wars in the airline industry decimated carriers. Hospitals also need to understand what consumers are willing to pay for, which will reduce the risk of hospitals simply raising prices to overcome volume reductions for services that need to be redesigned to meet customer expectations.

► **Gladstone:** Having a rational pricing strategy is all about mitigating risk, whether you view risk as bad public relations policy or potential litigation. Today, there is a heightened level of scrutiny. In the

old world, HMOs were trying to eliminate explanations of benefits, and patients never saw prices. But now, patients in consumer-directed health plans see those EOBs and prices. It's become a consumer issue.

► **Rountree:** The way we have counteracted pricing concerns is by having one of the lowest charge structures in the state. A study was just completed that published the markup percentage from cost of charges in all 155 hospitals in Ohio. The study, which looked at a dozen DRGs, showed that our markup of services was well below the median markup for the state. So I can very easily stand in front of my community and say that our charges are defensible. Now, they may still think that we are expensive, but our charges are defensible.

In general, I don't think that it is the best strategy to have the lowest charges. There must be an ROI—we do have bricks and mortar, and new technology costs to cover. The best strategy, in my opinion, is to be in the middle of the road on charges in order to support high quality services.

► **Bookman:** Going back to what I've already said, although there is a risk of community backlash if prices are considered unreasonable, this can be mitigated with a charity care policy. But it must be adequately explained to staff and patients.

► **Heffernan:** I agree. If an organization has made a solid commitment to its community, pricing is less likely to come into question. That doesn't mean that an individual can't pick apart a case. But by and large, local agencies should know that the organization has a very strong commitment to the community. In our experience, this is the most constructive response in these situations.



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