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# Strategic Price Setting: Ensuring Your Financial Viability Through Price Modeling

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No one yet has figured out a formula or come up with a chart to tell hospitals when and how much to change their pricing. Tools that take the guesswork out of this essential but complicated task would be worth their weight in—well, increased revenues.

Without such tools, hospitals have to figure out pricing strategies on their own.

Years of reimbursement challenges coupled with skyrocketing labor and technology expenses have spurred hospitals to explore other avenues to enhance their revenue growth. Many are returning to a strategy that enjoyed more popularity a decade ago when fixed-fee payments were less dominant in the payer mix: strategic price modeling.

Compared with pricing strategies of years past, today's enhancement efforts are more limited in scope because the fixed-fee payment population grows every year. Still, pricing can be a highly effective strategy for hospitals in today's market. Through strategic, appropriate pricing, healthcare institutions can boost their revenue, fund greater access to capital, and remain financially viable.

## It's not Wal-Mart

For the most part, research shows few differences in pricing behavior between not-for-profit and for-profit hospitals. And both types of hospitals struggle with the absence of a “magic” formula or industry standard to calculate charges.

Not long ago, many volume-hungry hospitals put marketplace issues before cost when determining pricing. But after years of tight margins and escalating costs—particularly in labor and supplies such as drugs, implants, and surgical devices—administrators are less pained at losing volume. Instead, they want higher revenues per unit, which they can achieve through strategic pricing. Hence, cost has regained its throne as king.

Getting an accurate sense of labor, supply, and other expenses is critical for a successful pricing strategy. That means determining the cost per procedure by DRG code, APC code, or payer, says Edward B. Carlson, vice president and CFO at Munson Healthcare, a regional not-for-profit healthcare system in Traverse City, Mich. Time studies, value units, and other basic cost-accounting techniques can help finance departments to drill down data to that level.

“You need some sense of what the relationship of cost-to-charge is at the procedure level, as opposed to just an overall ratio,” says Carlson.

## Charging Ahead with the CDM

Hospitals hoping to improve their revenue with pricing strategies often begin by gathering information. They start by turning a critical eye toward their chargemaster, or charge description master (CDM).

Keeping a CDM current and compliant can be a challenge for many organizations faced with constantly changing CPT codes and ever-evolving rules and regulations. But an accurate CDM and effective claims process are two of the hospital’s most important allies, particularly under the CMS outpatient prospective payment system.

To ensure accurate claims and appropriate payment, the hospital must maintain its CDM. Ongoing maintenance of the CDM involves many steps, including:

- Eliminating rarely used or inaccurate codes
- Adding missing charges
- Correcting mismatched CPT and revenue codes
- Reviewing charges for accurate structure in the APC payment environment
- Making sure the CDM is compliant with all CMS regulations

Administrators at Seton Healthcare Network in Austin, Tex., have conducted strategic pricing studies for several years, aided by various software programs that help them determine where they’ll get the best returns on pricing adjustments, based on their payer mix and market constraints. Douglas D. Waite, the network’s senior vice president and CFO, is surprised by how many hospitals still don’t follow similar strategies.

“Hospitals whose payer mix is very high in fixed payments from Medicare or Medicaid may not think this process is worth the investment in time or money,” says Waite. “Or they may have a lot of contracts that limit the size of their annual price increases or limit where they put those increases. But even for those hospitals, I would say it is worth the investment.”

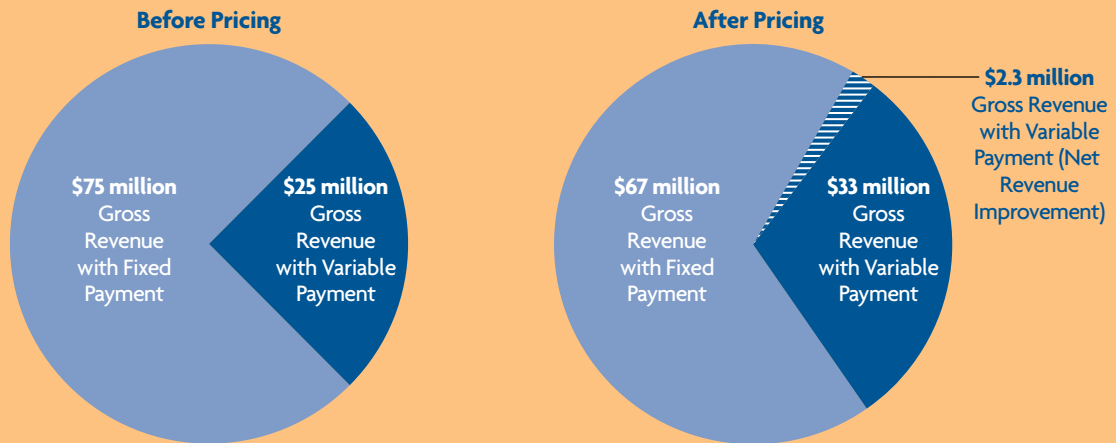
At Seton Healthcare Network, part of Ascension Health, administrators determine where they will get the best return on pricing opportunities on a charge-by-charge basis, not just a department-by-department basis.

“When we run the chargemaster, we might have 30,000 line items or more that we will review charge by charge with our department directors,” Waite says. “We want to ask them if we will be pricing ourselves out of the market or encountering compliance issues if we change charges.”

## “Before” and “After” Pricing

The results of effective pricing can be significant. Take, for example, one hospital with about \$100 million in gross revenue per year, where \$75 million is paid on a fixed basis and \$25 million is paid on a percent-of-charge basis. The finance department wanted to increase net revenue but limit individual procedure price changes to plus or minus 15 percent and remain gross-revenue neutral.

By lowering prices in primarily fixed-payment revenue and raising prices in primarily percent-of-charge payment revenue, the percent-of-charge payment revenue is increased to \$33 million. The hospital gained about \$2.3 million in net revenue while holding its gross revenues constant.



Note: Every dollar increase is expected to achieve \$0.25 more net revenue within the variable payment revenue.

## Gathering—and Sharing—Intelligence

Involving clinicians in effective pricing strategies is critical, experts say. Hospitals should maintain formal and informal lines of communication for clinical managers to share important market information. These communication lines have helped at Robert Wood Johnson University Hospital (RWJUH) in New Brunswick, N.J. “We like to know in advance when technology and technique are changing—we don’t want to first learn of it when we see a budget variance in a financial report at the end of the month,” says John J. Gantner, treasurer of RWJUH.

Other information gathering is also crucial. When deciding where price increases make the most sense, administrators should review market prices from

public databases, which include charges on items at the CPT or HCPCS level based on Medicare claims data. Market intelligence reports and robust software programs can help hospitals compete effectively with other facilities in their area. Using the data, hospitals can determine their competitive pricing posture. Do they want to be a high-volume-low-price competitor in the market? A high-end provider? Or a moderately priced alternative? Many hospitals choose to position their prices in the middle of the market, while others may choose to be the lowest or position their prices just below another competitive hospital.

Not every facility has the resources to manage this guerrilla-like process on its own. In this case, consultants may be helpful in identifying some of these problems and providing CDM improvement strategies.

## Key Factors Affecting Pricing Decisions

Even with an accurate picture of costs, a clean CDM, and market intelligence, pricing is still a complicated dance. The challenge is this: Hospital rates should cover costs and losses from payers that pay less than cost, such as Medicaid. And overall prices should reflect a reasonable return on investment so the facility can stay financially viable.

To help them choreograph their pricing strategies, many hospitals conduct careful studies that factor in variables such as payer contracts, utilization, and market competition.

Another key factor that finance managers consider is pricing elasticity, which demonstrates the benefit to a hospital in raising or lowering a price. In academic terms, the formula is:

$$\frac{\text{Percentage change in quantity/demand}}{\text{Percentage change in price}}$$

A related factor is customer price sensitivity, which measures how business might change as a result of pricing adjustments. For example, customer price sensitivity can help project how a payer might shift patient flow to other facilities as a result of a 10 percent price increase.

Some customers are more price-sensitive than others, which can make price elasticity difficult to determine, particularly in a hospital environment. In general, though, outpatient procedures—often paid out of pocket, at least in part—are more price-elastic than inpatient procedures, making them ideal targets for appropriate pricing strategies that boost net revenue.

Take the lab market, for example. In Michigan, home of Munson Healthcare, competition for lab business is fierce. In an effort to balance rising salaries and

other costs, Munson upped its lab charges. But when physicians started moving their business, the hospital realized it needed to lower prices. When it did, it generated a lot more business. “You can’t price yourself out of the market,” Carlson says. “We learned that lesson, perhaps the hard way.”

At RWJUH, administrators recognized a pricing opportunity at its outpatient executive health center. Armed with the knowledge that most patients pay for these comprehensive physicals out of pocket and “shop” the best prices, RWJUH priced the service competitively and is reaping the benefits of that strategy.

Although strategic pricing options on the inpatient side are limited, one area of significant opportunity is plastic surgery, which is generally not covered by managed care payers. (Refractive eye surgery is another self-pay area.) Plastic surgery is a market-driven service with significant demand elasticity—lower prices result in higher volumes, while higher prices lead to lower volumes. To cater to this market, RWJUH has been able to lower its per-day hospital costs to increase the volume of plastic surgeries.

## Contract Negotiation: Pricing’s Cousin

One of the real dangers of raising rates is that administrators could find their hospital becoming increasingly unattractive to managed care plans. Of course, having managed care companies move business away from the hospital undermines its whole strategy for improving revenue.

It’s a delicate balance, particularly for hospitals facing stiff market competition, such as Seton Healthcare in Texas. The state has no certificate-of-need laws, so many niche hospitals have popped up to provide cardiac, orthopedic, and other surgical services.

That's why Waite argues that hospitals can't move forward on pricing strategies without considering contracting strategies. "The trap is that you can pick up some nice revenue increases year to year, but after a while your level of charges can get too high and your strategy could start to backfire through lost managed care contracts," says Waite. "So while pricing can give you a quick boost, it's no substitute for expense controls over the long term."

It's in this area, too, where pricing studies are critical. Financial models that consider the current CDM, payer contracts, and claims data can be extremely helpful

for CFOs who want to determine how procedure price changes will impact net revenue. Pricing studies and scenarios may detail targets and allowable upper and lower price change limits, as well as impact on gross and net revenue.

The finance department at Texas Children's Hospital in Houston uses financial models "so sophisticated they smoke," half-jokes Sally I. Nelson, CPA, executive vice president and CFO. In seriousness, she adds that building the models was an intensive, nine-year initiative aimed at helping managers make decisions that wouldn't negatively affect the facility or the community.

## Contracting Tips that Complement Pricing Strategies

Robert Wood Johnson University Hospital has been particularly successful with managed care negotiations. In 1993, about 70 to 80 percent of RWJUH's payer mix was self-pay or commercially insured. Today, Medicare, Medicaid, and the underinsured/uninsured make up at least half of the hospital's business. Some of the specific strategies that have worked at RWJUH:

- **Bundling case rates and payments** for episodes of care for tertiary and quaternary procedures.
- **Openers:** If RWJUH can demonstrate that a new drug or technique has dramatically changed the practice of care, the managed care plan will consider making an adjustment to its contract. RWJUH was able to negotiate for these periodic reviews, which usually occur every six months.
- **Stop-loss and outlier provisions:** Stop-loss thresholds are an important strategy to protect the hospital in cases in which charges rise above

pre-set thresholds. Many managed care contracts use a percentage-of-charge arrangement when charges exceed the threshold. These ensure that the institution receives an extra level of payment above the per diem or case rate for outlier patients. Inappropriate use of outlier provisions, however, can land a hospital in hot water.

- **Corridors to protect against market shifts:** RWJUH has built corridors into its contracts to protect itself against dramatic shifts in a particular payer's portfolio of products. So, if a contract is drawn when the business is 50 percent PPO and 50 percent POS, the hospital will be protected if the mix shifts to 30 percent PPO and 70 percent POS the following year. "A lot of strategic pricing today is not so much around the charge setting, but really around the managed care contracting that we do to make sure the contracts reflect the complex type of organization that we are," says John J. Gantner, treasurer at RWJUH.

“It is a big, big responsibility, how you balance out this whole pricing methodology,” says Nelson. “You have to do it right, otherwise you won’t be around for kids in the future.” Her hospital maintains a massive database that has run hundreds of sophisticated, stratified financial models examining whole modes of treatment to help set prices and manage risks in managed care contracts.

“When we price our models, we consider a variety of variables, from what wellness programs are available from the employers to the services available here,” Nelson says. “It would be a lot easier just to price it on cost, but we want to get a really good profile of the patients in the plan. This way, we get a good idea of what kind of risk factors we need to put into our model.”

When Nelson joined Texas Children’s Hospital in 1986, the hospital had an operating loss of about \$17 million and no cash. Today, it’s considered one of the most financially secure pediatric hospitals in the country. Nelson attributes her hospital’s Aa2 bond market rating and financial stability to quality patient care and appropriate pricing.

## The Pitfalls of Pricing

Hospitals that set out to capture the maximum net profit from gross revenues while staying competitive in their market face a number of challenges. Here are some of the common mistakes financial managers make.

**Across-the-board markups:** Many hospitals equate strategic pricing with across-the-board markups from year to year. In many cases, across-the-board markups have little impact on net revenue, particularly for services that are primarily charged to Medicare or Medicaid patients. Strategic pricing is just that—stra-

tegic. It should involve *selective* price increases or decreases for each item code to achieve an overall charge increase.

### **Lack of pricing standardization throughout**

**the institution:** Few issues are likely to bring more customer complaints than services that are priced one way in Department A and another way in Department B. A careful examination of the CDM can help correct these problems.

**Pricing below fee schedule:** Medicare pays the lower of fee schedule or charge. Many finance managers assume that Medicare is paying cost—at least theoretically. So if a hospital sets a price below fee schedule, it fails to capture even its cost. CFOs should treat Medicare APC payments as a fee schedule, and review fee schedules from Medicaid or other payers to make sure prices aren’t too low. Correcting this problem can result in immediate profit gains.

**Failure to bundle appropriate charges:** Some providers don’t understand that routine supplies should not be billed separately to Medicare; these are considered part of the room or procedure rate. For example, gowns, gloves, and masks should not be billed as separate items for a surgical procedure. Again, CDM reviews can help identify problematic areas.

### **\$5 aspirin and other public relations nightmares:**

Hospitals must take into account high-visibility charges during their pricing strategy. When setting prices, hospitals should be sure their prices and level of profit are reasonable—for the hospital, board of directors, and the community.

**Not paying attention to outlier effects:** The industry is seeing greater government scrutiny over pricing in general as a result of current investigations

into outlier pricing strategies. Government regulators want to ensure that hospitals do not “scheme” or implement systems designed to offer facilities additional compensation when they care for the “sickest of the sick.” Raising prices could result in Medicare outlier payments that are above what would be considered “reasonable.”

**Failure to take into account bad debt:** If prices are increased for self-pay patients, hospitals write off additional bad debt. Yet contractual allowances are not treated the same way as bad debt. Hospitals that fail to take into account bad debt or that mismanage their contractual allowances could undermine their financial viability.

**Not providing proper education to clinical managers:** There’s a myth among many clinical managers that pricing doesn’t have much impact on revenue. Some clinical managers believe they get a percentage of every dollar they charge, regardless of the payer. Others can’t see beyond their own department budgets and staffing. Open communication with department managers can help clear up confusion and facilitate buy-in.

**Not understanding your market situation, particularly as it relates to managed care payers:**

“When thinking about your competitive situation, you have to take into account what the HMO’s current hospital network would be and how easy it would be for them to shift patients to another hospital if they had to drop you from the network,” says Robert J. Town, Ph.D., assistant professor of health economics at the University of Minnesota’s School of Public Health in Minneapolis. Town co-authored a report on hospital pricing and competition in the September 2001 issue of the *Journal of Health Economics*. The study used

data from hospitals in Southern California to estimate factors affecting the negotiated prices paid to hospitals by two major HMOs. The authors found that a hospital’s bargaining power—and hence its price—decreases when HMOs are able to construct alternative networks outside the hospital.

**Not looking for trends soon enough:** Some healthcare CFOs rely primarily on 12-month data to identify trends. But Waite suggests that CFOs look for trends using smaller time frames. He recommends examining data every quarter for shifts in business that might indicate a need to adjust pricing. He has established a revenue integrity department to support this effort.

**Failure to factor in the cost of technology:**

One of the stickiest areas for financial managers is how to price technology that is now being used in treatment plans. Such is the case at Texas Children’s Hospital, the largest freestanding children’s hospital in the United States. Nelson says the challenge is to get payers to think beyond days of care and think instead about modes of treatment. This problem is particularly acute at specialty hospitals and academic medical centers, which tend to be more expensive than other hospitals.

Gantner agrees. “Assessing a price involves some evaluation of cost and value—not only ‘What did I spend?’ but ‘What did I get for my money?’” says Gantner. “So one of the challenges for our administrators is to explain and defend our higher prices. We do that by making sure we’re able to demonstrate the quality differential and the superior outcomes at this hospital, such as lower infection rates and other complications. We need to be sure we are worth more and that we can demonstrate why we are worth more.”



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