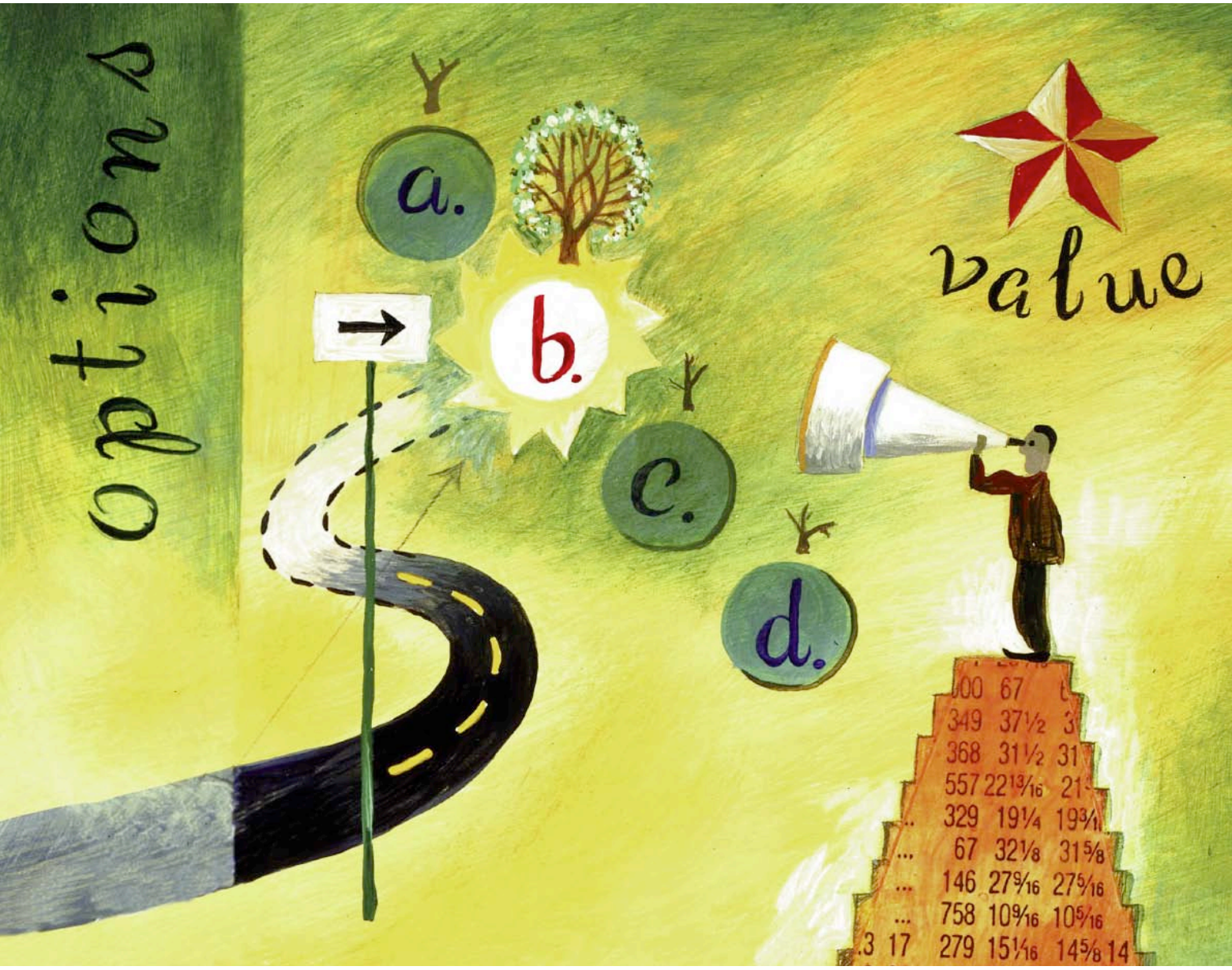

Setting healthcare prices at levels that are appropriate for both your revenue stream and your community's well-being, while challenging and fraught with landmines, is possible. How do you set prices that generate enough revenue to sustain operations and that are still considered reasonable to your consumers and payors?

Setting Defensible and Appropriate Prices in Healthcare

by William O. Cleverley, PhD, and James Cleverley

There is no magic formula, but healthcare pricing can be leveraged to manage your hospital's bottom line. When tackling price setting for your organization, some fundamental tenets must be understood. First, to the extent that revenue from any patient class is insufficient, payment increases will be needed from other classes. Second, any pricing strategy should recognize the impact of costs, competitors, contracts and return on investment.

Healthcare Pricing Factors

Three sets of factors affect healthcare pricing: desired net income, competitive position and market structure. The foundation for most short- and long-term pricing decisions is the desired net income. Every business must be able to generate enough revenue through its sales of products and services to sustain its operations and allow for the replacement of its physical assets as well as provide a return to its investors. Deficiencies in net income levels can be tolerated for short time frames, but inadequate pricing eventually will result in failure of the business.

Competitive position also affects pricing policy significantly. Organizations must assess their quality, cost, market share, capital intensity and payor mix as compared with its competitors. Healthcare organizations that are perceived as quality leaders in a marketplace often can realize higher prices in several ways. They may be able to negotiate more favorable payment terms with major health plans in the area. If the general community perceives one hospital to be higher quality, employers may desire to have that hospital in the plan's network. The hospital also can establish prices that are above its local competitors' because it knows that it has a premium quality advantage.

Lower-cost healthcare organizations can afford to sell their services at lower prices and still generate adequate levels of profit, or they can sell their services at competitive prices and realize higher returns. In either case, it usually means market expansion for the lower-cost organization. By establishing lower prices, the organization should be able to increase its market share. If it maintains competitive prices, the greater profit may lead to expansion in the marketplace because of better access to capital; it may even be in a position to acquire local competitors.

Setting Defensible and Appropriate Prices in Healthcare

Most healthcare markets are regional and subject to the travel limits beyond which most consumers will not go for care. Greater market share leads to greater leverage when negotiating managed care contracts. For example, if a hospital controlled 85 percent of the acute-care capacity in the region, virtually every health plan would be required to include that hospital in its network. This gives the hospital tremendous leverage when negotiating payment terms with payors or for contracts.

Organizations that are heavily capital intensive often have higher levels of fixed cost. Their variable cost of production as a percentage of total cost also may be lower, which may lead to marginal cost pricing in markets that have excess capacity. This behavior was seen in many urban hospital markets in the early days of managed care growth. Hospitals would sign agreements with health plans at payment levels below their average total cost but above their variable or marginal cost. These hospitals were afraid that they might be excluded from a plan's network and lose critical volume, so they agreed to payment levels that just barely covered their variable costs.

Payor mix has perhaps the most pervasive influence on prices in the healthcare marketplace. Organizations with heavy percentages of Medicaid and uninsured patients usually will experience large losses on these books of business no matter how efficiently they produce healthcare services. Therefore, these organizations must be in a situation to increase revenue derived from other patients to offset losses from Medicaid and uninsured patients.

Realities of Price Setting

The realities of price setting in healthcare, then, are dictated by such concerns as average costs, losses on patients who pay less than cost, discounts to uninsured and commercial charge patients, and return on investment that is at a reasonable level to sustain growth.

Another important factor is the public's perception of your pricing policy and its reaction to the demoralizing stories in the press about overcharging the poor. For example, according to a March 17, 2003, article in *The Wall Street Journal,* the uninsured typically are charged 100 percent to 230 percent more than insurance companies for the same service and are thus subsidizing the for-profit insurance industry.

To assure the media and your community that your healthcare prices are appropriate, you must have a pricing model in place that is defensible. This means developing or maintaining a pricing strategy that covers your costs, considers the factors discussed earlier, and does not allow excessive charges to any one population of patients, particularly the self-pay segment.

To be sure that your organization's prices are not excessive, measure your organization against the return on investment (ROI) public utility model.

The ROI public utility model formula is:

$$\text{ROI} = \frac{\text{revenue} - \text{cost}}{\text{investment}} = \frac{\text{volume} \times \text{net price per unit} - \text{volume} \times \text{cost}}{\text{investment}}$$

This equation has four variables: ROI, cost, price and investment. If a hospital can demonstrate that its cost is reasonable, it is not making excessive levels of profit and it does not have excessive levels of investment, then by definition its revenues are reasonable, which means that its prices are reasonable.

Answering the question of cost reasonableness often is difficult; it involves comparisons of costs between similar hospitals. The measure that is often used is the cost per adjusted discharge-case mix adjusted. We believe this measure suffers from several fatal flaws that render its application useless at best, and potentially misleading at worst. In a July 2002 article in *Healthcare Financial Management,* "The Hospital Cost Index: A New Way to Measure Hospital Efficiency," we proposed a new methodology. The hospital cost index assigns a separate cost measure for inpatient and outpatient costs and adjusts those measures for differences in case mix complexity.

Comparing your hospital's relative cost index can help you assess the reasonableness of your current and proposed prices. Hospitals with excessive levels of cost may find it much more difficult to justify price increases until their relative cost is near or below industry standards.

Getting to Appropriate Pricing Levels

If your organization needs to tweak—or even overhaul—its pricing approach to bring it in line with defensible criteria, one of your most valuable resources in this effort is your hospital's charge description master (CDM). Changing prices at the CDM level can lead to a healthy bottom line, and using a mechanism such as the CDM can help ensure that hard data are driving your pricing, not a vague, broad-brush approach to pricing. This allows you to set prices that are responsive to the community and enable the organization to provide high-quality care both now and in the future.

Hospitals that initiate price changes at the CDM level usually adopt one of two strategies. The first approach is the "across the board" increase. In this method, all item codes in the CDM are changed at some constant percentage. The second approach is selective price increases—or decreases—for each item code to achieve some stated overall charge increase. The latter approach usually attempts to place price changes in areas where recovery opportunities are greater. Our experience in pricing studies suggests that selective price increase strategies are more effective, often generating 30 percent to 80 percent more profit than a given overall rate increase. Perhaps of greater importance in today's climate, this approach provides better alignment of rates with both cost and competitive prices.

Before starting a pricing study, three data sets must be available: the current CDM, three to nine months of claims with line item detail and payor contract information. A review of the CDM should be part of the initial process for gathering the required information. This review should include the following areas:

1. Deleted or invalid Common Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes
2. Duplicated line items
3. Medicare noncovered items
4. Item codes requiring a CPT code for Medicare payment
5. Incorrect revenue code
6. Pass-through codes

Most hospitals typically encounter issues in all six areas; a careful review may help avoid lost reimbursement.

Line Item Claims

Line item claims provide the basis for determining recovery rates by item code. A recovery rate defines the percentage of any charge increase that will be recovered as increased profit. Recovery rates may range from 0 percent (no payors pay charges) to 100 percent (all payors pay 100 percent of charges).

Recovery rates are defined by relating payor frequencies by item code to payor payment terms. An item code that had only Medicare patient utilization would have a zero recovery. The major issue in claims sampling is the period of time to review. We have found that a minimum three-month sample should be used with a maximum of nine to 12 months. Sample periods less than three months can lead to a bias in estimating payor frequencies by item code. A larger sample over a longer period of time should be used when seasonality could be a significant factor. For example, hospitals in Florida with high winter Medicare utilization may require nine months to a year sample period.

When using CDM data for pricing changes, be aware of one potential problem. When CDM changes have taken place in the claims period, the claims data will not totally reflect the current CDM. Some remapping of claims data

to current CDM will need to be done.

Payor Contract Information

A review of all the claims data will identify the relevant payors represented in the claims sample. Each of those payor categories must be reviewed to appropriately define payment terms. This is perhaps the most critical part of any pricing study. If payment terms are not accurately modeled, the study's conclusions will be flawed. Key areas that should be examined are:

- Presence of stop-loss provisions
- Presence of carve-outs for drugs or devices
- Nongrouped outpatient surgical categories
- Expected recovery on self-pay portions
- Presence of fee schedules for selected outpatient areas, such as lab and radiology

Usually a large number of payors have no hospital contract. They may account for a relatively small dollar volume, but it is important to validate specific recovery rates for these payors and not apply a universal factor that may not be accurate. While dollar volumes for these payors may be relatively small, they represent a substantial percentage of the total recovery rate for many item codes.

Model Constraints

Most pricing studies deal with three major model constraints: absolute total charge increase, corridors for individual item codes and competitive price limits. Rate corridors limit individual item code price changes. A rule of thumb in pricing studies is to limit the corridors to no more than twice the absolute rate increase. For example, a 10 percent overall rate increase would limit rate corridors to increases between 0 and 20 percent. Larger corridors permit hospitals to load more of the total rate increase into areas with higher recovery rates, thus maximizing rate-increase profitability.

There are, however, two major disadvantages to high-rate corridors. First, they may destroy present pricing relativity. Second, they may eventually kill the goose that laid the golden egg. Increasing prices to payors who pay charges may hurt their competitive position and eventually force them to exit the market, leaving low fixed-fee payors.

Pricing is an effective strategy for increasing hospital profitability. Across-the-board price increases, while easy to implement, usually are not as effective as selective price increases. In addition to providing an increase in profit, selective price increases may create stronger price competitiveness if combined with detailed competitive price constraints and cost-based modeling.

The two major model constraints in pricing studies, competitive price comparisons and estimated cost of production, can provide conflicting signals. For example, a specific radiology procedure may be priced well below competitors but have an extremely high mark-up (price to cost) relationship in comparison with other procedures. Let us also assume that this procedure has a high recovery rate, which means that a price increase for this procedure is likely to generate a larger increase in net patient revenue than other procedures.

There is no simple solution to a dilemma like this, which is often the rule and not the exception in hospital pricing. Hospital management must carefully evaluate and assess the importance of required levels of profit compared to price competitiveness and price-to-cost alignment.

William O. Cleverley, PhD, is president of Cleverley and Associates, Worthington, Ohio. He can be reached at bcleverley@cleverleyassociates.com. James Cleverley is a consultant with Cleverley and Associates. He can be reached at jcleverley@cleverleyassociates.com.

William and James Cleverley will present their seminar, "Setting Defensible and Profitable Prices in Healthcare," during ACHE's Congress on Healthcare Leadership, March 19–22, 2007, in New Orleans.