



How Much Should You Charge for Your Services?

MODULE 6



Yes, your collaboration can charge for the services it provides! But how do you even begin to decide what amount to charge? It's not as hard as it sounds.

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Once you and your multisector partnership or organization have decided which interventions to pursue, what's next? This module addresses a specialized case: the case in which you seek funding from a payer(s)—e.g., an insurer, private employer, or the government—for a specific intervention or integrative activity. Oftentimes, this is done through a health care payment model. In other, words, you want them to pay for a specific service you are providing to them. This module will help you think about how to price your services.

Once you've completed your value sequence and return on investment (ROI) analyses (by completing [Module 5](#)), you'll have a good idea how much value an intervention or integrative activity creates and for whom, and to what extent you might be able to turn that value into income. The next step is to convert that information into a revenue stream. This module will guide you through the following questions:

1. Who might be willing to pay?
2. What is our revenue target?
3. How do we structure a price?

In the field of population health, there is a great deal of emphasis on demonstrating ROI. Knowing the ROI of an intervention helps ensure we make good investments and helps make the case for funding. But ROI may not be the deciding factor in whether or not a payer will purchase your services.

Indeed, many variables influence payers' decision making. These include mission, organizational reputation, political considerations, organizational priorities, power dynamics, competitive pressures, risk tolerance, and regulatory considerations. This chapter will help you navigate these variables.

In the end—even with a strong ROI—your success in acquiring funding will be dependent on becoming an astute observer of your working environment, forming important relationships, and building your persuasive powers and negotiation skills.

Who might be willing to pay?

Look at the results from your value sequence ([Module 5](#)) and system analysis ([Module 2](#)) and ask yourself who might be willing to pay for the value you're creating. Consider:

- Is the value financial in nature (i.e., monetary returns) or is it social, economic, or organizational? That is, is there cash associated with the value?
 - If there's financial value, is it in the form of revenue, cost savings, or avoided costs? Avoided costs are costs that you would expect to incur in the future, but can be avoided entirely or in part through the intervention. Note that avoided costs are important financial returns, but they don't automatically produce cash flow that can be shared.
- How much and what type of evidence will potential payers expect?
- What is your relationship with potential payers? What is their decision-making process?

To help you with this analysis, consult *A Typology of Potential Financing Structures for Population Health* ([Module 3](#)). The *Typology* categorizes various sources of funding by the type of decision makers and decision processes involved. It also indicates how important an ROI is likely to be in the decision-making process.



What is your revenue target?

How much money do you want? It seems like an easy question if you have information, but nearly impossible if you are lacking information about key variables. For example, how much of a mortgage do you want for a house? This will depend on the price of the house you are buying, how much the bank is willing to lend you, and the size of your down payment. If you know none of these things, it will be nearly impossible to answer the question of “how much?”

Likewise, when seeking funding for an intervention, the question of “how much?” depends both on the costs associated with that intervention, as well as what is feasible to expect from specific funders. It’s useful to start by identifying a range.

First, set the lower bound equal to your costs. Presumably, you’d like to cover your costs at a minimum. If you haven’t yet estimated your costs, now is a good time to do so, and [Module 4](#) can help you with that process.

Then, set the upper bound, which should be an estimate of value to the payer. Presumably, payers won’t pay more than what they perceive to be the value to them. [The Value Sequence \(Module 5\)](#), the [“Considering Costs and Benefits” worksheet \(Module 2\)](#), and [A Typology of Potential Financing Structures for Population Health \(Module 3\)](#) all point out that the same product or service has different financial value to different potential payers; treat that value as an upper bound.

For example, one multisector partnership was paid by local hospitals to conduct a joint community health needs assessment because each avoided the full costs of conducting its own assessment—the upper bound for each payer.

Now you have a sense of the boundaries for your funding request. It is possible that the range is quite large. In this case, a large range is okay. As you approach potential payers or investors, you are likely to be in a negotiating situation, so your range is just a starting point. As you engage in negotiations the range will likely get smaller, and eventually you’ll settle on an acceptable number.

It’s also possible that the value to any single payer will be less than your costs. In this case, assuming you have scaled your costs down to a minimum, you need to seek funding from multiple payers and/or seek grants to cover your full costs.

How do you set a price?

Now that you have a revenue target for your intervention, the next step is to figure out a pricing structure. While the final determination of price will likely result from some type of negotiation process, it’s important to understand your costs in relation to risk, and designing a pricing structure can help you do that.

Price is more than “how much?”; it also must address “for what unit of goods or services?” This can get tricky, but in a value-based pricing environment, where outcomes matter, fee-for-service is no longer always an option. Increasingly, providers are paid based on the value they provide—regardless of the time or effort that went into creating that value—as opposed to the previous standard of fee-for-service, where they were paid based on providing a unit of service no matter how much (or little) value was created. For instance, medical services are moving away from fee-for-service payment toward value-based payment structures, such as bundled payments or the Medicare Quality Incentive Program.

Refer back to the [Value Sequence \(Module 5\)](#). Each column of the Value Sequence suggests a different way to set prices—activities would lend themselves to one pricing arrangement, results would be well suited to another, etc. Here’s a refresher on each link, and a note about how each relates to price:

- **Activities:** payment for services provided (essentially fee-for-service), such as a charging for each time a service is rendered (e.g., a flu shot) or per patient managed (e.g., a case management fee)



- **Results:** payment for specific results, such as job placement, weight loss, or reduced recidivism.
- **Impacts:** payment for changing people’s lives in material ways, such as fewer heart attacks or increased employment income for a person reentering society from prison
- **Financial value:** payment for a portion of the additional revenues, costs savings, or avoided costs. For example:
 - An assigned value per outcome, such as \$4,000 for every avoided heart attack compared to the previous measuring period
 - The Centers for Medicare and Medicaid Services’ shared savings formula for accountable care organizations

Note that the further you move across the Value Sequence, from activities and results to impacts and value creation, the complexity of the payment mechanism and level of risk increase—more measurement is needed, even perhaps to the point of requiring expensive evaluation. Assumptions multiply. Time periods stretch out. Attribution gets harder to ascertain. Getting paid is less assured.

As a rule, you should consider “expected value” when setting a price, if possible. Expected value is the payment multiplied by the probability of getting paid. Let’s say, for example, that you hope to earn at least \$200,000 to cover your costs of serving 1,000 people, with the aim of 10 pounds of weight loss per person diagnosed as pre-diabetic.

- **Activities:** You could be paid a per-person fee of \$200 for every person served regardless of weight loss; there is no risk to you because the probability of getting paid is 100%.
- **Results:** You could be paid based on how many people lose at least 10 pounds. You are at risk because payment is entirely contingent on the results you produce. Suppose the likelihood of this is 50 percent, or 500 persons with at least 10 pounds lost. To earn \$200,000, you need to charge \$400 per person who loses 10 pounds.
- **Hybrid:** You might also structure a hybrid. For example, \$100 per person served plus \$200 per result. This splits the risk between you and the payer.
- **Impacts and Value:** Maybe the payer is highly risk averse and will only consider paying for those who avoid diabetes. Your evidence shows that for every person with pre-diabetes who loses 10 pounds, 30 percent avoid diabetes within five years and that there is evidence to show that this will save \$3,000 per person in health care costs over the five years. The expected value to the payer is 150 people (500 people who lost 10+ pounds x 30 percent who avoid diabetes = 150 people) times \$3,000, which equals \$450,000. In this case, the payer has shifted all of the risk to you, so you negotiate a substantial portion of the savings—say 60 percent. Your total payment is 60 percent of \$450,000, which equals \$270,000, or \$1,800 per person who avoided diabetes ($\$270,000 \div 150 \text{ people} = \$1,800 \text{ per person}$). If your program performs well, you’ll more than cover your \$200,000 costs. But if, for example, only 100 people avoid diabetes, you’ll only earn \$180,000 and you will fail to cover your costs.

If you want to negotiate a price based on financial value, you will likely need very strong evidence that

1. the result will be produced by your intervention, and
2. the result will actually produce the financial value. However, the likely ROI is only one consideration of a prospective payer; others may include:
 - You have a solid, trusting relationship with the payer.
 - You are solving a thorny problem for the payer.
 - Your product or service enhances certain reputational, political, or competitive goals the payer would like to address.

Learn more at ReThinkHealth.org/FinancingWorkbook and contact us with questions and comments at ThinkWithUs@ReThinkHealth.org.

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