Health Management Associates

Examination of Payment and Cost Coverage Variation Across Payers for Hospital Services

Presented by Mark Podrazik
Burns & Associates, a Division of Health Management Associates
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KEY FINDINGS

1. **Within the data examined in the study, hospitals were paid between 87% and 95% percent of their costs for inpatient services and between 112% and 117% of their costs for outpatient services in the three-year period studied. This factors in all payers combined.**

2. **The overall payment-to-cost ratio for inpatient and outpatient hospital services combined eroded over the three years examined, from 101.9% in hospital year 2017 to 100.8% in hospital year 2018 to 97.5% in hospital year 2019. The 2018 and 2019 results are considered a lower bound due to potential incomplete payments from Medicare for ACO members.**

3. **The cost shift between the public and private payers is significant as evidenced by the ratio of payment to costs covered by payer.**

	Inpatient 2017	Inpatient 2018	Inpatient 2019		Outpatient 2017	Outpatient 2018	Outpatient 2019
Medicaid	73%	73%	73%		76%	73%	71%
Medicare	95%	89%	82%		69%	74%	75%
Commercial	114%	110%	109%		256%	255%	204%

4. **The root cause of the variation in cost coverage is weighted more towards a wide variation in the rate of payment between commercial and public payers rather than variation in the costs incurred for services between payers.**

KEY FINDINGS

5. There is wide variation in the percentage of costs covered by payments for each hospital in Vermont.
6. There is wide variation in the percentage of costs covered by public and private payers for specific inpatient and outpatient service categories examined.
7. There is no direct correlation between hospital charges and net payments received by hospitals or the hospital's payment-to-cost ratio.
8. The findings presented today do not comprise each hospital's entire budget.
    - Data is limited to what is reported in Vermont's All Payer Claims Database.
    - Services included are those delivered to Vermont residents only (this affects results for UVMC and Dartmouth more than other hospitals).
    - Services are limited to those paid under Medicare's MS-DRG payment system for inpatient care and Outpatient Prospective Payment System (OPPS) for outpatient services.
    - About half of self-funded plan utilization is not reported in the All Payer Claims Database.
    - Payments and costs reported are limited to the hospital (technical component) of services. The professional component is billed separately.
    - Payments outside of claims (e.g. disproportionate share payments) and costs outside of claims (e.g. hospital provider tax) are not factored into this analysis.

BACKGROUND ON TODAY'S PRESENTER

Mark Podrazik, MBA
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Mark Podrazik has been working with state Medicaid and other social service agencies for the last 25 years providing technical assistance in the design, implementation and evaluation of public programs. He has set rates for most acute care service categories as well as Medicaid waiver services in the I/DD, mental health and substance use disorder delivery systems.

With Peter Burns, Mark founded Burns & Associates in 2006. He was the firm's President from 2016 to 2020 until the company's acquisition by Health Management Associates.

For hospital reimbursement, Mark and his team implemented DVHA's migration to MS-DRGs in 2008 and has since conducted three rebase projects of these rates. He also led DVHA's move to use Medicare's OPPS to set outpatient payments in 2008 and assists in the annual update process for these rates.

Other hospital rate projects conducted by Mark and his colleagues:

- Inpatient rate rebase for Arizona Medicaid in 1998 (tiered per diem); migration to Medicare OPPS in 2005
- Inpatient rate rebase for Georgia Medicaid in 1998 (CHAMPUS grouper)
- Inpatient rate rebases for Ohio Medicaid in 2013 and 2017 (APR-DRG); another rebase is ongoing now
- Outpatient rate rebases for Ohio Medicaid in 2018 and 2019 (EAPG); another rebase is ongoing now
- Hospital rate studies for Maine Medicaid (MS-DRG, 2017) and Louisiana Medicaid (APR-DRG, 2013, 2017)
- Served as Expert Witness for Connecticut Medicaid related to provider rate appeals (2018)

AGENDA ITEM 1

BACKGROUND

STUDY OBJECTIVES

1. **Assess the variation in the rate of payment for inpatient and outpatient hospital services across major payers in the State of Vermont.**
2. **Examine the payment variation across hospitals and major service categories.**
3. **Assess the percent of hospital costs covered through payments by each major payer for inpatient and outpatient hospital services.**
4. **Examine the percent of costs covered across hospitals and major service categories.**
5. **Assess the reliability of the data sources used to examine payment variation and cost coverage in the study.**

TERMINOLOGY

Inpatient Discharge: Represents all services received by an individual as an inpatient from admission to discharge.

Outpatient Service: Multiple outpatient services can be billed on the same claim. So the count of outpatient services is not the number of claims. But it is also not the total number of claim lines. The claims may be split into pieces to associate significant procedures and ancillary services together and to create separate 'pseudo claims' (CMS term) to distinguish each of the significant procedures on the same claim as their own 'claim'.

Charges: The amount billed by the hospital to the payer. Charges appear on each claim line.

Payments: The amount paid to the hospital by the payer + co-pays + deductibles. For ACO-assigned services, a "would have paid" amount is used in lieu of the actual paid amount ($0 on the claim) to simulate what would have been the fee-for-service payment.

Costs: The amount derived by HMA using the process described later.

Payment-to-Cost: Also referred to as *Cost Coverage*. This represents the percentage of hospital costs that are covered by the payment made by the payer.

Prospective Payment System Hospital (PPS): Hospitals that are paid under Medicare's inpatient and outpatient methodologies on a prospective basis for services rendered (as opposed to a percentage of costs). PPS hospitals may be paid less than, more than, or near full costs for services rendered and this can vary by service category.

Critical Access Hospital (CAH): Hospitals given a special designation by CMS based on their size. CAHs are paid 99% of their costs by CMS in the Medicare program for inpatient and outpatient hospital services. Other payers may or may not adopt this approach.

DATA SOURCES USED IN THE STUDY

- **VHCURES (Vermont Health Care Uniform Reporting and Evaluation) dataset**
  - Services incurred during Hospital Fiscal Years (Oct 1 – Sept 30) 2017, 2018, and 2019 as submitted by payers to VHCURES by Dec. 2020
  - Inpatient and outpatient hospital claims (professional services component excluded)
  - Claims with a status of Paid
  - All Vermont acute care hospitals and Dartmouth-Hitchcock Medical Center included in the study
- **Form 2552-10 (CMS's Hospital Cost Report)**
  - A standardized series of reports required to be submitted annually by hospitals to CMS
  - All Vermont acute care hospitals and DHMC have a fiscal year end date of September; each hospital's cost reports for the periods ending 09/30/2017, 09/30/2018 and 09/30/2019 were used

DATASET PREPARATION

- **Identify the services in VHCURES (the All-Payer Claims Database)**
  - Institutional claims with type of setting = inpatient or outpatient hospital
  - Note that hospitals also bill for professional services on the professional claim type. These payments and costs are not included in this study.
- **Identify the hospitals in VHCURES**
  - Since each payer may use unique provider billing IDs, the hospital's federal tax ID was used.
- **Identify the payers in VHCURES**
  - Payers submit data to VHCURES using a Submitter ID. Each Submitter ID was mapped to one of six categories:

    Vermont Medicaid (DVHA)

    Medicare Fee-for-Service

    Medicare Advantage
(low volume, excluded from study)

    Blue Cross Blue Shield of Vermont

    MVP Health Plan

    All Other Commercial Payers Combined
(approx. 2% of all volume)
- **Create inpatient hospital service categories based on primary diagnosis**
- **Create outpatient hospital service categories based on procedure code**

INPATIENT AND OUTPATIENT SERVICE CATEGORIES

Inpatient Categories	Outpatient Categories
Well Babies	Emergency Dept (ED) and Observation
Neonatal Intensive Care Unit (NICU) Babies	Clinic Visits
Deliveries	Imaging Services with Contrast
Mental Health / Substance Use Disorder	Imaging Services without Contrast
Nervous System	Musculoskeletal Procedures
Respiratory System	Cardiac, Vascular & Pulmonary Procedures
Circulatory System	Gastrointestinal (GI) procedures
Digestive System	Urology, Dialysis and Gynecologic Procedures
Musculoskeletal System	Pathology, Excision/Biopsy/Incision, Diagnostic Tests
Kidney Related	Nuclear Medicine, Radiation, Related Surgeries
Infections	Neurostimulator & Electrophysiologic Procedures
All Other Surgeries/Procedures	Ear, Nose & Throat and Eye Procedures
	Skin Procedures
	Other Minor Procedures
	Drug Administration

DATASET PREPARATION (continued)

- **Validate trends for consistency across years**
  - Total inpatient and outpatient hospital volume by hospital
    - Within each hospital, we validated volume by payer across each hospital fiscal year (or HFY) 2017, 2018, and 2019
  - Total inpatient and outpatient payments by hospital
    - Within each hospital, we validated payments by inpatient and outpatient category
    - For services delivered through OneCare, we captured the amount that would have been paid to the hospital by Medicare or Medicaid if the service was paid on a fee-for-service basis.
    - Potential data limitation: Although “would have paid” amounts from DVHA for Medicaid ACO services appear complete, the total “would have paid’ for Medicare appears lower than expected, particularly for inpatient services
  - Total costs by hospital and by inpatient or outpatient service category
  - Payment-to-cost ratios by payer across years HFY 2017, HFY 2018, and HFY 2019
- **Validate inputs used to assign costs to claims**
  - Accommodation (room and board) cost per day values by hospital across years
  - Cost-to-charge ratios from the 2552-10 reports at the departmental level for ancillary services by hospital for each of the three study years

ILLUSTRATION OF ASSIGNING COST VALUES TO CLAIM LINES

Each claim in the dataset is assigned costs in this same manner using the hospital-specific cost report values.

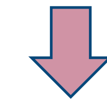
Excerpt from Hospital ABC Form 2552-10

Worksheet D-1	Per Diem Cost
Line 38. Routine Service Cost per diem	$1,420.00
Line 42. Nursery	$ 455.00
Line 43. Intensive Care Unit	$2,936.00

Worksheet C	Cost-to-Charge Ratio (CCR)
Line 50. Operating Room	0.2475
Line 51. Recovery Room	0.5642
Line 54. Radiology-Diagnostic	0.2743
Line 57. CT Scan	0.1368
Line 60. Laboratory	0.2863
Line 71. Medical Supplies	0.5368
Line 73. Drugs Charged to Patients	0.6325
Line 76. Endoscopy	0.1608
Line 91. Emergency Room	0.4196

Example of a Claim in VHCURES

Revenue Code	Billed Charges
120 (Routine Room)	3 days
200 (ICU Room)	1 day
360 (Operating Room)	$5,200.00
250 (Drugs)	$1,100.00
300 (Laboratory)	$ 742.00
270 (Supplies)	$ 468.00



Multiply Room & Board Days by Hospital Per Diem Cost
Multiply Ancillary Charges by Ancillary CCR

Revenue Code	Computation	Derived Cost
120 (Routine Room)	3 * $1,420.00	$4,260.00
200 (ICU Room)	1 * $2,936.00	$2,936.00
360 (Operating Room)	$5,200.00 * .2475	$1,287.00
250 (Drugs)	$1,100.00 * .6325	$ 695.75
300 (Laboratory)	$ 742.00 * .2863	$ 212.43
270 (Supplies)	$ 468.00 * .5368	$ 251.22
Sum of All Lines to Obtain Total Cost =		$9,642.41

APPLICATION OF HOSPITAL CASE MIX SCORES

- **Because the patients at each hospital have different levels of acuity needs, it is common to compute an average cost per service or average payment per service for a hospital both with and without an acuity adjustment.**
- **The acuity adjustment effectively allows for an "apples-to-apples" comparison across hospitals. Consider the following example of two hospitals:**

	Hospital A	Hospital B
Average Payment per Discharge	$10,000	$10,000
Average Cost Per Discharge	$11,000	$9,800
Hospital Acuity (Case Mix Score)	1.230	0.896
Average Payment with Acuity Adjustment	$8,130	$11,161
Average Cost with Acuity Adjustment	$8,943	$10,938

- **Hospital A serves much more intensive patients (their case mix score is higher).**
  - Without regard to case mix adjustment, it appears that these two hospitals are paid, on average, the same for the services that they render ($10,000). Further, Hospital A's costs are higher than Hospital B's
  - When case mix adjustment is factored in, however, Hospital A is receiving a much <u>lower</u> payment than Hospital B. Hospital A's costs are also lower when adjusting for patient acuity.

COMPUTATION OF HOSPITAL CASE MIX SCORES

- **In order to assess average payment and average cost values on an "apples-to-apples" basis, the HMA-Burns team computed case mix scores for each hospital by applying the costs from the hospitals in the study to compute weight values for each inpatient and outpatient service examined in the study.**
  - CMS creates weight values for inpatient services in its Medicare MS-DRG system and for outpatient services in its Medicare OPPS system. These weights were not used in this study.
  - Instead, HMA-Burns used the MS-DRG and OPPS categories, but computed Vermont-specific all payer weights. In other words, the data from all payers (Medicare, Medicaid, and commercial payers) were used to assign weight values for each service.
- **By creating all payer weights, the average payment per hospital or per service category as well as the average cost per hospital or service category can be reviewed with or without the hospital's case mix adjustment.**

HOSPITAL CASE MIX SCORES USING ALL PAYER WEIGHTS COMPUTED

The average case mix score is 1.0 across hospitals. If a hospital has a value > 1.00, it has higher acuity patients than the statewide average. A value < 1.00 indicates lower acuity.

	Peer Group	INPATIENT HOSPITAL			OUTPATIENT HOSPITAL		
		HFY 2017	HFY 2018	HFY 2019	HFY 2017	HFY 2018	HFY 2019
		0.982	**1.001**	**1.024**	**1.009**	**1.000**	**1.008**
Dartmouth-Hitchcock	AMC	1.33	1.41	1.42	1.23	1.23	1.25
UVMC	AMC	1.07	1.09	1.12	1.09	1.10	1.10
Brattleboro Memorial	PPS	0.79	0.81	0.78	0.91	0.89	0.89
Central Vermont	PPS	0.81	0.87	0.90	0.90	0.90	0.89
Northwestern	PPS	0.85	0.83	0.82	0.91	0.91	0.92
Rutland Regional	PPS	0.93	0.91	0.91	0.90	0.89	0.94
Southwestern	PPS	0.78	0.79	0.79	0.87	0.85	0.85
Copley	CAH	0.84	0.87	0.93	1.11	1.05	1.03
Gifford	CAH	0.70	0.71	0.71	0.91	0.89	0.88
Grace Cottage	CAH	1.37	1.43	1.46	0.75	0.73	0.72
Mt Ascutney	CAH	1.28	1.27	1.09	0.93	0.91	0.90
North Country	CAH	0.71	0.71	0.73	0.97	0.93	0.92
Northeastern	CAH	0.80	0.78	0.81	1.07	1.01	0.98
Porter	CAH	0.76	0.72	0.75	0.88	0.85	0.85
Springfield	CAH	0.76	0.77	0.81	1.03	0.98	0.97

HFY = Hospital Fiscal Year, October 1 - September 30

AGENDA ITEM 2

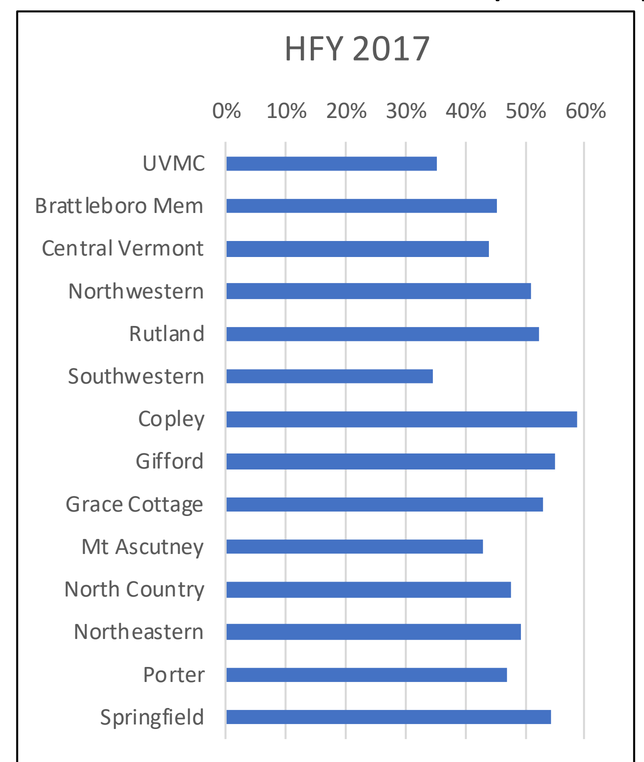
KEY FINDINGS

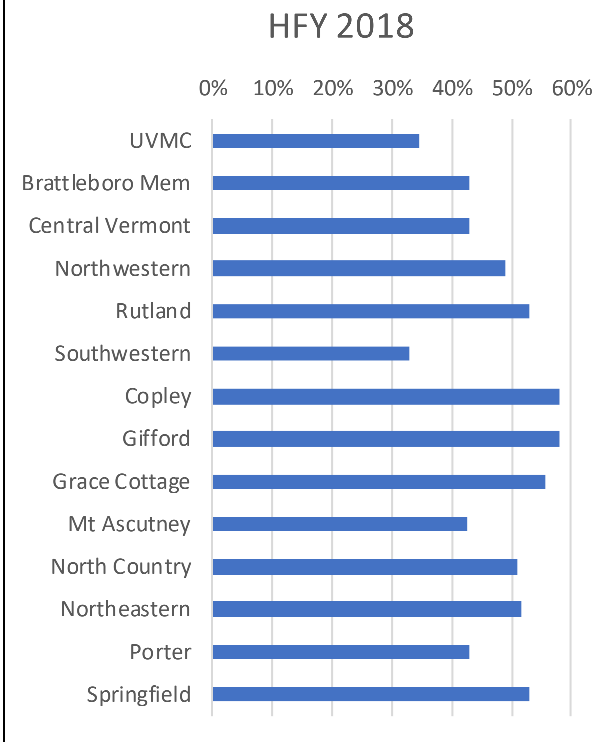
HEALTH MANAGEMENT ASSOCIATES

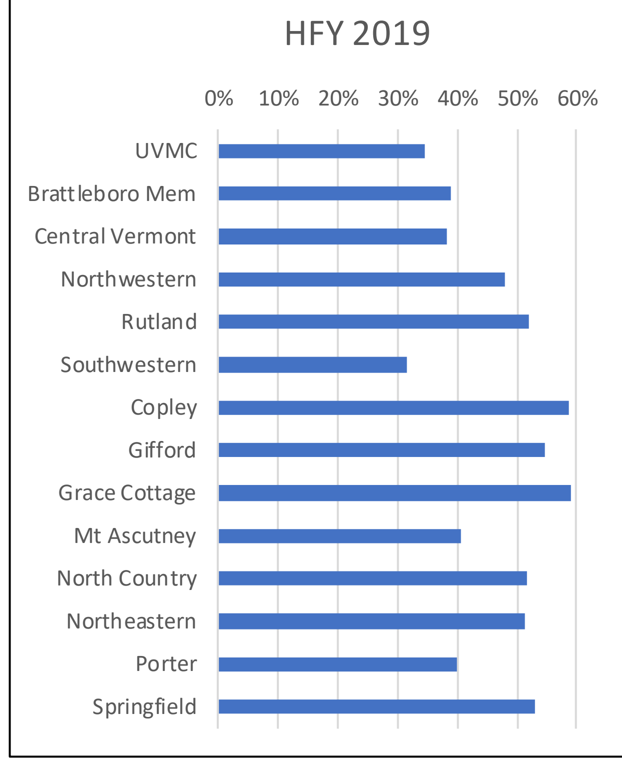
PERCENT OF PAYMENTS BY HOSPITAL IN THE STUDY

Each hospital reports its Gross Revenue and Net Patient Revenue to the GMCB each year. The GMCB report values were compared to the Paid Amounts on claims in this study. Statewide, this study represents 40% - 41% of payments each year. The balance of payments not in the study include some self-funded commercial plans, out-of-state patients, and—importantly– the professional component of revenues billed by hospitals.

Percent of Total Hospital Net Payer Revenues Included in the Study in Each Year (excludes Medicaid DSH payments)

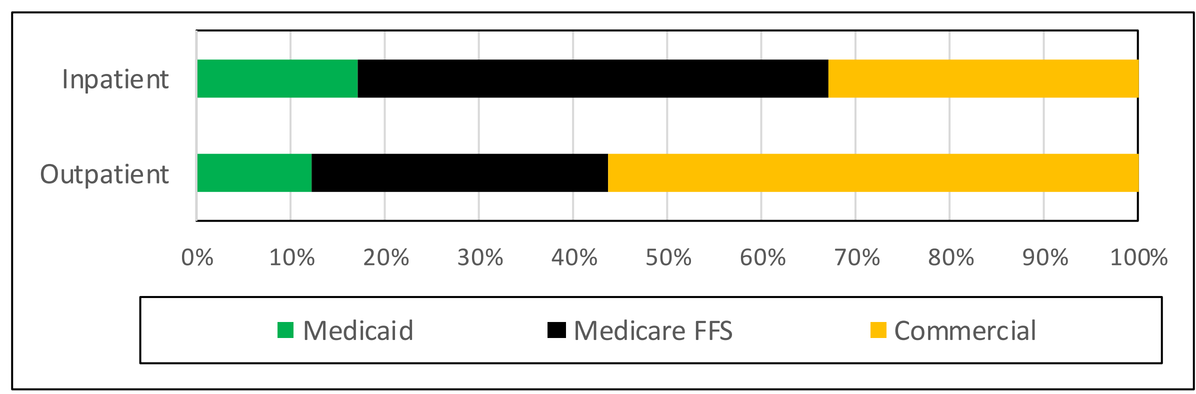


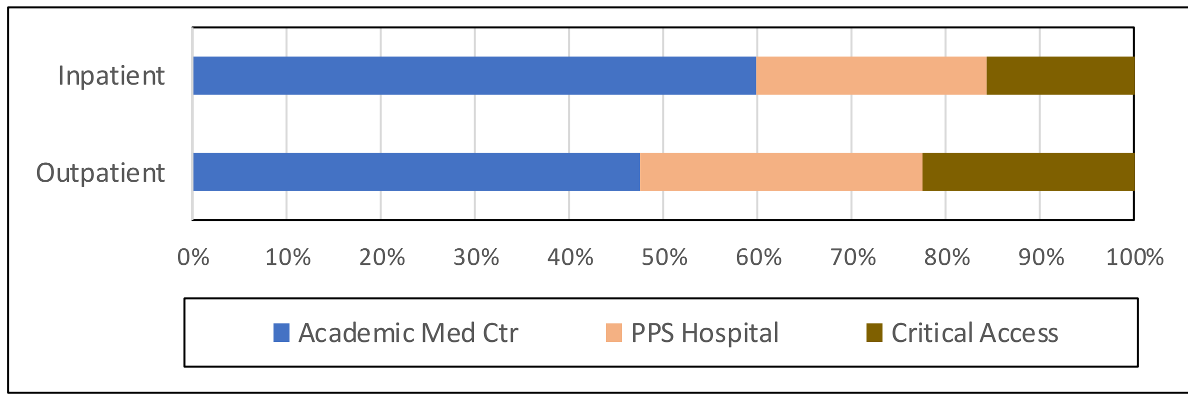




PERCENT OF PAYMENTS BY PAYER AND HOSPITAL PEER GROUP, HFY 2019

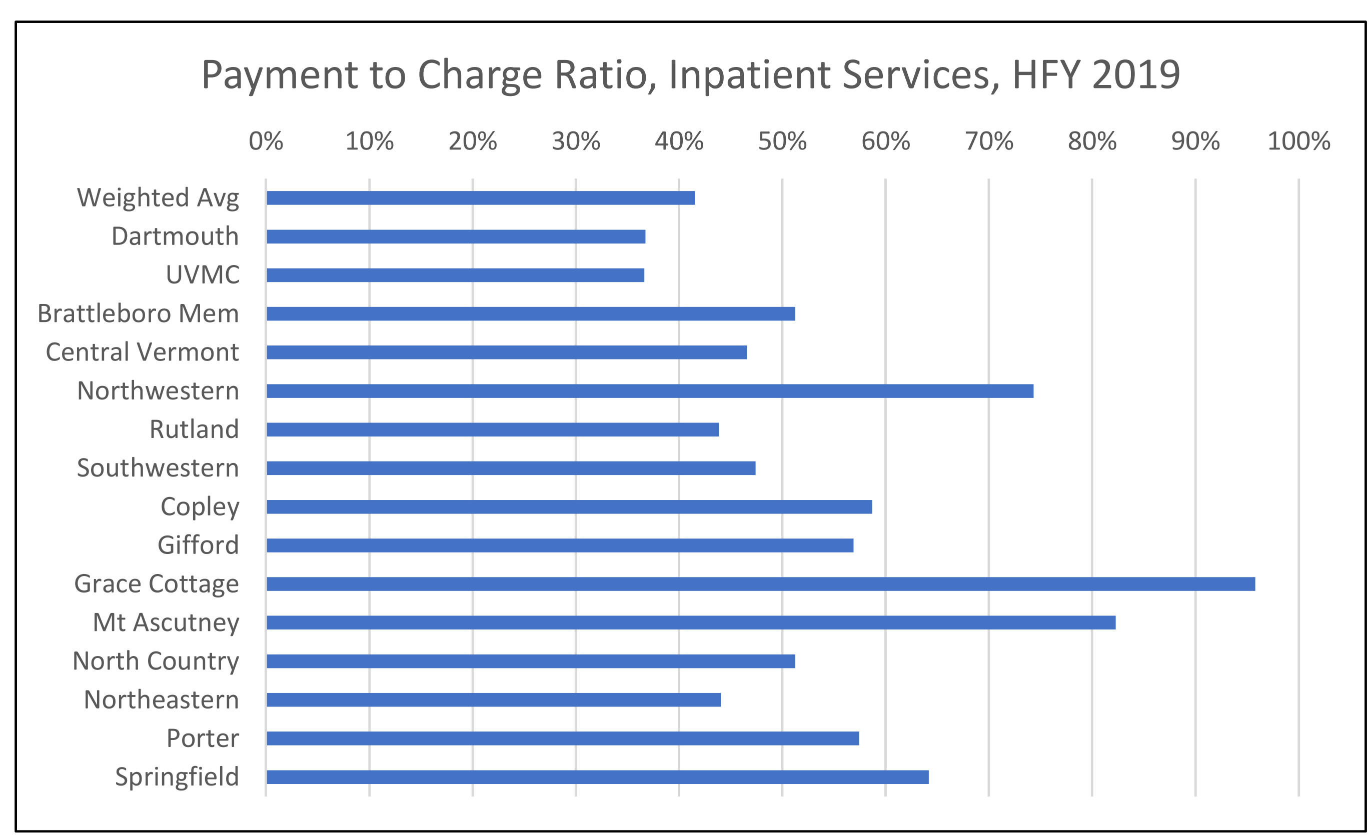
Total Inpatient Payments Used in Study, HFY 2019: $685 million
Total Outpatient Payments Used in Study, HFY 2019: $558 million





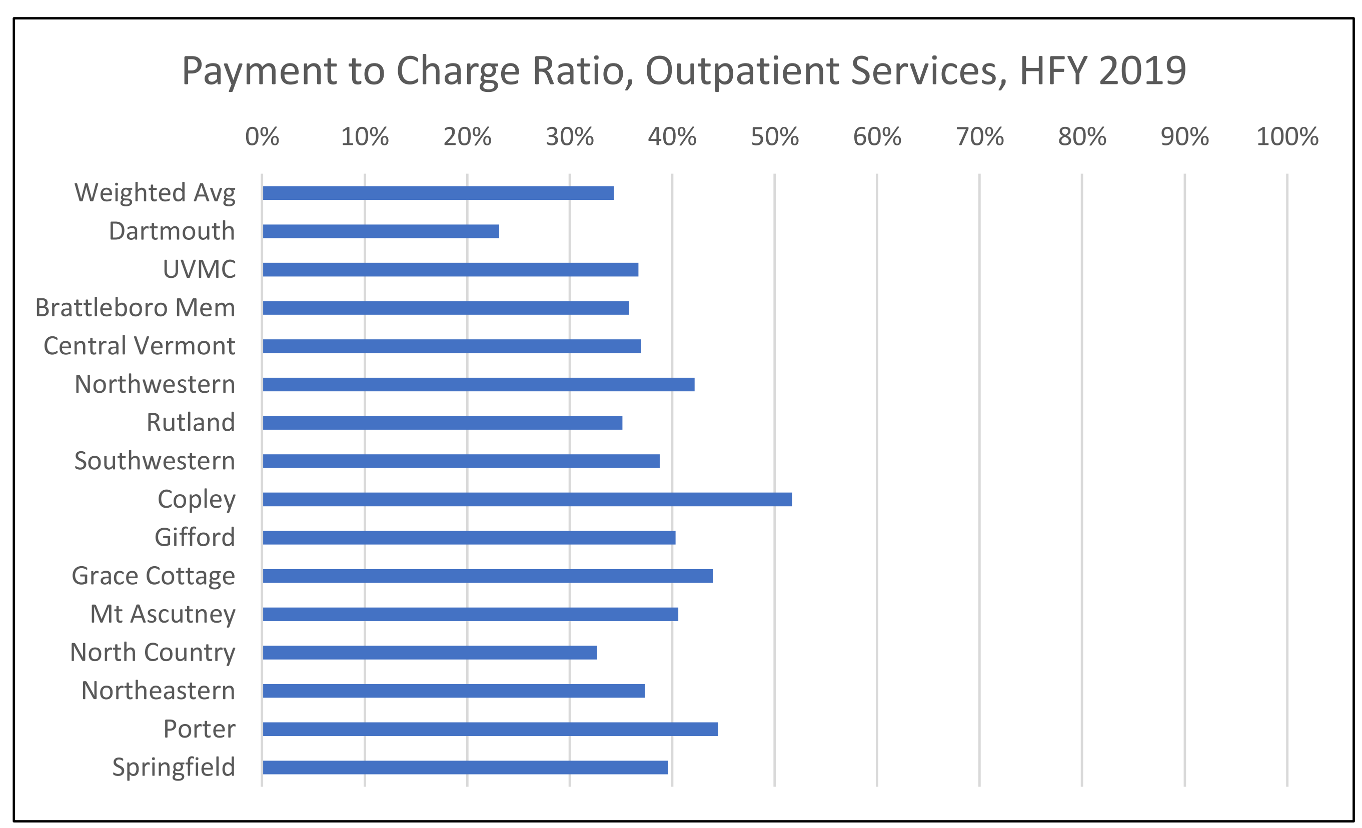
KEY FINDINGS ON CHARGES AND PAYMENTS

There is wide variation in the ratio of net payments to charges. In other words, increases or decreases in a hospital's charge master does not appear to directly influence the net payment received.



KEY FINDINGS ON CHARGES AND PAYMENTS, continued

The ratio of payments to charges is even lower for outpatient services than seen for inpatient services. This means that the spread between what is charged and the net payment received is wider.



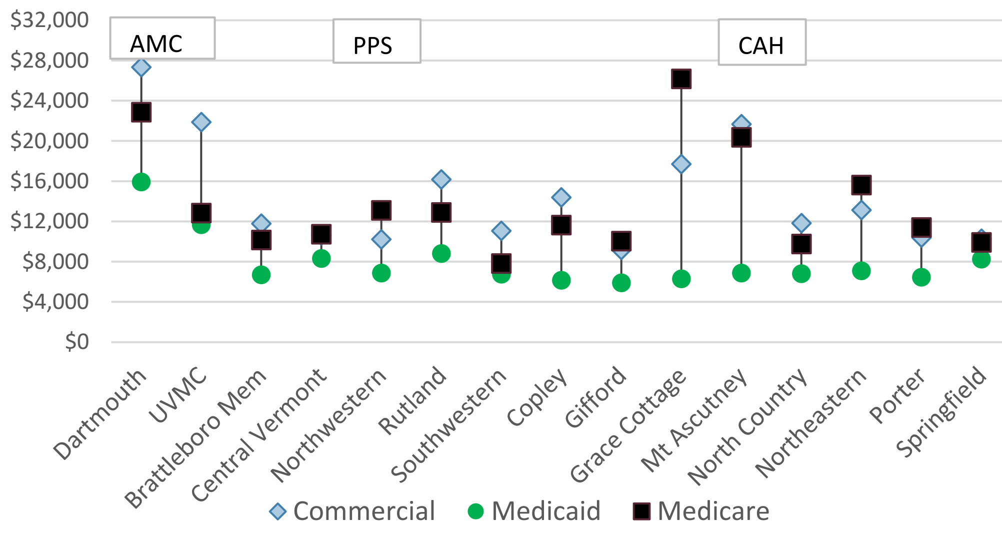
PAYMENT VARIATION FOR INPATIENT SERVICES BY PAYER/HOSPITAL

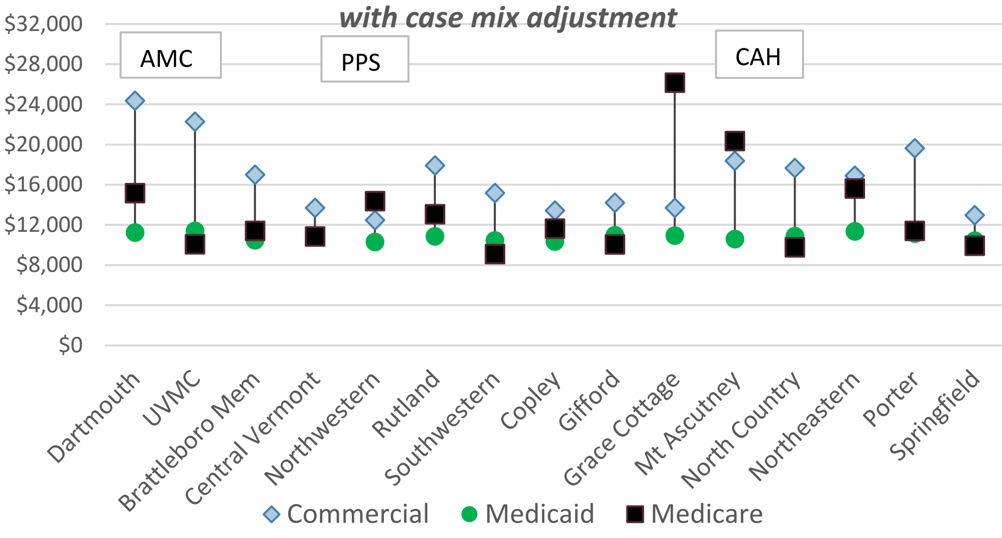
The two boxes shown here reflect the impact of applying case mix adjustment to payments. The top box shows results without applying a case mix adjustment. The bottom box shows after case mix adjustment is applied.

The case mix adjustment accounts for the acuity of the cases that each hospital serves. Typically, cases with a higher acuity are paid more.

Even after applying case mix adjustment, however the commercial payments are higher than the public payers except Northwestern, Grace and Northeastern.

For many hospitals, average payments from Medicare and Medicaid are similar when viewed on a case mix adjusted basis.





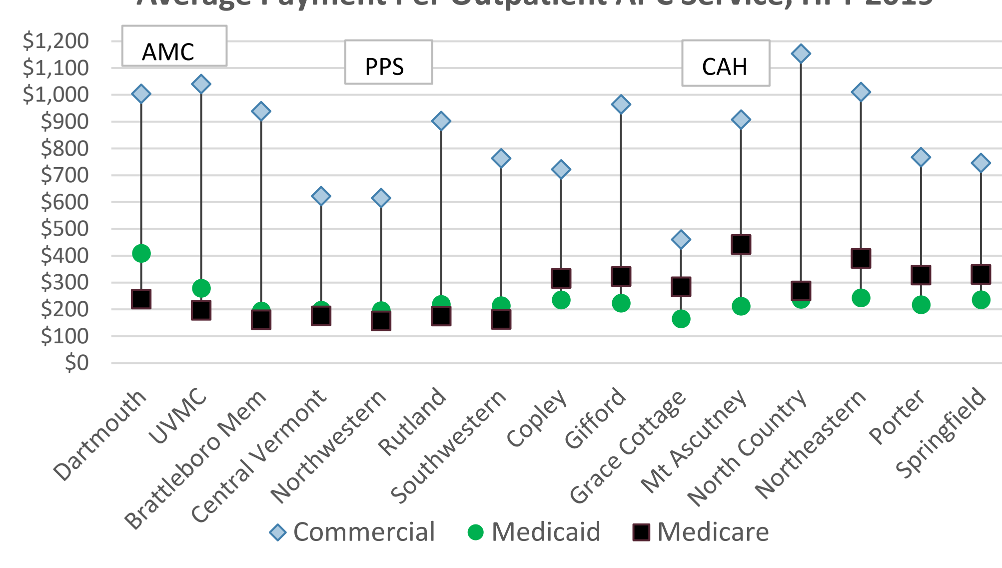
PAYMENT VARIATION FOR OUTPATIENT SERVICES BY PAYER/HOSPITAL

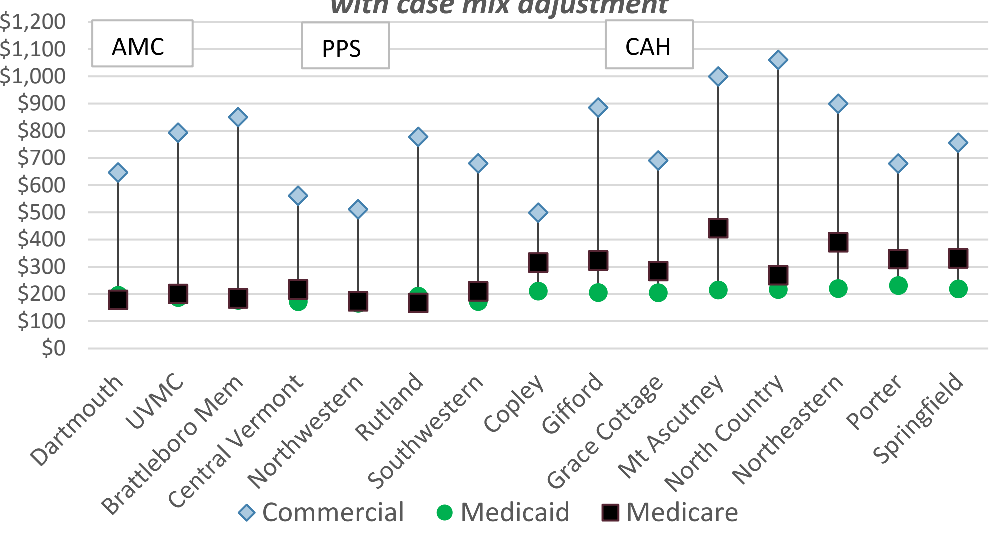
The same exhibits were created to view outpatient APC services.

On average, commercial outpatient payments are much higher than Medicare and Medicaid. This is even true after applying the case mix adjustment.

Medicaid benchmarks closely (not exactly) to Medicare for the PPS hospitals, but not for the CAH hospitals.

Commercial average outpatient payments are variable across hospitals.





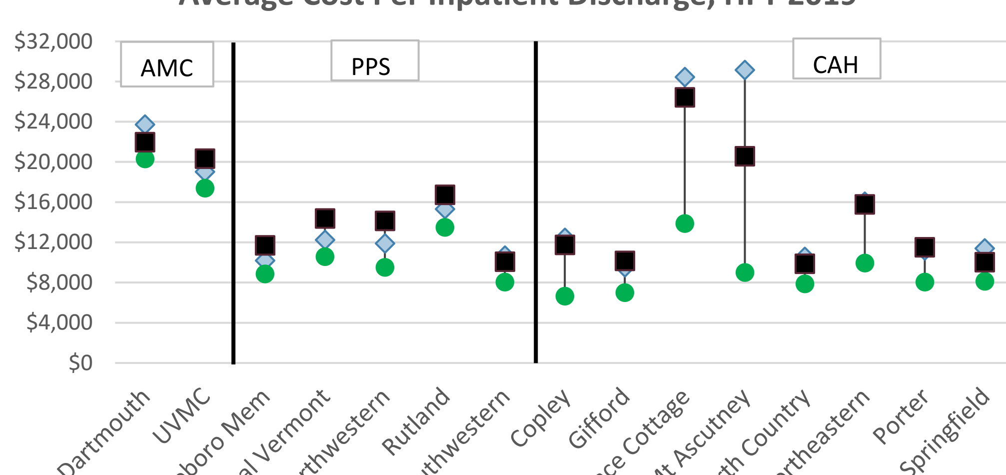
COST VARIATION FOR INPATIENT SERVICES BY PAYER/HOSPITAL

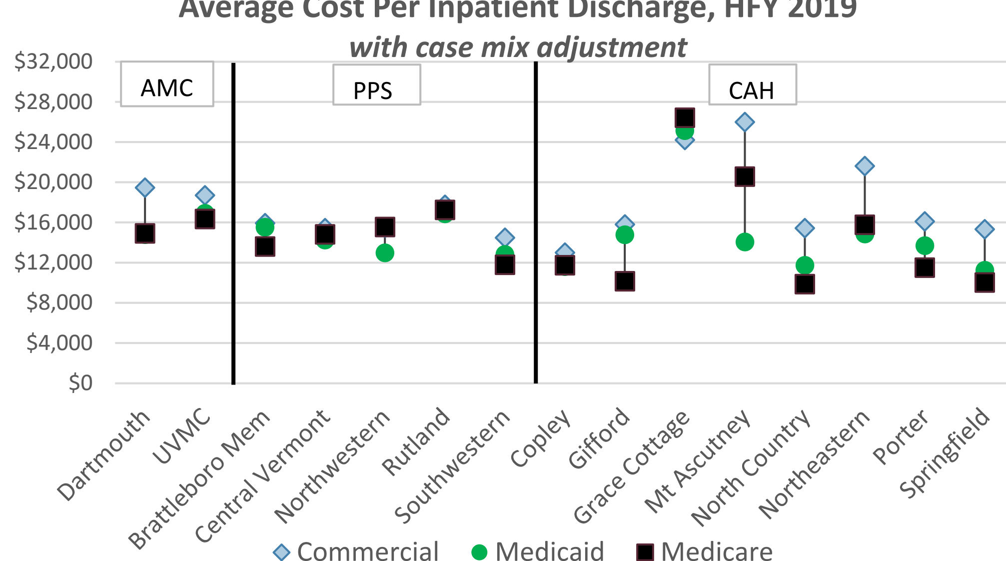
There is much less variation in average cost per case across payers (except for some CAHs with very low volume).

There is variation, however, in the average cost per case among the hospitals in the study.

When comparing hospitals in their own peer group, the average costs are more similar (Grace and Mt. Ascutney being the exception).

Applying the case mix adjustment to costs tightened the band between payers within a hospital to some degree.



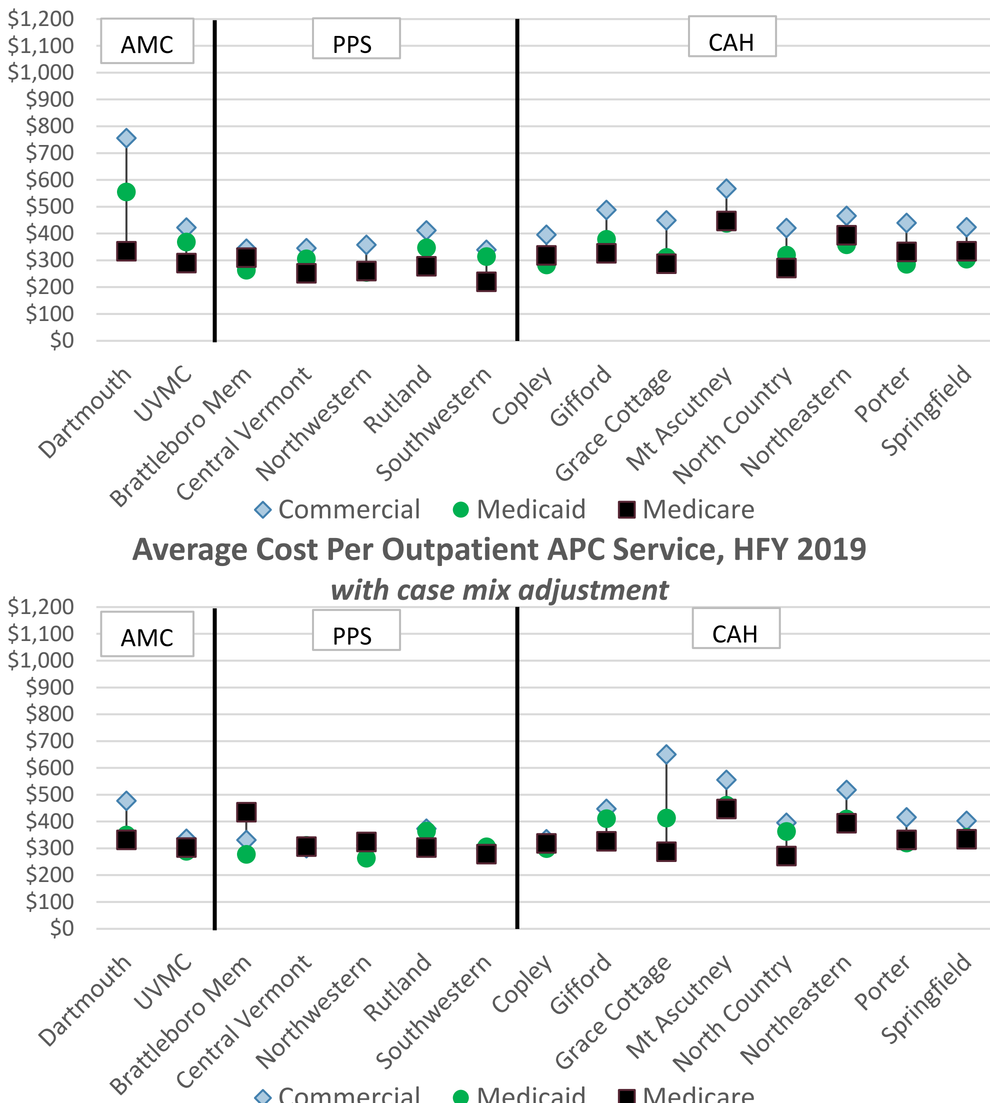


COST VARIATION FOR OUTPATIENT SERVICES BY PAYER/HOSPITAL

As seen for inpatient services, there is much less variation in average cost per outpatient across payers (the exception is Dartmouth).

After applying case mix adjustment (bottom box), the average cost per service tightens between the payers for a specific hospital.

Further, after case mix adjustment is applied, the average cost per outpatient service is similar for hospitals within a peer group (Dartmouth again the exception here).



COST COVERAGE VARIATION BY PAYER

The public payers (Medicaid and Medicare) represent 76% of both inpatient and outpatient services examined in the study. Therefore, the much lower cost coverage from the public payers greatly influences the weighted average all payer cost coverage ratios shown below.

	Inpatient 2017	Inpatient 2018	Inpatient 2019		Outpatient 2017	Outpatient 2018	Outpatient 2019
Medicaid	73%	73%	73%		76%	73%	71%
Medicare	95%	89%	82%		69%	74%	75%
Commercial	114%	110%	109%		256%	255%	204%
All Payers Combined	95%	91%	87%		112%	117%	114%

COST COVERAGE VARIATION BY HOSPITAL, ALL PAYERS COMBINED

There is wide variation in the percentage of costs covered by hospital.

The numbers on the weighted average row indicate the percent of costs covered for all hospitals combined. The color coding indicates the cost coverage band that each hospital falls into for each of the years studied.

The values shown below are prior to applying any case mix adjustment factor.

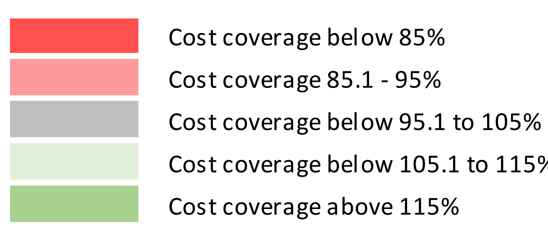
- Cost coverage below 85%
- Cost coverage 85.1 - 95%
- Cost coverage below 95.1 to 105%
- Cost coverage below 105.1 to 115%
- Cost coverage above 115%

		Inpatient + Outpatient			Inpatient Only			Outpatient Only		
		HFY17	HFY18	HFY19	HFY17	HFY18	HFY19	HFY17	HFY18	HFY19
Weighted Average		101.9	100.8	97.5	95.1	90.8	87.1	111.8	116.5	113.7
Dartmouth	AMC									
UVMC	AMC									
Brattleboro Mem	PPS									
Central Vermont	PPS									
Northwestern	PPS									
Rutland	PPS									
Southwestern	PPS									
Copley	CAH									
Gifford	CAH									
Grace Cottage	CAH									
Mt Ascutney	CAH									
North Country	CAH									
Northeastern	CAH									
Porter	CAH									
Springfield	CAH									

COST COVERAGE VARIATION BY HOSPITAL, INPATIENT ONLY BY PAYER

Cost coverage variation is more consistent across hospitals for Medicaid and Medicare services for inpatient services (Medicaid is lowest, then Medicare). There is greater variation in the percentage of costs covered by hospital among commercial payers.

The values shown for Medicare cost coverage, particularly HFY18 and HFY19, should be considered the lower bound due to potentially incomplete payment information on Medicare ACO clients.

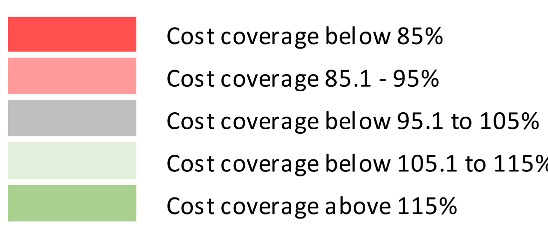


		Medicaid			Medicare			Commercial		
		HFY17	HFY18	HFY19	HFY17	HFY18	HFY19	HFY17	HFY18	HFY19
Weighted Average		73.1	73.1	72.6	95.4	89.4	81.8	114.5	109.7	109.1
Dartmouth	AMC									
UVMC	AMC									
Brattleboro Mem	PPS									
Central Vermont	PPS									
Northwestern	PPS									
Rutland	PPS									
Southwestern	PPS									
Copley	CAH									
Gifford	CAH									
Grace Cottage	CAH									
Mt Ascutney	CAH									
North Country	CAH									
Northeastern	CAH									
Porter	CAH									
Springfield	CAH									

COST COVERAGE VARIATION BY HOSPITAL, OUTPATIENT ONLY BY PAYER

Cost coverage variation is consistently low for all hospitals for Medicaid and Medicare, but the cost coverage from commercial payers for outpatient services is significantly higher than what was seen for inpatient services.

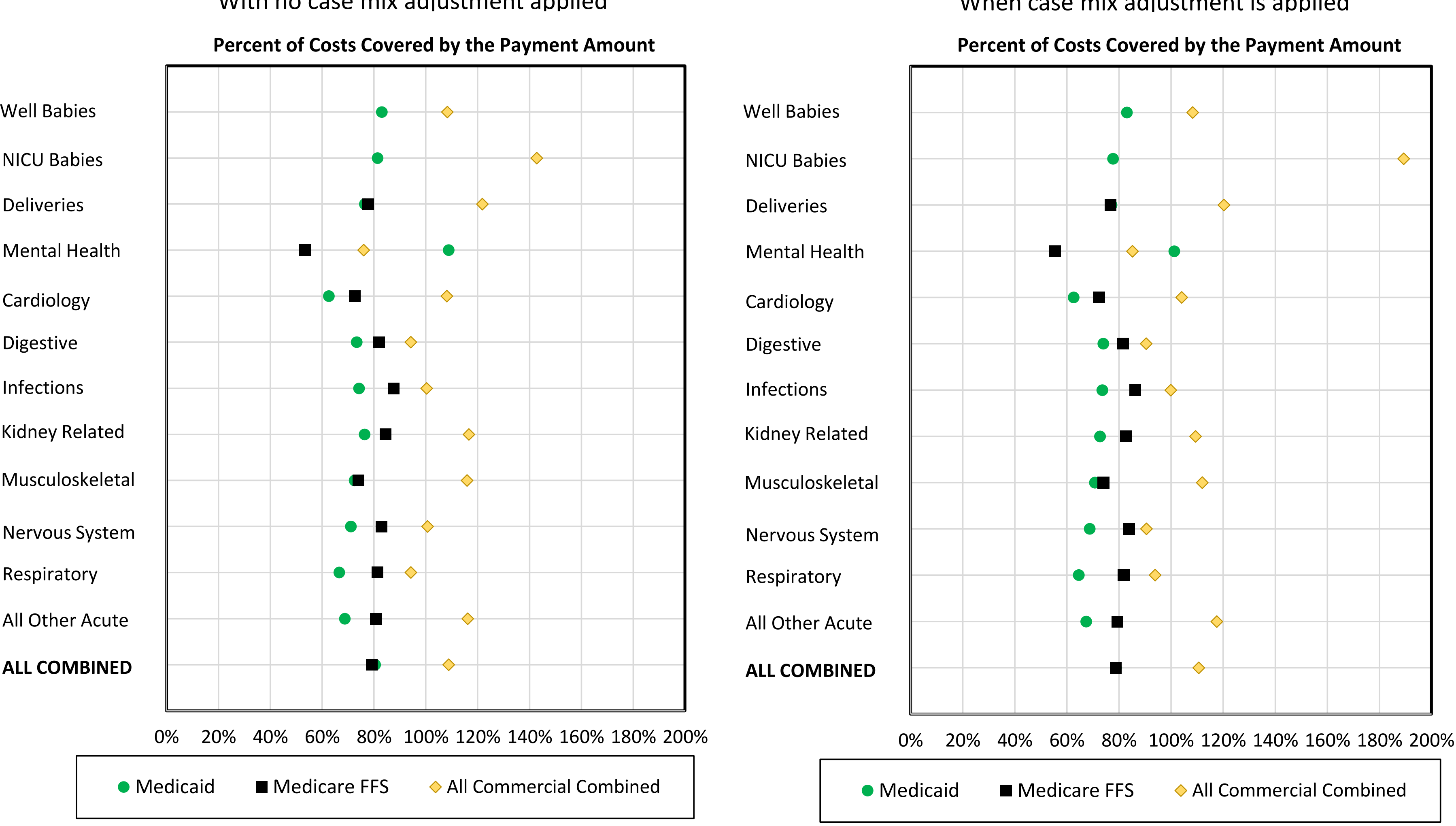
A hospital's overall cost coverage, therefore, is heavily-dependent on their volume of commercial basis and, more specifically, their outpatient services to commercial clients.



		Medicaid			Medicare			Commercial		
		HFY17	HFY18	HFY19	HFY17	HFY18	HFY19	HFY17	HFY18	HFY19
Weighted Average		76.0	72.6	71.2	68.7	73.8	75.1	255.6	254.6	204.0
Dartmouth	AMC									
UVMC	AMC									
Brattleboro Mem	PPS									
Central Vermont	PPS									
Northwestern	PPS									
Rutland	PPS									
Southwestern	PPS									
Copley	CAH									
Gifford	CAH									
Grace Cottage	CAH									
Mt Ascutney	CAH									
North Country	CAH									
Northeastern	CAH									
Porter	CAH									
Springfield	CAH									

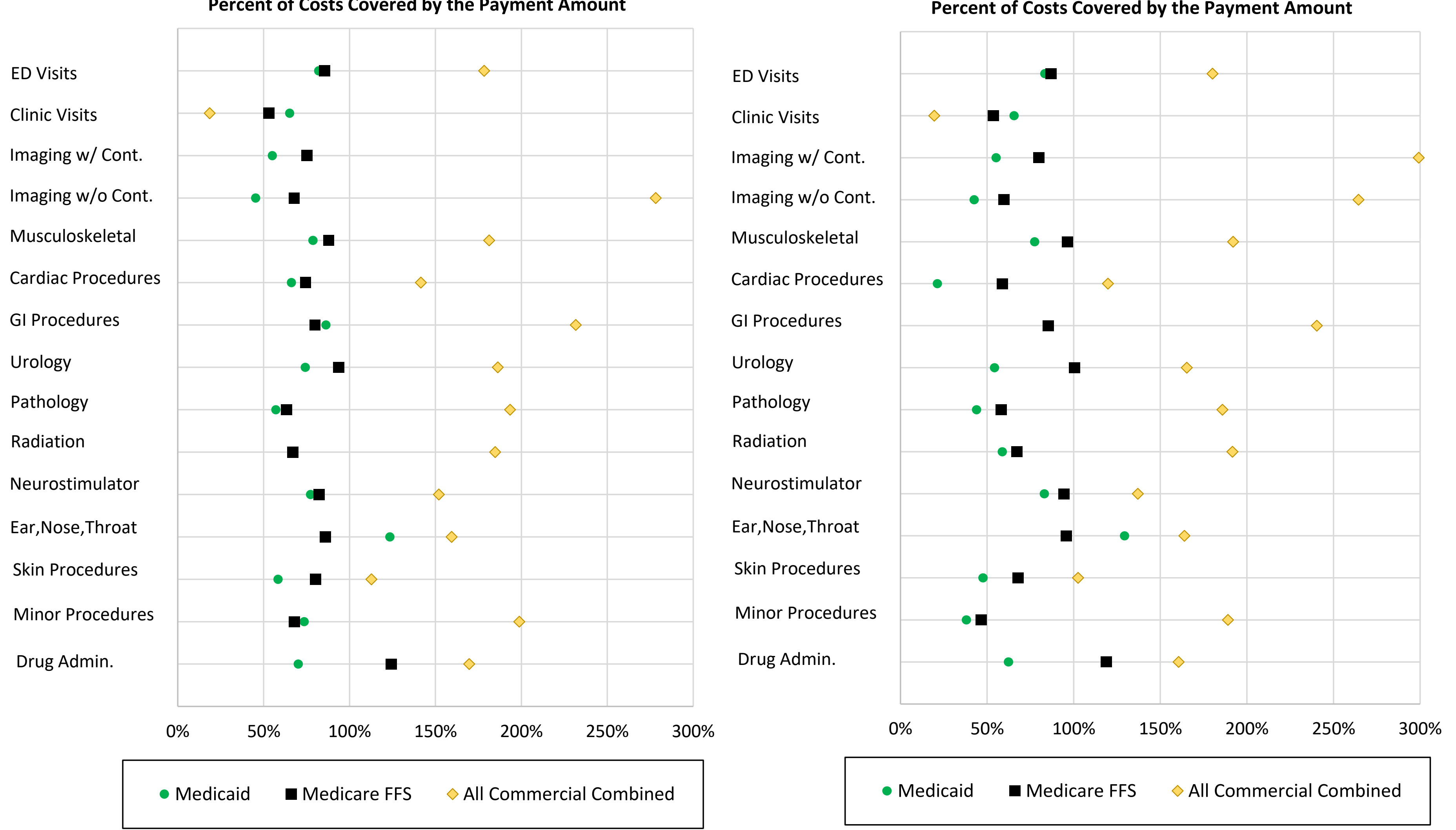
COST COVERAGE BY INPATIENT SERVICE CATEGORY VARIES BY PAYER

Although the variation in percent of costs covered does usually tighten when applying a case mix adjustment, there is still considerable variation in cost coverage at the major inpatient service category level. Results below are from HFY 2019.



COST COVERAGE BY OUTPATIENT SERVICE CATEGORY VARIES BY PAYER

Similar to what was observed for inpatient service categories, there is wide variation in the percent of costs covered by outpatient service category. This is true even after applying a case mix adjustment factor. Results below are from HFY 2019.



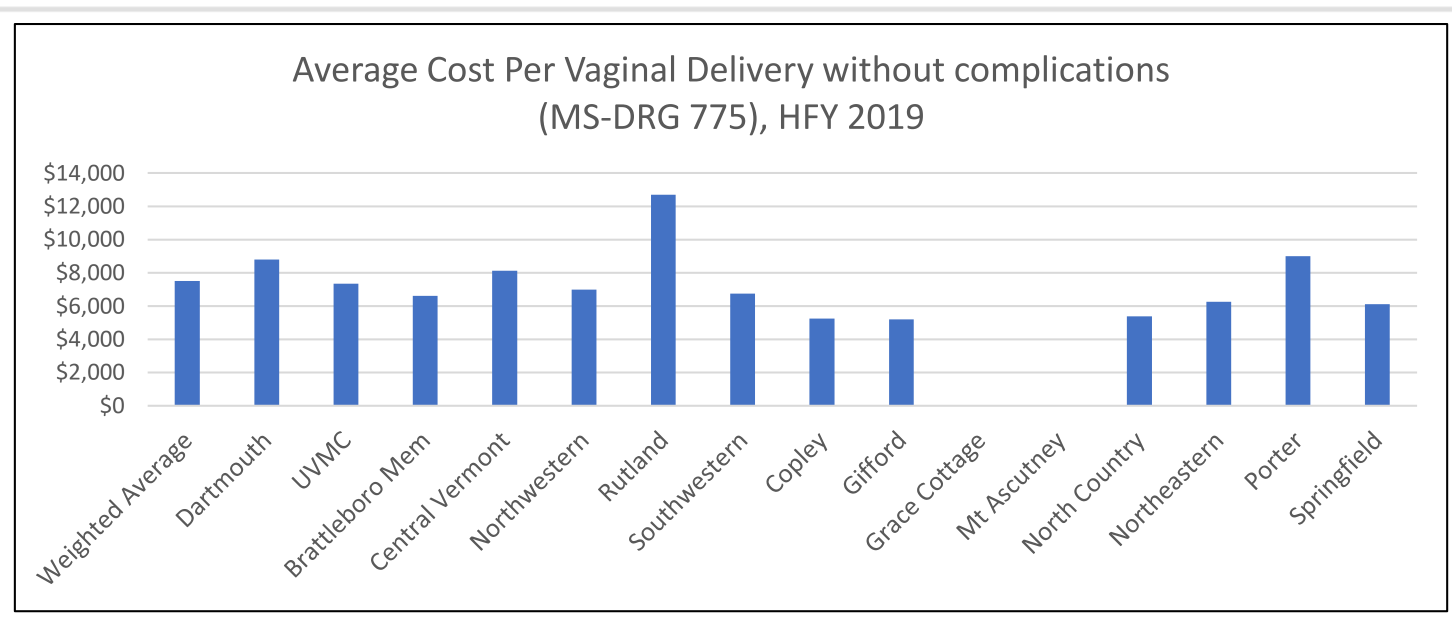
VARIATION IN COST COVERAGE FOR THE SAME SERVICE BY HOSPITAL

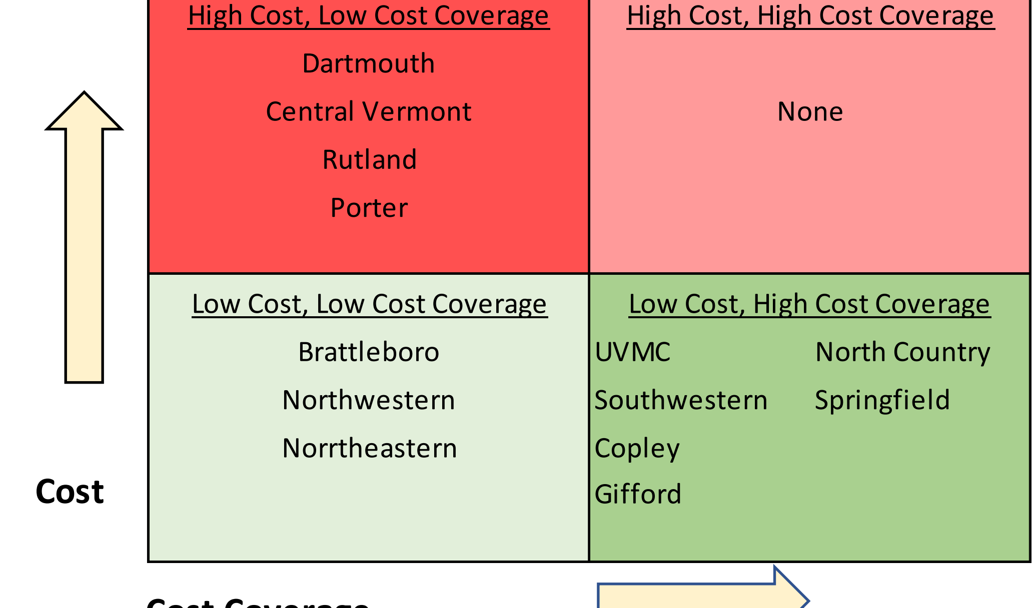
- **The fact that one hospital's costs are not fully covered or not covered as much as another hospital's costs is not necessarily an issue in and of itself.**
  - From a public policy perspective, those hospitals that deliver the highest quality at the lowest cost should be rewarded the most. If a hospital's costs for a service are inefficient (higher) than their peers, it is not always necessary to cover all of these costs.
- **Among the hospitals examined in this study, not only is there a high degree of variation in cost coverage overall (all services combined), but there is also variation in the average cost and cost coverage values across hospitals for the same service.**
- **The next 4 slides show examples of two inpatient services and two outpatient services. On these slides, the hospital's cost coverage is not case mix adjusted because the acuity level should be the same for patients in the service category examined by nature of the classification group.**
  - Hospitals classified as "low" cost means that the hospital's average cost for the service is lower than the statewide mean. Conversely, "high" cost means the hospital's average cost is above the statewide mean.
  - Hospitals classified as "high" cost coverage are those with an all-payer payment-to-cost ratio above 100%. Hospitals classified as "low" cost coverage have an all-payer payment-to-cost ratio below 100%.

MS-DRG 775, VAGINAL DELIVERY WITHOUT COMPLICATIONS

The weighted average cost for this inpatient service in HFY 2019 was $7,518. Four hospitals had average costs above this, all others below this average. [UVMC was right near the average and has the highest volume. Grace Cottage and Mt Ascutney had no volume.]

As seen in the box below, the four hospitals with higher-than-average cost all have cost coverage below 100%. But some hospitals with lower-than-average costs also have cost coverage below 100% (Brattleboro, Northwestern, and Northeastern.

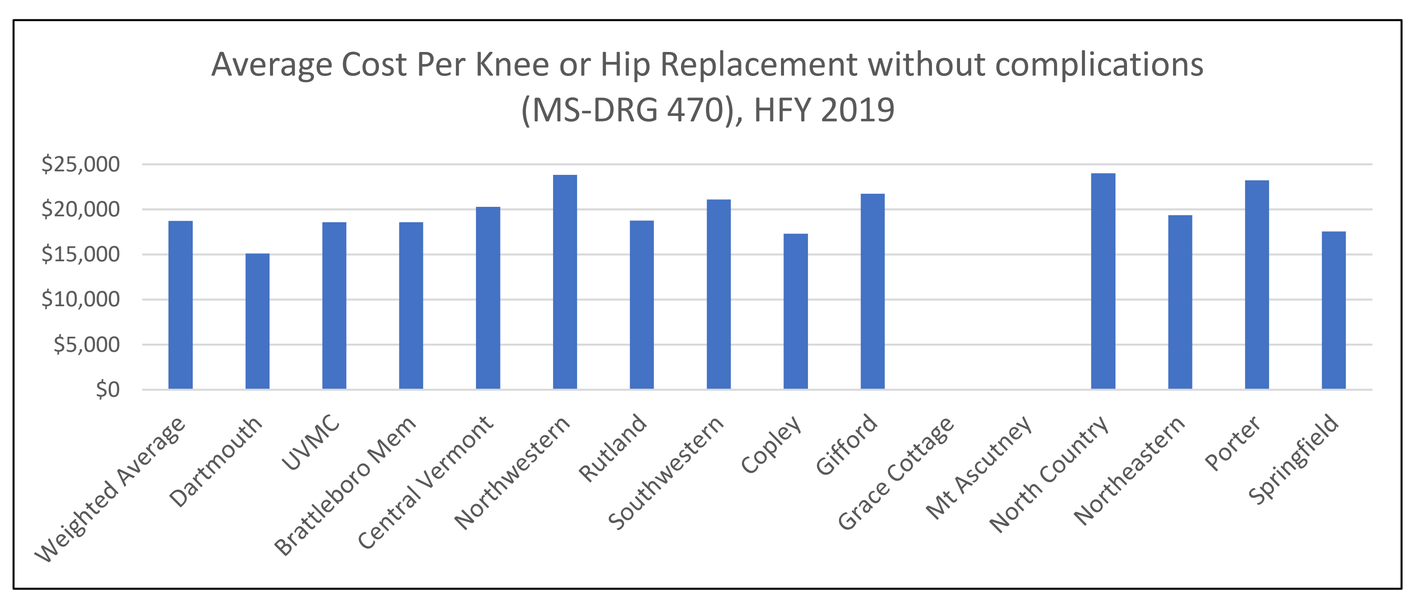


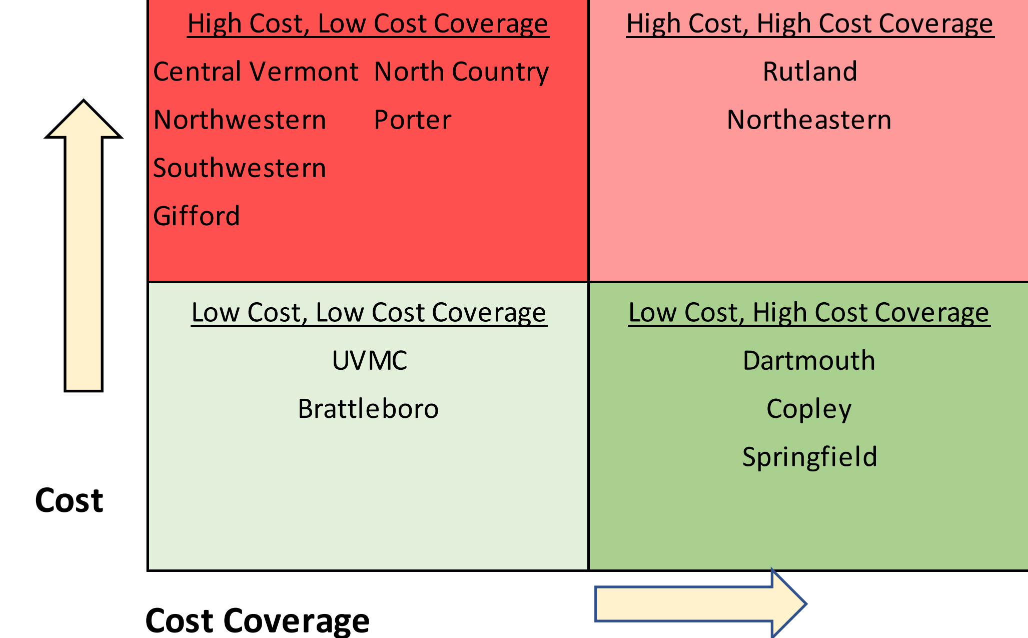


MS-DRG 470, KNEE or HIP REPLACEMENT WITHOUT COMPLICATIONS

The weighted average cost for this inpatient service in HFY 2019 was $18,730. Eight hospitals had average costs above this, the other five are below this average. [Grace Cottage and Mt Ascutney did not have any volume.]

As seen in the box below, the six hospitals with higher-than-average cost all have cost coverage below 100%, but two had cost coverage above 100%. Some hospitals with lower-than-average costs have cost coverage below 100% while others are above 100%.

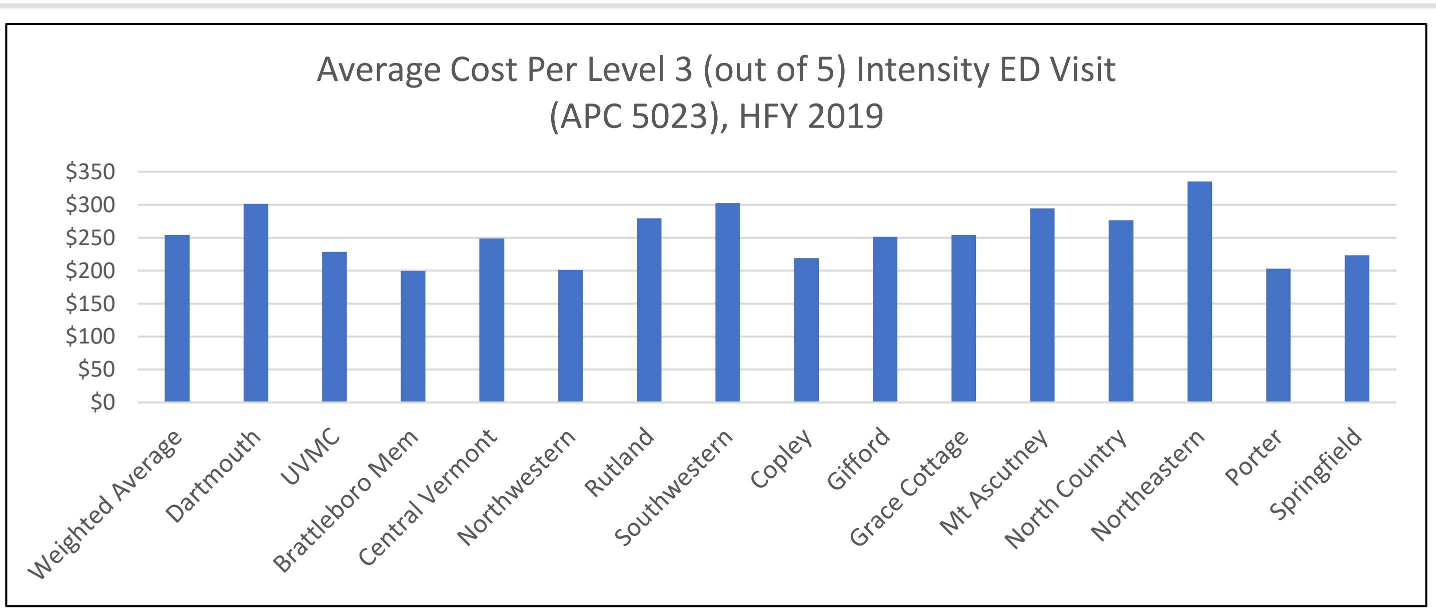


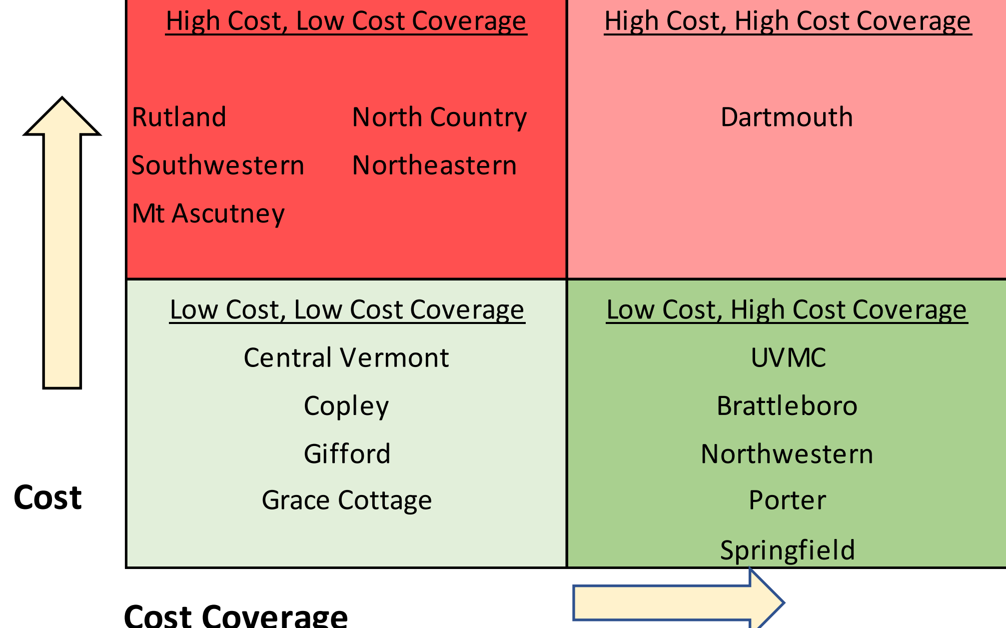


APC 5023, MID-LEVEL EMERGENCY DEPARTMENT VISIT

The weighted average cost for this outpatient service in HFY 2019 was $254. Six hospitals had average costs above this, the other nine are below this average.

Similar to what was seen in the inpatient service examples, there is a disparity between average costs incurred and ultimate cost coverage. Five hospitals have lower-than-average cost and also cost coverage above 100%, but four hospitals have lower-than-average cost but cost coverage below 100%. Dartmouth has higher-than-average costs for this service but also higher cost coverage than others.

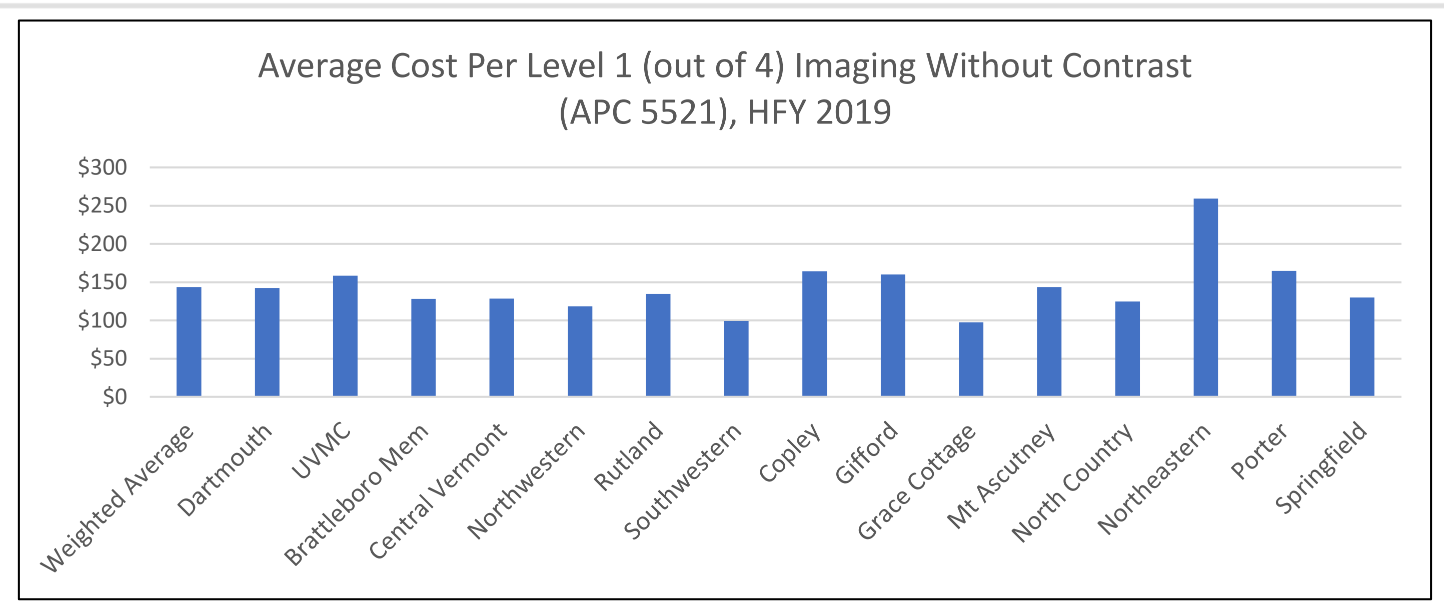


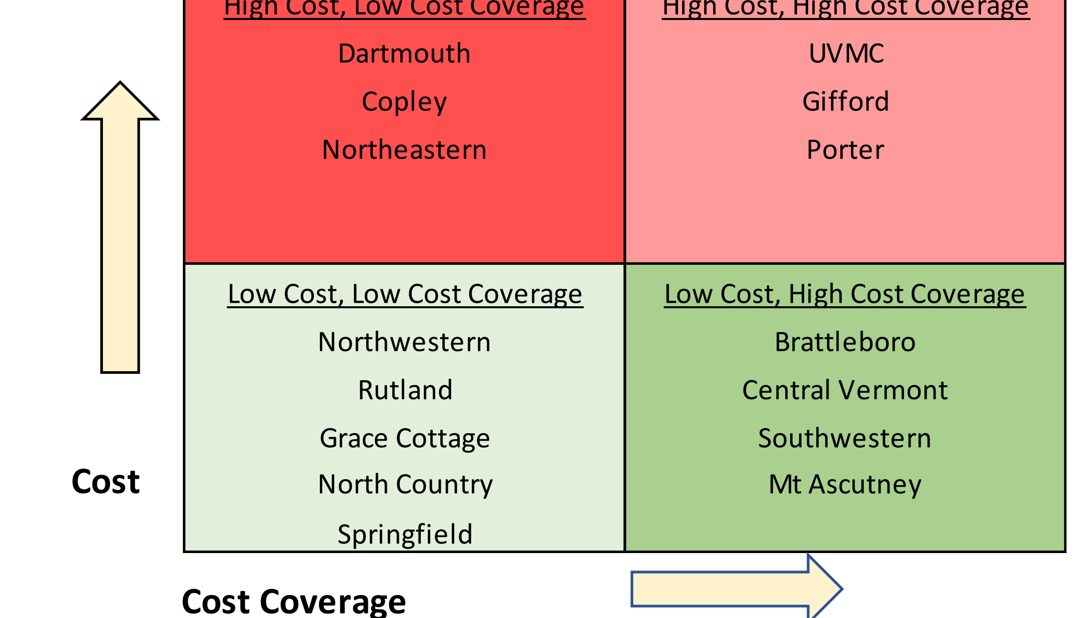


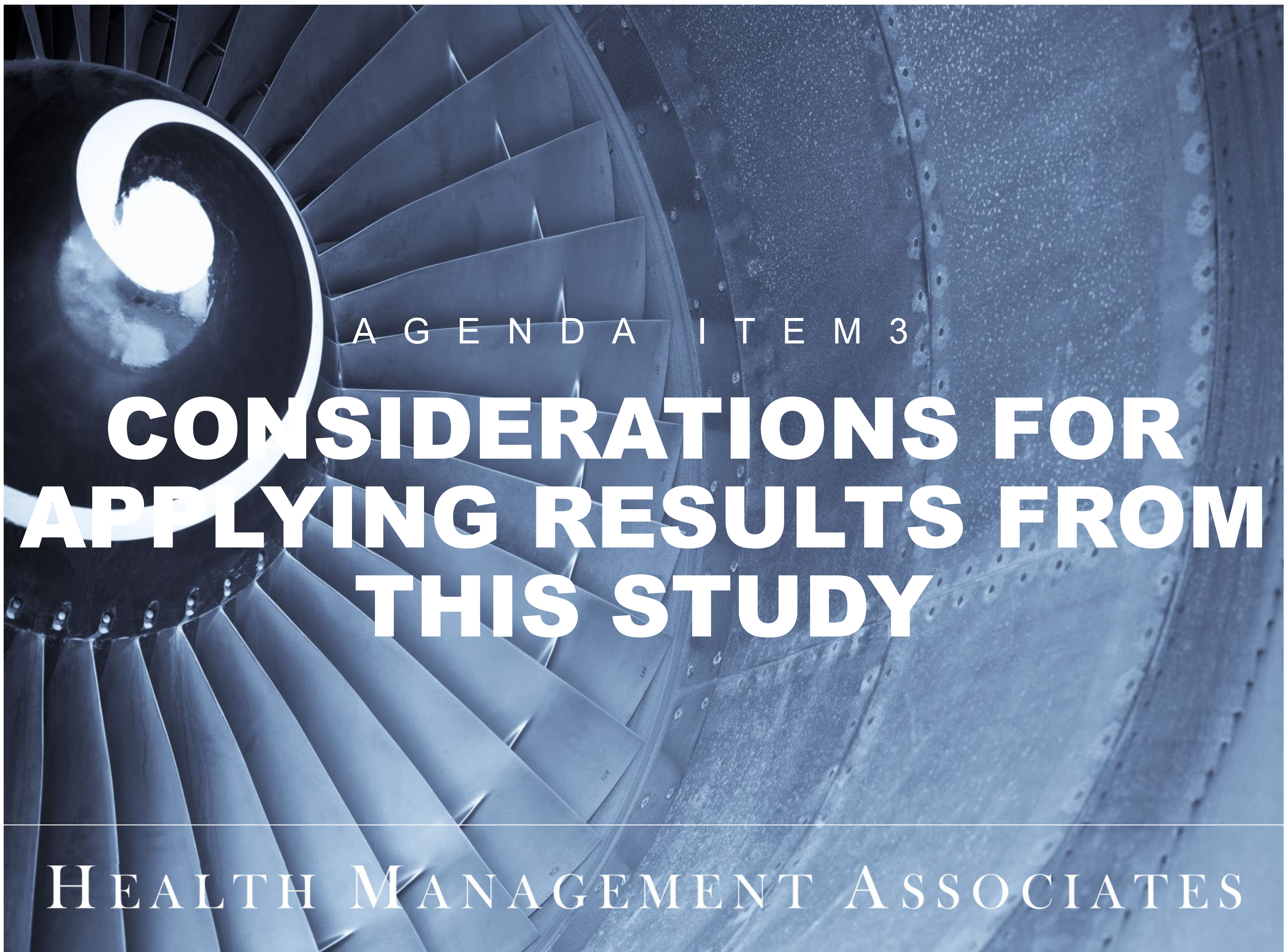
APC 5521, LEVEL 1 IMAGING WITHOUT CONTRAST

The weighted average cost for this outpatient service in HFY 2019 was $144. Six hospitals had average costs above this, the other nine are below this average.

As was seen in the other examples, there is not always a correlation between efficient (lower) costs and higher cost coverage. For this service, there is variety between lower and higher cost coverage among hospitals with more efficient and less efficient costs.






A G E N D A I T E M 3
CONSIDERATIONS FOR APPLYING RESULTS FROM THIS STUDY
HEALTH MANAGEMENT ASSOCIATES

APPLICATION OF THE RESULTS FROM THIS STUDY

As the GMCB assesses future policy making and regulatory consideration, the following recommendations may be considered:

1. **Regulation of hospital charge masters does not appear to be an effective tool to manage hospital revenues and efficiencies.**
2. **The GMCB should consider developing a roadmap to pivot to cost coverage as a lever for regulating hospitals. Inherent with this recommendation, however, the following items need to be addressed:**
    - At minimum, consideration should be given to the type of hospital (that is, teaching hospitals, general acute care non-teaching hospitals, critical access hospitals) when examining costs and cost coverage. This is because the cost structures of each hospital type are different.
    - Achieving 100% cost coverage or more for every hospital for every service is not necessarily a goal. As seen in the examples provided, some hospitals deliver the same service more efficiently than other hospitals. Financial reward should be focused on high quality services delivered as efficient costs.
    - A specific cost coverage value for each service is also not realistic. Hospitals need to have the flexibility to manage their costs with the understanding of a general target. Instead, the GMCB may consider an acceptable band of cost coverage when applying oversight.
    - Different inpatient and outpatient service categories have different inherent costs. Consideration may be given to different cost coverage bands that are deemed acceptable depending upon the category of service delivered.
    - If cost coverage is considered as a future metric by the GMCB, more scrutiny will be required to ensure the baseline data used in the development of regulatory policies.