VERMONT ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS - NETWORK SERVICES ORGANIZATION

Act 53 Financial Reporting and Payment Variation

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Overview:

- General Definitions
- Basic Reimbursement Methodologies
- Existing “Pricing” Tools
- Act 53
- Payment Variation
- Summary

General Definitions

Gross Charges – Often categorized as Price. It captures all services (lab, radiology etc) provided to the patient for a visit or discharge. Captured in Act 53 Reporting.

Contractual Adjustments – Represent the discount arrangements that providers have with private payers.

Bad Debt – Gross charges that are not collected, when collection was expected.

Free Care or Charity Care - is care for which hospitals do not expect to be reimbursed. All hospitals have charity care policies that are publicly available within Act 53.

Net Revenue – The green dollars or payment collected for services provided. Typical calculation: gross charges minus (free care, bad debt and contractual adjustments) = Net Revenue.

Charge Master – Complete set of itemized charges for all services and supplies. Charge master prices are not set for complete services, they are itemized. For example pricing for a hernia repair would be comprised of all services and supplies received. Pricing does not vary based on payer, but will differ by patients based on services delivered.

General Definitions

Rate Sensitivity - Variations in reimbursement rates based on who is paying and what services are being provided.

MSDRG – Medicare Severity Diagnostic Related Groups sometimes referred to as DRG. The MSDRGs are utilized to code inpatient discharges; they identify severity and are utilized in reimbursement methodologies for inpatient discharges.

Payer Mix – Payer mix is the proportion of hospital net revenue received from different public and private payers. (Medicare, Medicaid, BCBS, MVP)

Service Mix - Some services tend to be reimbursed more favorably than others. For example, surgical care is more profitable than medical care and tends to lose money on emergency departments.

Basic Reimbursement Methodologies

Hospital net revenues (green dollars) are equal to Medicare, Medicaid and Commercial insurance expenses. A hospital's net revenue stream is equal to the insurer's expense. In Vermont, Net Payments are derived generally from three types of Payments:

1) **DRG Payment** – A predetermined base payment adjusted for acuity = Net Revenue. Gross Charge or Price has no impact on Net Revenue often referred to as Rate Sensitivity.

2) **Outpatient Prospective Payment** - A predetermined base payment adjusted for acuity = Net Revenue. Gross Charge or Price has no impact on Net Revenue often referred to as Rate Sensitivity.

3) **Percent of Gross Charges** – Payment is based on the agreed upon contractual percent amount. Net Revenue fluctuates based on the amount of the charge.

These reimbursement methodologies are commonly referred to as **fee-for-service**, meaning reimbursement is tied to volume.

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"Pricing" Information

- Act 53 Reporting – Publishes Hospital Specific Quality and Financial Information

  http://www.dfr.vermont.gov/insurance/insurance-consumer/2013-hospital-report-card

- Vermont HC Price and Quality Transparency Rule REG-H-07-05 - If the question is out-of-pocket spending (patient responsibility after insurance) this would be an insurance company question. The attached rule tries to get at the out-of-pocket issue.

  http://www.dfr.vermont.gov/sites/default/files/REG-H-07-05.pdf

- Health Care Payment Variation Report - http://gmcboard.vermont.gov/sites/gmcboard/files/Variation_Jun03.pdf

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Act 53 Reporting

Vermont law requires hospitals to publish annual reports containing information about quality of care, hospital infection rates, patient safety, nurse staffing levels, financial health, **costs for services** and other hospital characteristics. The law also requires the Department of Financial Regulation to publish some of that same information in comparative format on this website.

Act 53 Captures Average Gross charges for the most utilized Services for:

- Inpatient
- Outpatient
- Physician and Hospital Pricing of Other Common Services: (Office Visits, Lab, Cardiology, Emergency Services, Radiology (CT, MRI, Xray, Mammography)

Following are sample for Inpatient and Outpatient charges reported in Act 53.

CY 2011 Inpatient Average Charges By Hospital

Inpatient Care		Hospital System		Vermont Community Hospitals - Counts Displayed Include Each Hospital's Top Diagnoses By Volume													
MDC and MS-DRG[1]	Diagnosis Description	System Number of Cases[2]	System Average Gross Charge[3]	Brattleboro Memorial Hospital	Central Vermont Medical Center	Copley Hospital	Fletcher Allen Health Care	Gifford Medical Center	Grace Cottage Hospital	Mt Ascutney Hospital & Health Center	North Country Hospital	Northeastern Vermont Regional Hospital	Northwestern Medical Center	Porter Hospital	Rutland Regional Medical Center	Southwestern Vermont Medical Center	Springfield Hospital
MDC 1	Diseases and Disorders of the Nervous System																
66	Stroke without complications or comorbidities	242	$14,776	$12,690			$18,950								$13,361	$11,698	
69	Stroke like attack (TIA)	137	$12,366				$17,595								$13,942		
101	Seizures without major complications or comorbidities	252	$9,376				$9,698								$11,517		
MDC 4	`																
176	Blood clot in the arteries of the lung without major complications or comorbidities	269	$13,832				$13,496								$18,855	$11,268	
178	Respiratory infections & inflammation with complications	274	$21,198		$16,887		$28,139							$10,660	$22,335	$18,464	
181	Respiratory tumors with complication	76	$16,166				$18,894										
190	Chronic lung disease (emphysema) with major complications	485	$15,658	$14,181	$18,127		$13,999				$14,750		$12,496		$19,089	$14,617	
191	Chronic lung disease (emphysema) with complications	477	$12,967	$12,819	$12,870	$7,084	$11,719				$12,781		$11,492	$7,998	$17,130	$12,275	$10,576
192	Chronic lung disease (emphysema) without complications	444	$9,666	$8,410	$10,350	$7,479	$10,129	$9,447		$8,385	$10,269		$7,467	$7,783	$11,772	$11,057	$9,417
193	Pneumonia with major complications	385	$20,243		$20,698	$8,920	$21,078				$24,945		$12,245		$22,974	$21,367	
194	Pneumonia with complications	1,192	$12,734	$13,717	$13,866	$6,893	$12,449	$11,750		$10,722	$15,450	$12,452	$9,718	$8,346	$17,331	$13,306	$13,403
195	Pneumonia without complications	596	$8,821	$10,586	$9,769	$5,748	$8,372	$8,646	$5,701	$10,644		$8,984	$8,024	$8,131	$9,159	$9,503	$10,120
MDC 5	Diseases and Disorders of the Circulatory System																
247	Coronary artery stent (drug-eluting) without major complications	376	$38,393				$38,393										
281	Heart attack, discharged with complications	182	$14,411		$14,721		$16,135				$11,341				$13,829		
287	Heart disease requiring heart catheterization without major complications	197	$16,166				$15,757								$21,190		
291	Heart failure with major complications	310	$20,217		$16,529		$22,301				$17,704				$27,894	$19,610	
292	Heart failure with complications	560	$14,080		$16,466	$6,769	$16,128	$10,297		$12,063	$14,739	$12,918	$12,293		$15,896	$11,851	$13,041
293	Heart failure without complications	261	$9,606		$10,078		$10,001					$8,654	$9,673			$10,110	$11,568
309	Heart rhythm disturbances with complications	318	$11,750		$17,490	$6,789	$12,503				$12,098				$10,902	$11,664	
310	Heart rhythm disturbances without complications	486	$8,016			$3,845	$8,113				$8,581	$10,421	$8,330		$8,778	$7,434	$7,266
312	Syncope & collapse	279	$9,396		$11,867		$10,185						$7,771		$11,346	$8,848	$9,214
313	Chest pain	280	$8,901		$10,983	$3,417	$10,911								$9,640	$9,237	$8,053

Source: Act 53 Hospital Report Cards

CY 2011 Outpatient Average Charges By Hospital

Outpatient Procedures		Hospital System		Vermont Community Hospitals - Counts Displayed Include Each Hospital's Top Procedures By Volume													
CCS and Procedure Code[1]	Procedure Description	System Number of Cases[2]	System Average Gross Charge[3]	Brattleboro Memorial Hospital	Central Vermont Medical Center	Copley Hospital	Fletcher Allen Health Care	Gifford Medical Center	Grace Cottage Hospital[4]	Mt Ascutney Hospital & Health Center	North Country Hospital	Northeastern Vermont Regional Hospital	Northwestern Medical Center[5]	Porter Hospital	Rutland Regional Medical Center[6]	Southwestern Vermont Medical Center	Springfield Hospital
CCS 7	Operations on the cardiovascular system																
3722	Cardiac catheterization	618	$11,415				$11,590								$8,896		
3899	Blood draw	3,216	$1,025		$233	$198	$1,284			$175	$415	$1,538	$377		$276		
CCS 9	Operations on the digestive system																
4292	Dilating a narrowed section of esophagus	445	$3,527	$2,444	$3,489	$2,378	$4,288								$2,954	$1,539	
4513	Visualization of small intestine using a fiberoptic endoscope, via mouth	1,538	$2,723	$2,662	$2,798		$2,842			$2,405	$3,149		$1,584	$2,478	$2,701	$1,661	$1,659
4514	Biopsy (taking a small tissue sample) of small intestine using a fiberoptic endoscope, via rectum	95	$2,874													$2,785	
4516	Visualization and biopsy of esophagus, stomach, and first part of small intestine using a fiberoptic	4,402	$2,923	$2,412	$3,126	$2,446	$3,715	$3,965		$3,098	$3,454	$3,358	$1,363	$2,195	$3,367	$1,539	$2,006
4523	Visualization of large intestine with an endoscope, via rectum	9,362	$2,265	$2,018	$2,437	$1,505	$2,469	$2,757		$2,284	$3,092	$2,214	$1,432	$1,597	$2,468	$1,597	$1,754
4525	Biopsy (taking a small tissue sample) of lower intestine using a fiberoptic endoscope, via rectum	2,165	$3,252	$2,559	$3,594	$2,533	$3,828	$4,014		$3,182	$3,595	$3,518	$2,193	$2,445	$3,207	$2,106	$2,432
4542	Visualization and polyp removal from large intestine with an endoscope, via rectum	7,849	$3,066	$2,901	$3,659	$2,403	$3,892	$5,303		$3,123	$3,525	$3,453	$2,056	$2,568	$2,981	$2,225	$2,323
4824	Visualization and biopsy of last part of large intestine using a fiberoptic endoscope, via rectum	313	$2,581	$2,379	$3,323		$2,941			$2,754			$1,929		$2,706	$1,533	
4836	Visualization and polyp removal from last part of large intestine using a fiberoptic endoscope, via rectum	1,052	$2,864	$2,485	$3,545		$3,264			$2,740	$3,586	$3,275	$1,941	$2,469	$2,896	$2,063	$2,308
5011	Biopsy of the liver	219	$3,990	$2,644			$4,762								$2,276		
5123	Removal of gallbladder using fiberoptic scopes and instruments, via small incisions in the abdominal wall	1,181	$10,247	$7,997	$9,975	$12,994	$11,193	$19,119			$11,792	$18,222	$8,036	$14,729	$8,897	$7,684	$8,995
5304	Repair of a hernia in the groin	468	$7,772	$5,970	$6,826	$8,996	$7,613				$8,309	$10,049		$10,634	$7,093	$6,262	$6,848
CCS 10	Operations on the urinary system																
560	Transureth Remov Obst Ureter-Pelv	365	$10,799		$11,359		$9,481					$17,658	$8,510		$7,233	$10,462	
5732	Endoscopy of the bladder	1,167	$1,258		$1,539	$403	$1,155										
5794	Bladder Catheter Insertion	564	$1,610				$1,122			$2,650			$2,747			$2,387	
CCS 11	Operations on the male genital organs																
6011	Removal of a sample of prostate gland using a thin needle	129	$3,672			$2,933		$3,474				$3,228					
640	Removal of the penile foreskin	248	$3,058		$1,932		$5,191					$4,029				$879	$1,244

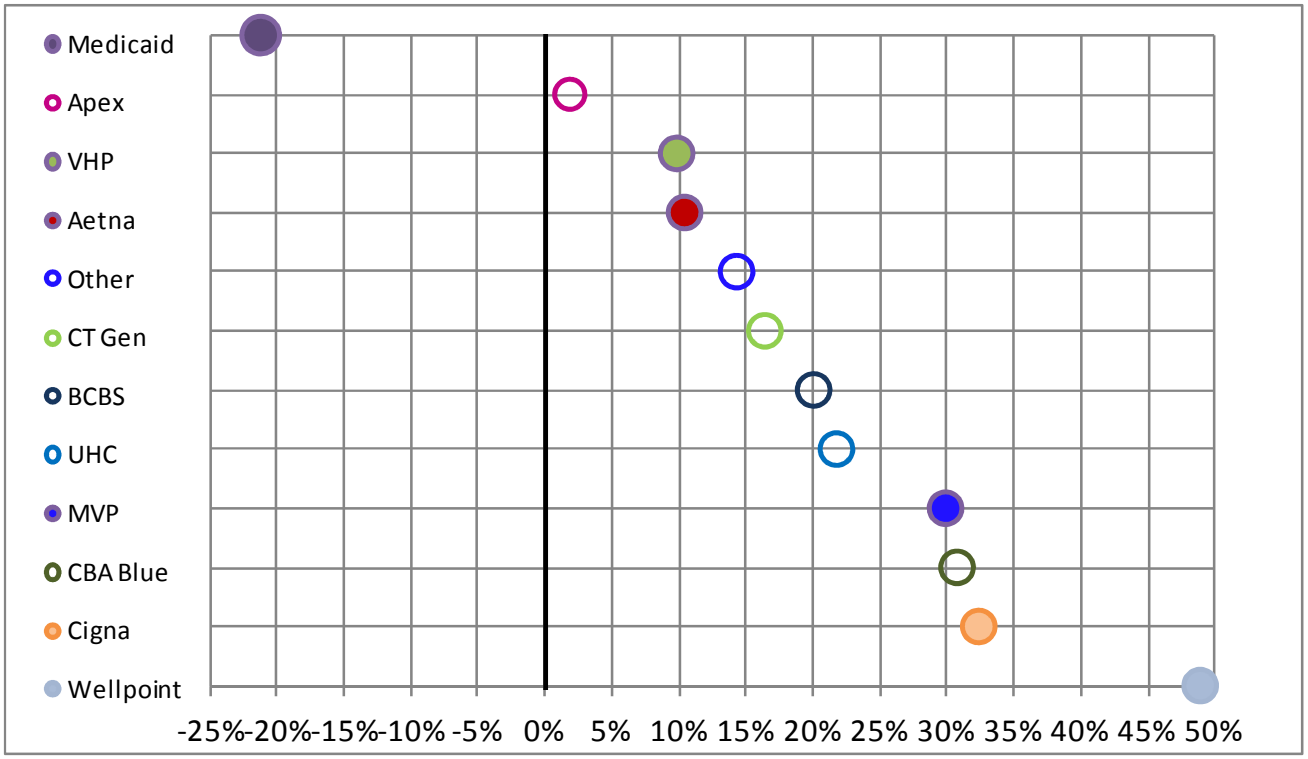
Source: Act 53 Hospital Report Cards

Payment Variation - Phase # 1

Fundamental Scope of work Included:

Development of Payment Variation Analysis
- By Provider
- By Payer

Inpatient Average Payer Payments - Relative to Statewide System Average Payment



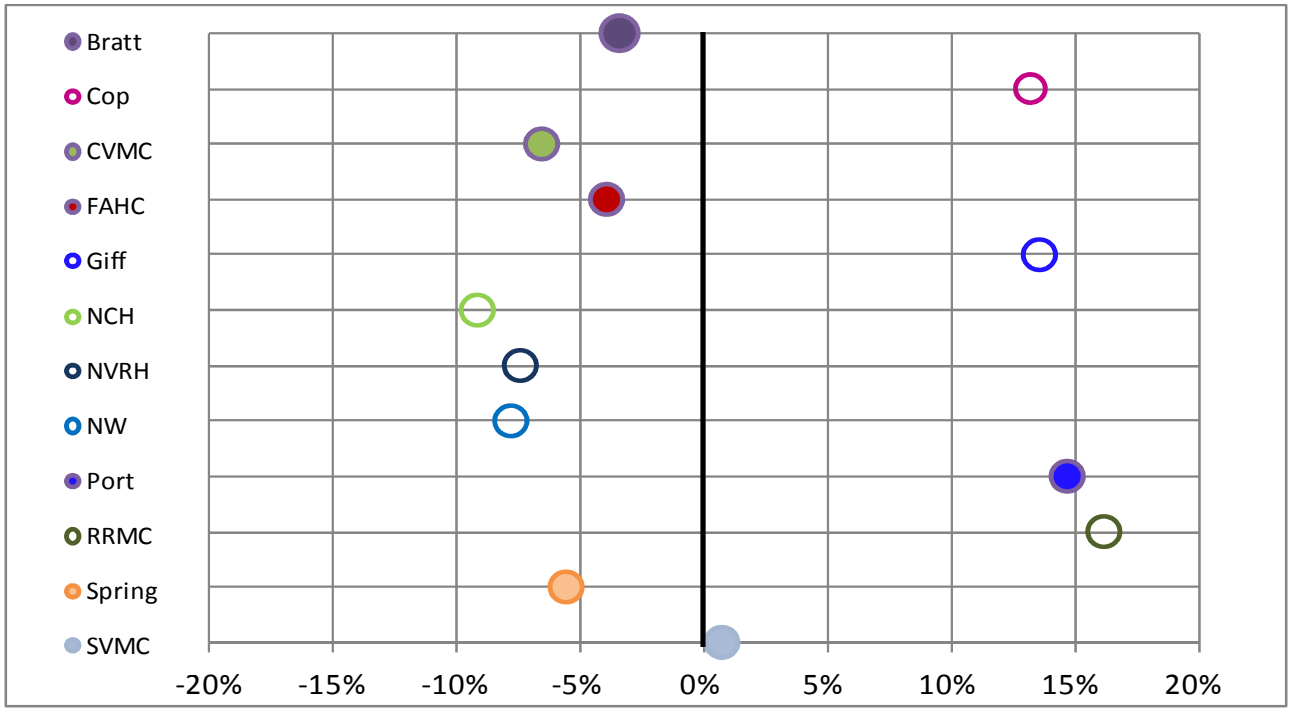
How to Read:

Data points represent the % over/under the statewide inpatient system average payment (system=commercial and Medicaid payments together).

Key Findings:

- Significant variation exists between the highest and lowest payers at the aggregate level, particularly between Medicaid and all other commercial payers. (Every payer listed has over 100 observations, so small numbers do not bias the statistical significance of these results.)
- Most commercial payers fall within ten points on either side of Blue Cross, which lies in the middle of the range.

Inpatient Average Hospital Payments - Relative to Statewide System Average Payment



How to Read:
Data points represent the percent over/under the statewide inpatient system average payment.
Zero % is the Statewide Average.

Key Findings:

- Hospital rankings are significantly influenced by payer mix. Hospitals with more Medicaid payments will skew to the left and hospitals with more commercial payments will skew to the right.
- Grace Cottage and Mount Ascutney hospitals are not shown due to small numbers.
- Fletcher Allen, due to its large volume, drives the statewide average payment.

Inpatient Payment Variation - Between Hospitals within Payer Networks

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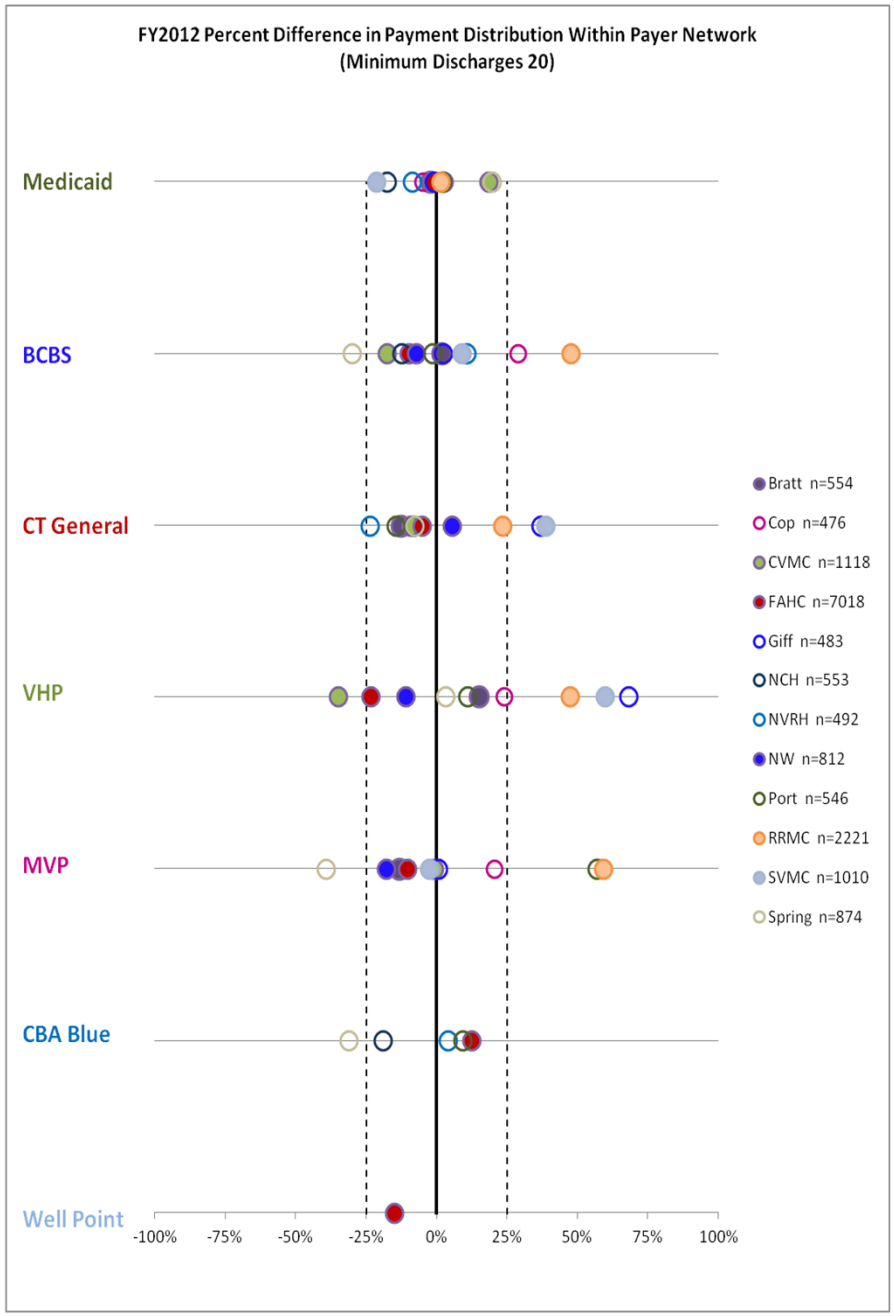


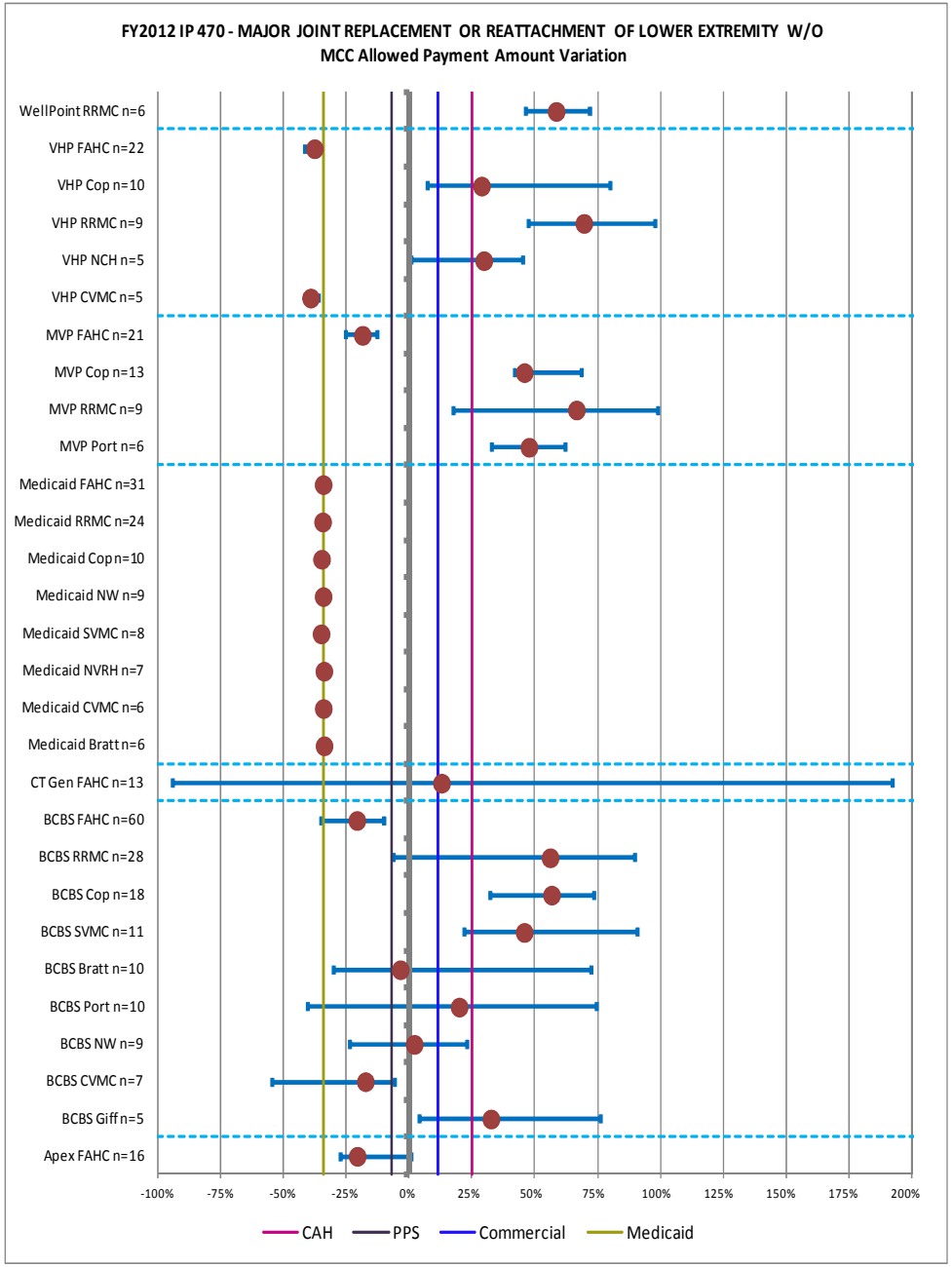
How to Read: Each row represents a payer network. The payers are ranked according to statewide total payments. Each data point represents a hospital's % over/under the payer network average payment.

Key Findings:

- Significant variation exists between hospitals at the aggregate level, within payer networks. The majority of payers have average payments both above and below the 25% level.
- 81% (57/71 data points) of the data falls within 25% of the average.
- Greater variation above 25% than below -25%.
- A hospital 25% above the average compared to a hospital 25% below the average represents a 67% higher average payment. Again, the larger payers show less variation.
- Variation is greatest within commercial payers.
- VHP is paying two of the largest hospitals (FAHC and CVMC) -23% and -35% below the average, which pulls the average down. VHP pays -8% below all other commercial payers. CAH are all paid above average.

Note: There are 2 hospitals that appear on the WellPoint line. FAHC is at -15% and Brattleboro is at -13%.

Inpatient Payment Variation by Payer, Hospital and DRG (Minimum 5 Discharges)



How to Read:

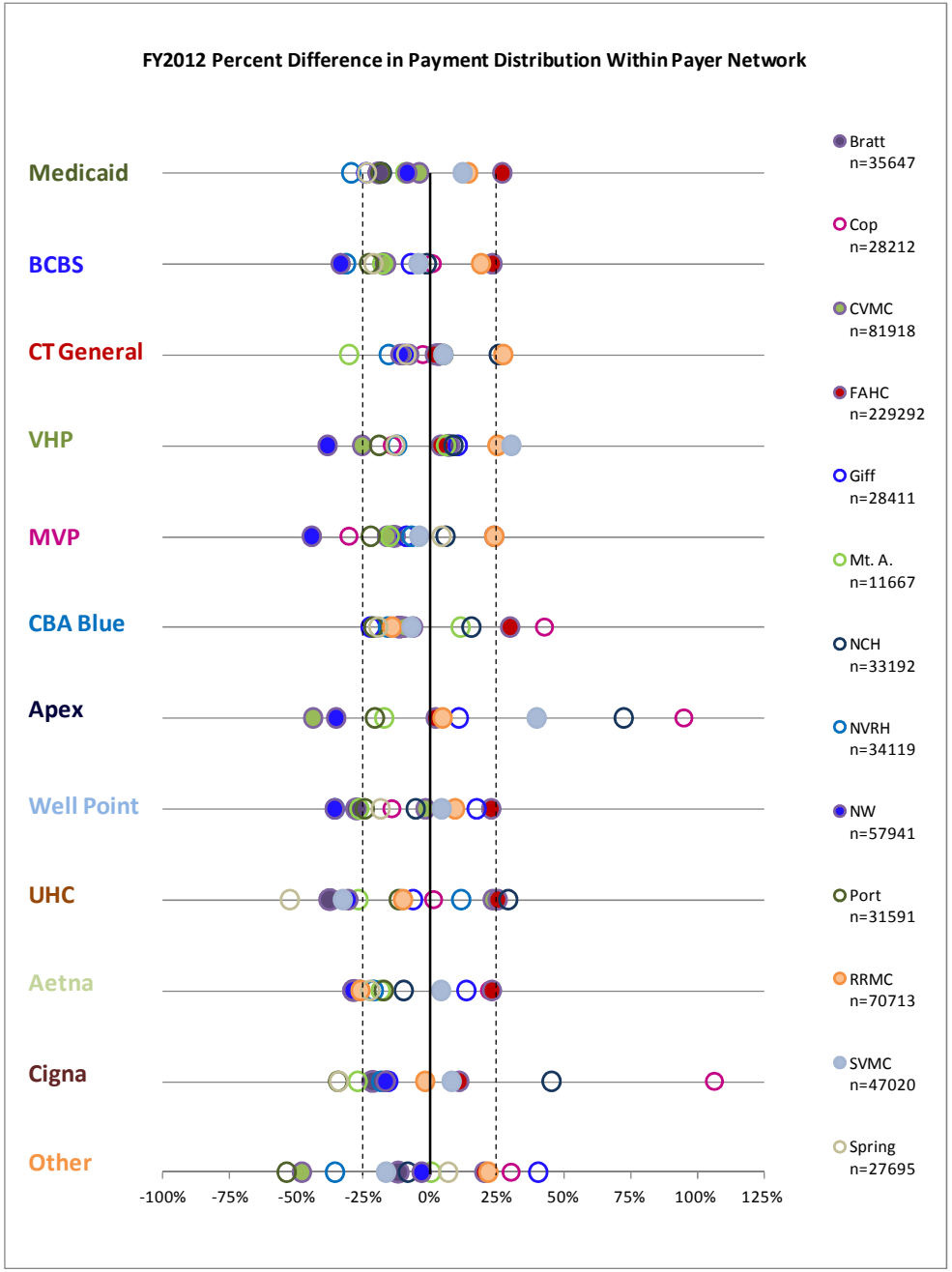
- Each row represents a unique payer-hospital combination
- The red data point is the average payment relative to the statewide system average. The whiskers show the 10th and 90th percentile payment levels.

Key Findings:

- Significant variation in payments exists between payer-hospital combinations. In addition, significant variation exists within any one payer-hospital. Small numbers explains some of this variability, but this highlights payment variation between individual cases.
- Additionally, differences in reimbursement rules may play a significant role in payment variation at this level. For example, Medicaid pays a DRG across all hospitals.
- Other variation may be explained by provider specific payer contracts.

Outpatient Overview

Outpatient Payment Variation Between Hospitals within Payer Networks

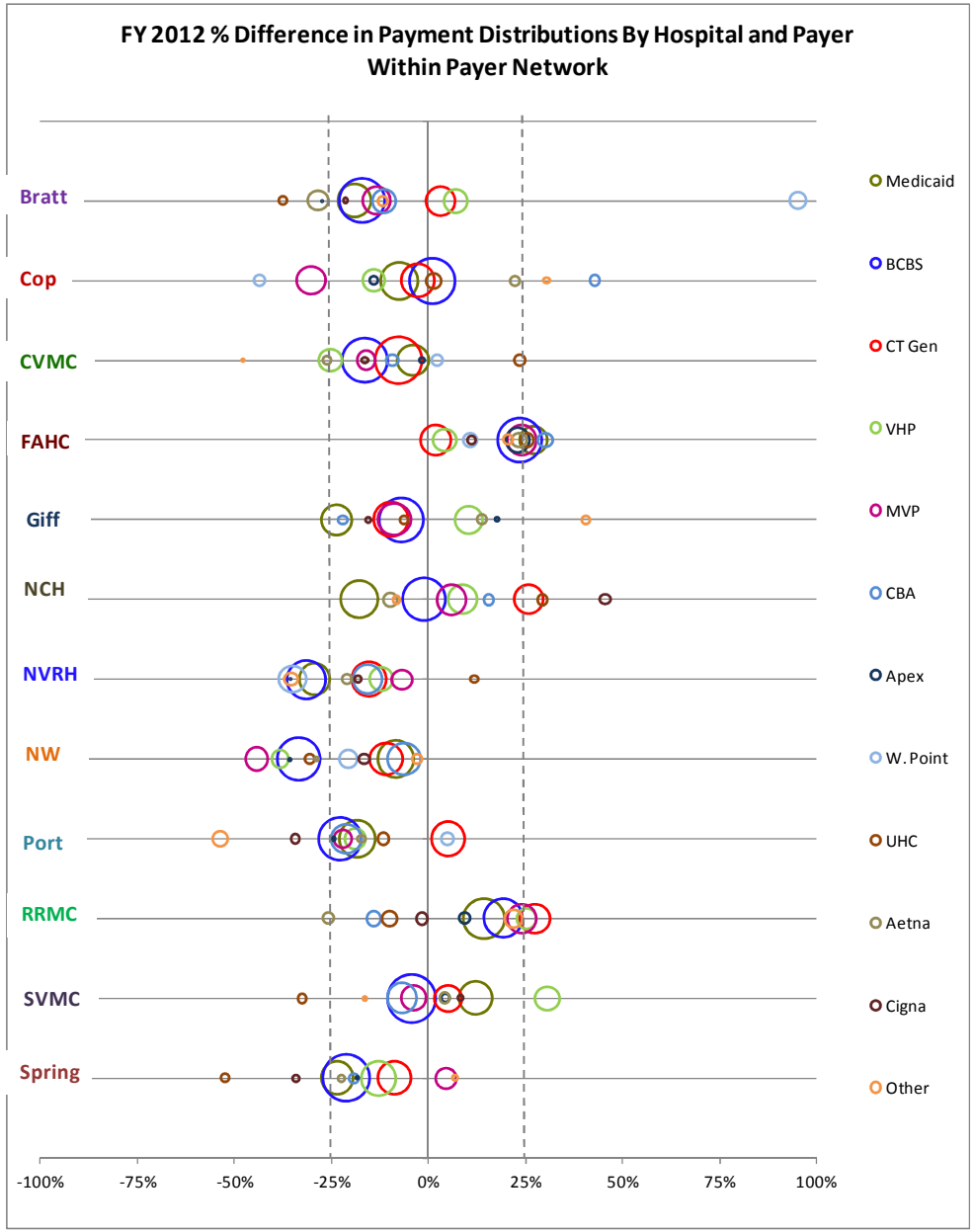


How to Read: Each row represents a payer network. The payers are ranked according to statewide total payments. Each data point represents a hospital's % over/under the payer network average payment.

Key Findings:

- Aggregate outpatient data was not case-mix adjusted. Variation seen here may be largely a result of differences in service intensity and contract terms between providers and payers.
- High degree of concentration falls between 25% plus and minus the statewide average.

Outpatient Payment Variation by Hospital and Payer within Payer network



How to Read: Each row contains a given hospital's network of payers. The bubbles for each payer are sized to reflect payer share for the given hospital. The data points represent the payer's average payment to that hospital, relative to its own payer network average.

Key Findings:

- Aggregate outpatient data was not case-mix adjusted. Variation seen here may be largely a result of differences in service intensity and contract terms between providers and payers.
- The majority of the data falls within +- 25% of the payer averages.

Outpatient Payment Variation by Payer, Hospital and ICD – 9 (Minimum 15 Discharges)

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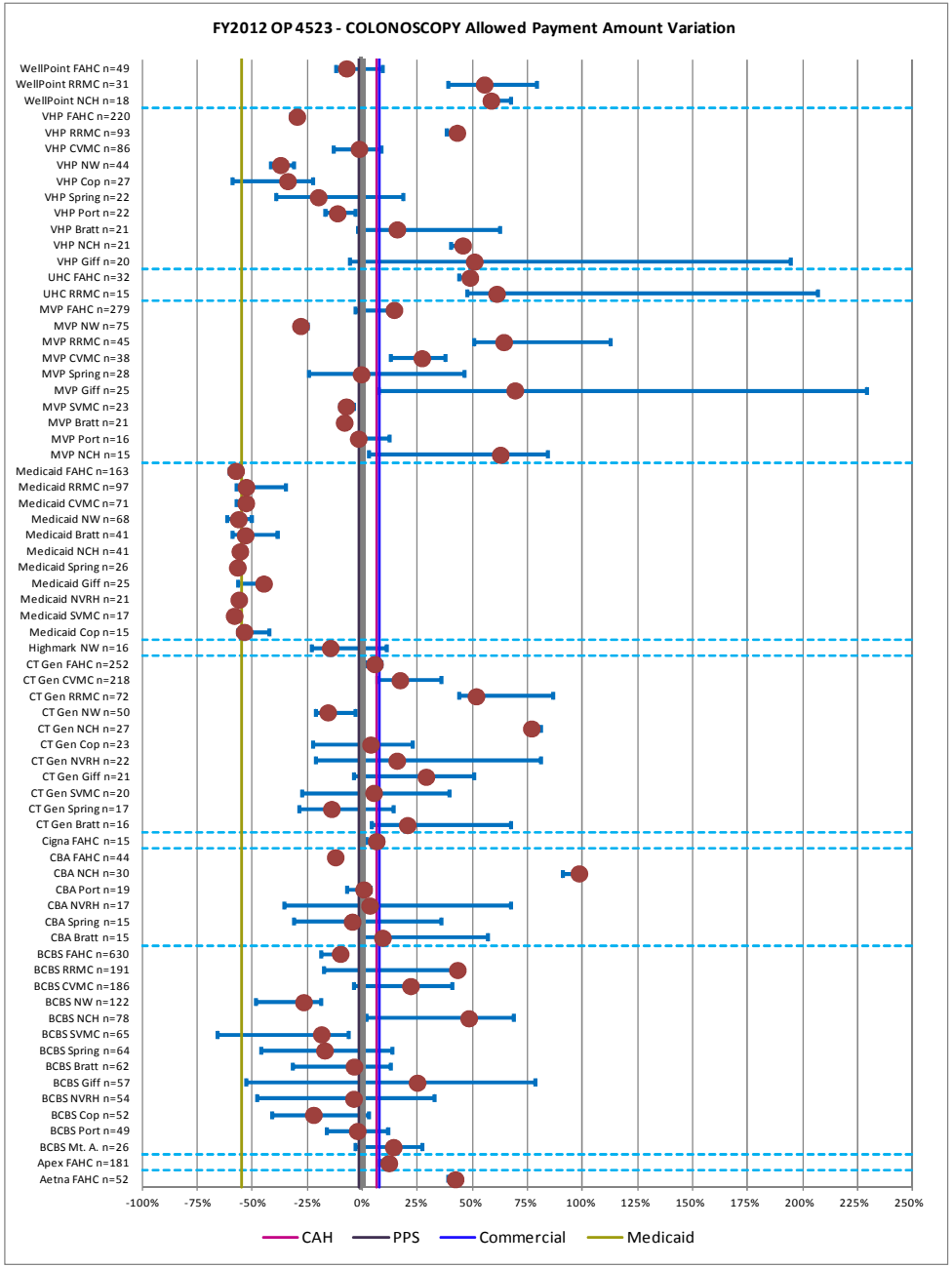


How to Read:

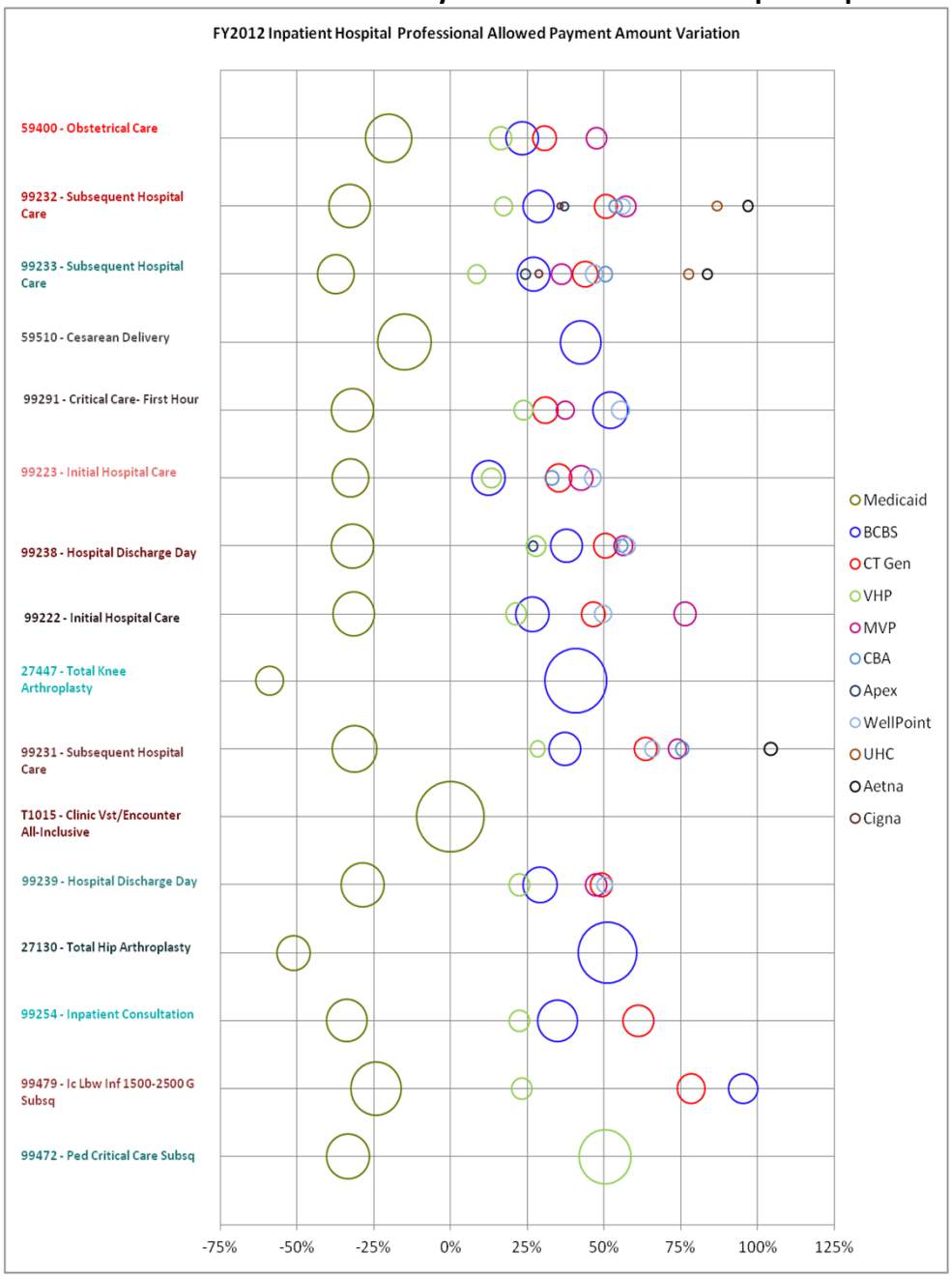
- Each row represents a unique payer-hospital combination. Rows are grouped by payer.
- The red data point is the average relative payment (relative to the statewide system average) for that payer to that hospital for that principal procedure.
- The whiskers show the 10th and 90th percentile payment levels.

Key Findings:

- Significant variation in payments exists between payer-hospital combinations. In addition, significant variation exists within any one payer-hospital. Small numbers explains some of this variability, but this highlights payment variation between individual cases.
- Additionally, differences in reimbursement rules may play a significant role in payment variation at this level. For example, Medicaid pays a the same APC rate across all hospitals.
- Other variation may be explained by provider specific payer contracts.

Professional Overview

Professional Variation by CPT - Service Site = Hospital Inpatient

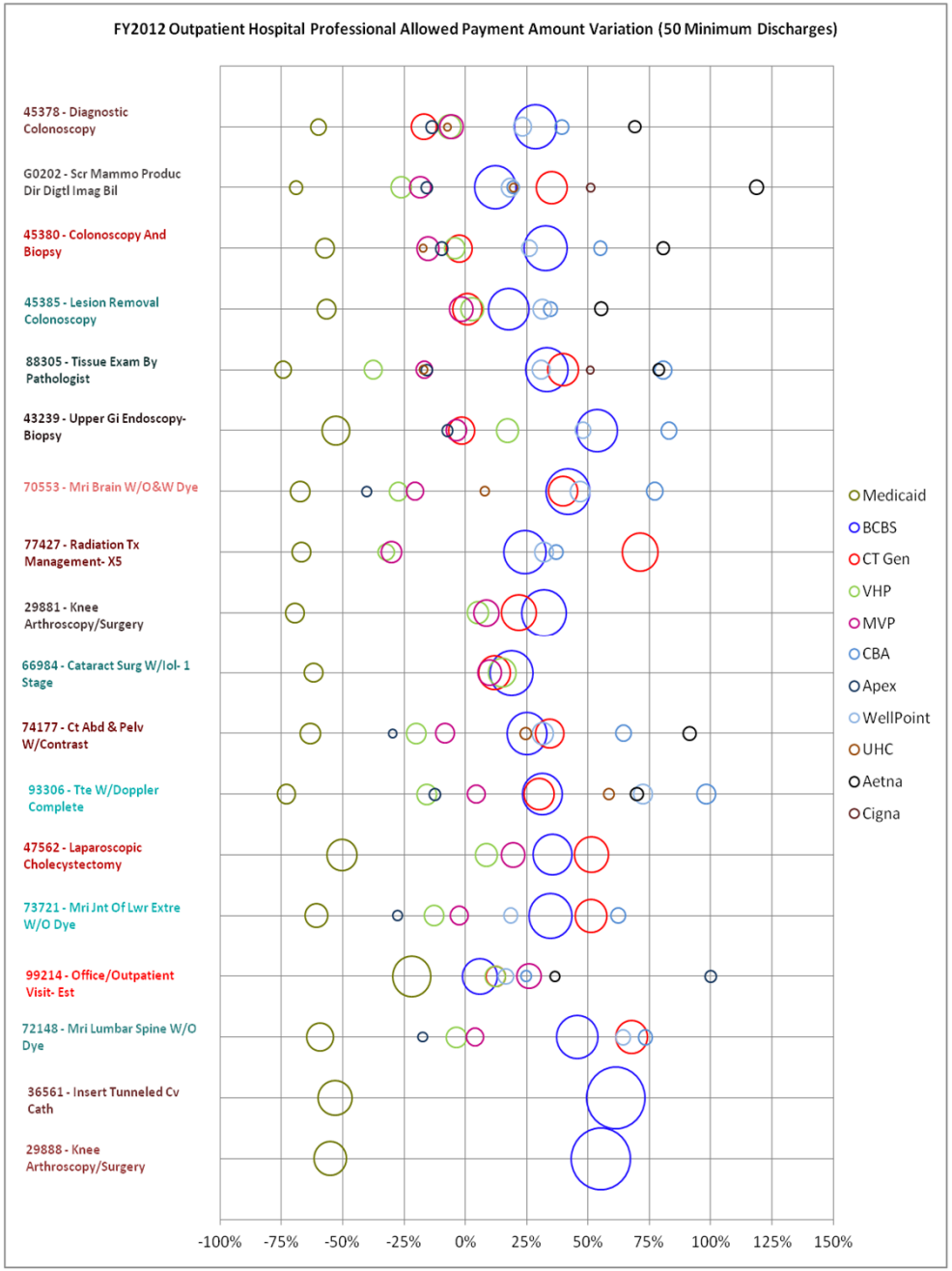


How to Read: Each row shows payment data for a given CPT. The CPTs are ranked by payments. The data points represent a given payer's average payment for that CPT, relative to the system wide average payment for the same CPT, effectively showing variation between payers for the same CPT. The bubbles for each CPT are sized to reflect payer share.

Key Findings:

- There is a high degree of variation between Medicaid and other payers.
- BCBS payments are approximately 25% higher than statewide averages.
- Medicaid payments are approximately 30% less than statewide average.

Professional Variation by CPT - Service Site = Hospital Outpatient



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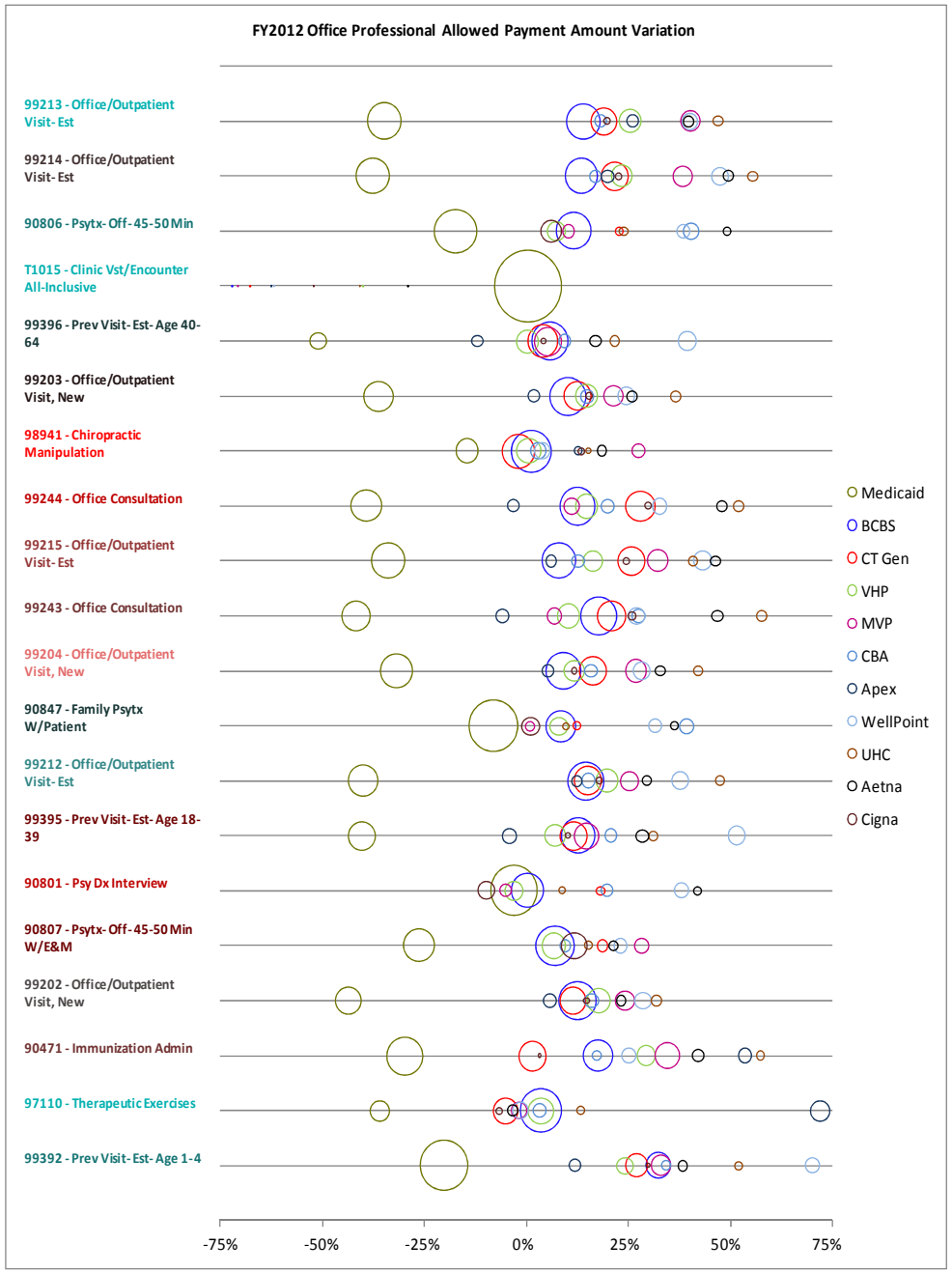
Key Findings:

- Chart indicates patterns of payment by specific payer. For example, BCBS generally pays between 25% to 50% above the system average.
- Aetna pays more for each procedure on average, but has one of the smallest market share.
- BCBS payments are approximately 25% higher than statewide averages.
- Medicaid payments are approximately 50% less than statewide average.

Professional Variation by CPT - Service Site = Medical Office



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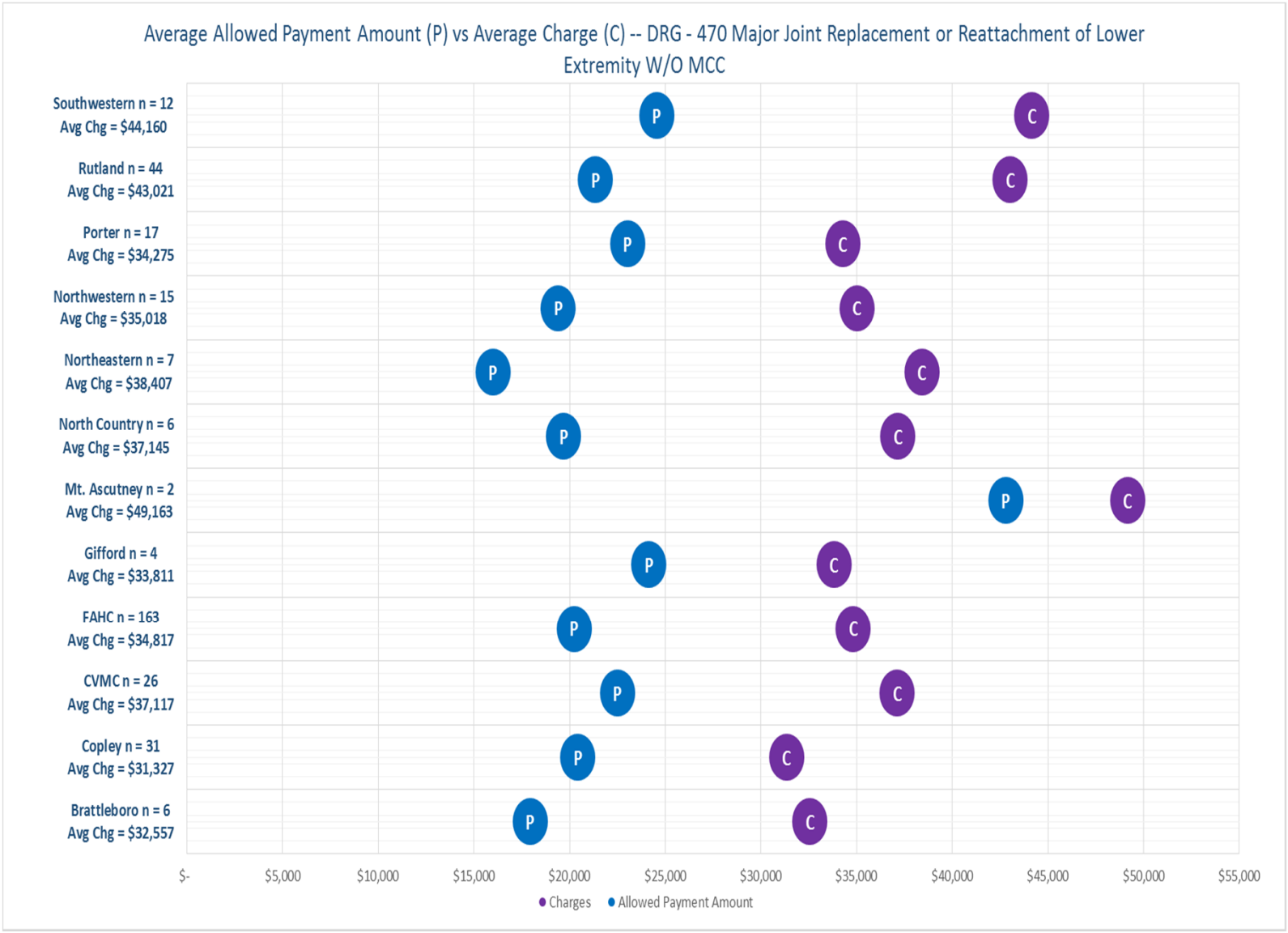
Key Findings:

- Average commercial payments are grouped around 15 - 25% above the system average. This distribution is more closely correlated when compared with inpatient, outpatient and other professional categories.
- BCBS payments are approximately 20% higher than statewide averages
- Medicaid payments are approximately 25% less than statewide average.

Act 53 and Payment Variation Transparency

FY 2012 Inpatient Average Gross Charge Vs Payment (Net Revenue)
*Does Not Include Medicare



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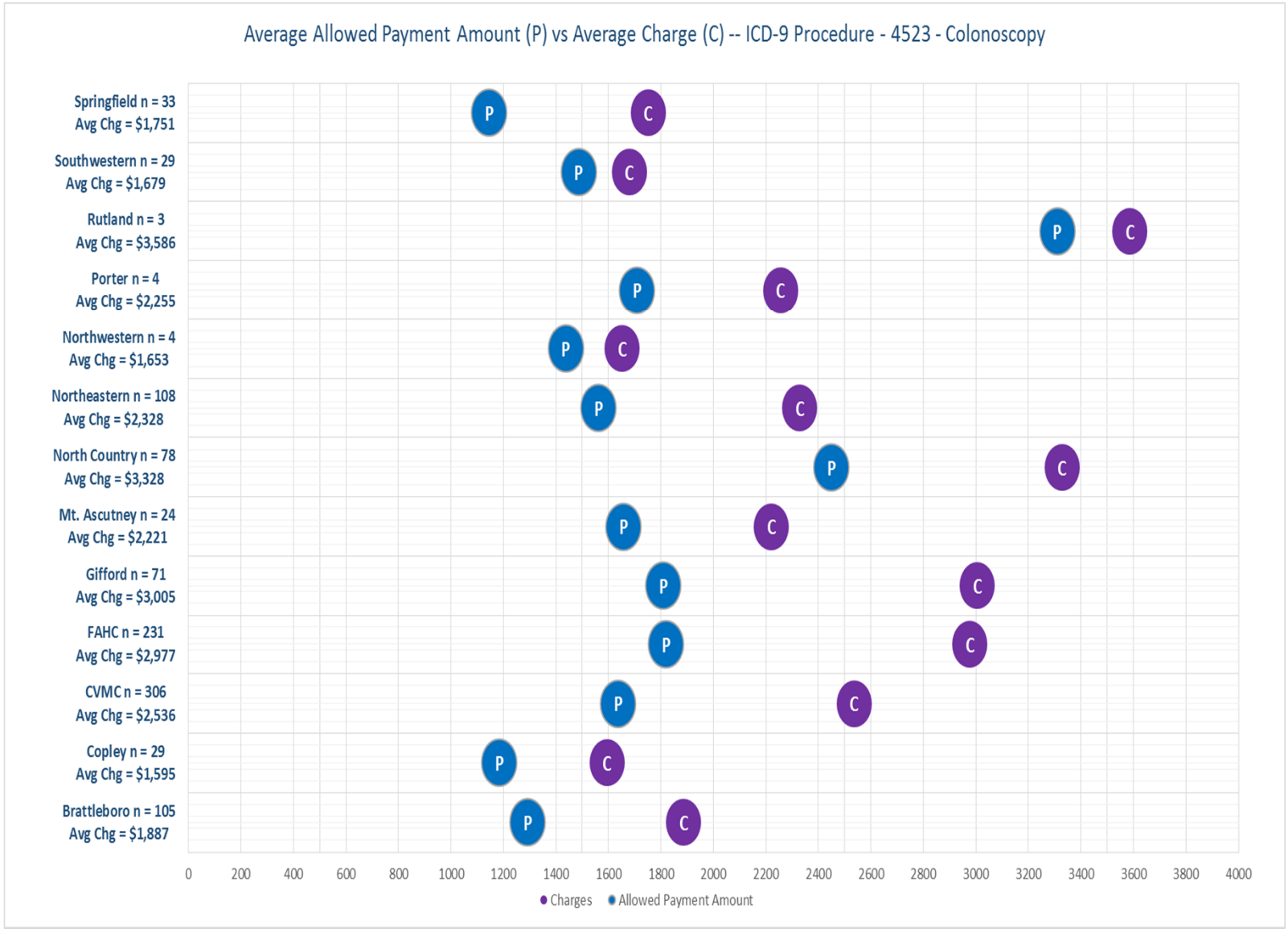
FY 2012 Outpatient Average Gross Charge Vs Payment (Net Revenue)
*Does Not Include Medicare



Summary:

Hospitals Position:

Hospitals are challenged and agree that the current fee-for-service payment system makes is cumbersome and not easily understood.

Hospitals are in agreement that it is necessary to move away from the fee-for service payment methodologies.

We believe that the "larger" health care reform efforts combined with the transition away from fee-for-service will enhance the value proposition of: 1) enhancing the delivery of high quality care, 2) creating opportunities to improving access and 3) helping to slow the growth in health spending.

Our Actions:

We are participating Health Care Reform at all levels: (ACO participation, Controlling Hospital Budget Growth, Enhancing Health Information Technology, Payment reform, State Innovation Model participation)

We are engaged in payment reform pilots aimed at improving population health, such as global budgeting and bundle payments.

Financial Realities:

Even with its complexities the current fee-for-service structure yields net revenue that meets the criteria of the GMCB budget guidelines (3% growth in net revenue) and supports innovation.

New payments methodologies must allow for appropriate revenues to cover operating expenses and allow for investment/innovation necessary to create efficiencies and improve the coordination of patient care.