Green Mountain Care Board
January 2015

HOSPITAL COST SHIFT

HISTORICAL BACKGROUND & CALCULATION METHODOLOGY

Background:

A Cost Shift Task Force was created by Act 191 to recommend changes needed to "ensure that reductions in the cost shift are reflected in a reduction or slower rate of growth both in hospital and provider charges and in private insurance premiums." The Task Force met in 2006 and filed a report after completing its work. The report was delivered to the Commission on Health Care Reform in December, 2006 and included a series of recommendations.

The following are Task Force recommendations from December, 2006:

1) Banking, Insurance, Securities, and Health Care Administration (BISHCA) should adopt policies and procedures in the Vermont Community Hospitals' Uniform Reporting Manual to include a definition of (and method for measuring) the cost shift based on the techniques used in the hospital budget review process.

2) BISHCA should measure hospital rates for each hospital to determine the effect of expense changes related to utilization and inflation, operating margin changes, and cost shift changes related to bad debt and free care, Medicaid, and Medicare.

3) BISHCA should instruct the hospitals to make reporting changes to support information needs relating to bad debt and free care in order to better understand the populations served. This includes the need to distinguish Vermont Medicaid revenues from out-of-state Medicaid revenues.

4) BISHCA should prepare an annual report to the legislature detailing its findings related to the hospital cost shift and the rate effects on hospital and insurance rate increases.

Recommendations that will require more time and analysis include:

5) BISHCA should work with the hospitals to determine whether a standard reporting instrument should be prepared to provide better information about the hospital cost shift.

6) BISHCA should work with stakeholders to examine potential information needs and/or changes for health insurance rate review processes needed to monitor the hospital cost shift.

7) BISHCA should prepare a plan and scope of analysis that seeks to measure the effect of the hospital cost shift on premium rates, once it is determined this can be accomplished reasonably.

8) The "science" to measure the cost shift across non-hospital providers needs to be developed in order to monitor changes in the non-hospital cost shift.

9) Any funds appropriated to alleviate cost shifts should be clearly designated so that their impact on the cost shift could potentially be monitored and measured across the Vermont health care system.

10) A feedback mechanism needs to be developed to report how the funds appropriated to reduce the cost shift were used across the health care system.

A Cost Shift Report (see cover letter at the end of this summary) was prepared for the legislature in March of 2008. In that report, it describes Recommendations One through Five as being met. In addition, in regards to Recommendation number Three, BISHCA did collect this information but stopped when the Green Mountain Care Board was created. Internal work continues for recommendations Six through Ten have been limited since creation of the GMCB.

Included in the 2008 report was the methodology, though it has changed some over the last several years. The changes are not considered material, when examined at a system level. Those changes are primarily related to the handling of the provider tax and disproportionate share.

Letter sent to the legislature in March of 2008.

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MEMORANDUM

TO: Representative Steven Maier, Chair, House Health Care Committee
Senator Douglas A. Racine, Chair, Senate Health & Welfare Committee

FROM: Michael Davis, Director of Cost Containment
Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)

RE: 2008 Vermont Cost Shift Analysis

DATE: March 14, 2008

CC: Susan Besio, Director, Health Care Reform
Paulette Thabault, Commissioner, BISHCA
Christine Oliver, Deputy Commissioner, DHCA
Joshua Slen, Director, OVHA
Heidi Tringe, Special Assistant to the Governor
Dr. James Hester, Director, Commission on Health Care Reform
Stephen Klein, Chief Fiscal Officer, Joint Fiscal Office

In response to recommendations made in the 2007 Cost Shift Task Force Report to the Commission on Health Care Reform, BISHCA has prepared the first *2008 Vermont Health Care Cost Shift Analysis.* This analysis significantly updates available cost shift information. We are committed to improving the analysis each year to address all of the recommendations outlined in the Cost Shift Task Force Report.

Please feel free to contact me at BISHCA (828-2989) if you have any questions or concerns regarding this publication. I am also available to meet with you to discuss these findings and answer any questions that you may have about the analysis.

Please contact BISHCA at (802) 828-2900 for more copies or link to our website at http://www.bishca.state.vt.us/HcaDiv/Data_Reports

VERMONT

Methodology:

The basic methodology was originally developed by the Vermont Hospital Data Council and Blue Cross/Blue Shield and subsequently was used by DHCA, and then adopted by the GMCB. The methodology has changed slightly over time due to accounting changes and improved reporting through the hospital budget process.

The basic calculation for each hospital follows this logic.

Revenues:

a. The amount of hospital gross patient revenues is reported by payer: Commercial insurance, Medicare, Medicaid, and Bad Debt/Free Care (BD/FC). BD/FC is considered a payer since information for that detail does not exist by payer.

b. Hospital reported physician gross patient revenues are also added to the gross revenues for each payer.

c. Deductions from gross revenue for each payer are deducted resulting in the net patient revenue for each payer. Disproportionate share payments (contra deduction) are presently included in that calculation and attributed all to Medicaid.

d. Other operating revenues are then distributed, allocated to the payers by the gross revenue percentage distribution of each payer.

e. Once the allocations are complete, you will have the total net revenues that each payer contributes for the total services that they have been billed (gross revenues).

Expenses:

f. Total operating expenses, not including the Provider Tax are then allocated by payer by the gross revenue percentage distribution. The Provider Tax expense is allocated to Medicaid.

g. The total operating surplus (revenue calculation total minus expense calculation total) is then allocated by payer by the gross revenue percentage distribution.

h. This result is the total cost that each payer is considered responsible – their share of expenses and operating surplus.

Cost Shift calculation:

i. Expenses for each payer are then subtracted from the net revenues for each payer. If the result is less than zero, then that payer has a shifted cost to another payer. If the revenues less expenses are greater than zero, then that payer contributes to offset the cost shift.

This schedule shows two approaches – the Provider tax as expense label is GMCB method.

	Provider Tax as Revenue deduction "State" FY 2013 Budget	Provider Tax as Expense "State" FY 2013 Budget	
Medicaid_VT			
Gross Patient Service Revenue	680.2	680.2	
Deductions			
Contractual Allowances	(467.2)	(467.2)	
DSH	37.3	37.3	
Provider Tax	**(116.1)**		
Total Deductions	(546.0)	(429.9)	
Net Patient Revenue	**134.2**	**250.3**	
Allocated: Other Revenue	15.2	15.2	
Total Revenue	**149.4**	**265.5**	A
Expenses:			
Allocation on RCC	307.9	307.9	
Provider Tax		**116.1**	
Total Expenses	**307.9**	**424.0**	B
Cost Shift Prior to Net Income/Loss	**(158.5)**	**(158.5)**	The same amount
Cost Coverage (Total Rev / Total Exp)	**48.5%**	**62.6%**	= A / B

Assumptions:

1. All patients contribute equally to the cost of providing care. For example, costs for a Medicare patient are assumed to be the same as a Medicaid patient for similar services. There is no adjustment for complexity.

2. Other operating revenues are allocated on a relative basis, i.e.; if a payer has 10% of the gross revenues, then they are allocated 10% of the other operating revenues.

3. Likewise, all payers are considered to contribute to the operating surplus on a relative basis, i.e.; if a payer has 10% of the gross revenues, then they pay for 10% of the surplus.

4. All reported dollars in the hospital budgets are accrued, not paid dollars.

5. Disproportionate Share revenues and Provider Tax expenses are included in the methodology. Disproportionate share is all attributed to Medicaid. Provider tax is attributed to all payers (this has been an area of disagreement over the years).

6. We now include Graduate Medical Education payments in the cost shift. They are applied favorably to Medicaid. This may be disputed in the future.

7. Non-operating revenues (a portion of the Total operating surplus) are not considered in the analysis.

Some outstanding questions/issues:

1. **UVM Health Care does not always agree with how we present the cost shift, though they tend to agree with the overall number. The disagreement centers around how cost to charge is calculated. The GMCB method reflects a more favorable "cost to charge".**

2. **How should we handle Graduate Medical Education payments going forward?**

3. **Should the Provider tax be allocated just to Medicaid? Some of the hospitals believe we should not allocate the cost to all providers.**

4. **Should we develop a more sophisticated allocation method? Should we handle physician activity separate from hospital activity?**