

Methods progress note: Hospital finances for the hospitalist

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INTRODUCTION

As critical community resources, hospitals meet the needs of acutely ill patients while working to positively influence surrounding communities. To pursue their mission, hospitals must be financially sound; managing their operations so that the hospital has a positive margin (i.e., revenues exceed costs).

Hospitalists can influence the value of care provided (defined as the quality of care divided by costs)¹ and thus can impact the financial health of their institution by understanding how the care decisions they make impact the hospital's bottom line. Traditionally, providers have focused largely on maximizing the quality of the services they provide but have been less eager to delve into the details of hospital finances.

The evolution of value-based care and rising costs due to the pandemic have placed increased operating and financial pressure on health systems and physicians. Several recent publications in the *Journal of Hospital Medicine* have highlighted the need to be familiar with the basic language of hospital finance. These papers have used different financial metrics to understand changes in charges during the COVID pandemic (Synhorst), costs and reimbursement for mental health hospitalizations (Herndon), and costs for observational hospitalizations (Kaiksow).¹⁻³ Understanding the concepts of cost, charge, and reimbursement, and the nuances of how they are used, is vital to engaging with hospital administration in a meaningful way. In this Methods Progress Note, we aim to help hospitalists understand basic hospital finances so that they can appreciate how what they do every day impacts the financial health of the hospital. We hope to simplify many of the confusing concepts within the complex system of healthcare finance.

KEY CONCEPTS

After a hospitalization, institutions and their providers must be paid for their services. However, unlike other industries where a service is rendered, a bill is presented, and the customer pays, hospitals must navigate a convoluted and dynamic ecosystem with multiple stakeholders, differing payment methodologies, and complex regulations. This challenging process is made even more difficult due to confusion around closely related financial concepts: costs, charges (a.k.a. prices), and reimbursements.

Costs

Defining and determining healthcare costs can be complicated since the term can refer to the costs to hospitals, payers, society, and so forth. For the purposes of this paper, "costs" will refer to the cost incurred by the hospital system.

Each service provided to the patient has an associated cost for the hospital. In broad terms, costs can be broken down into variable and fixed costs. Fixed costs are those that do not change based on the volume of services provided increases. The cost of facilities, rental of large equipment, and utilities are all examples of fixed costs. Variable costs, on the other hand, tend to increase as the volume of services provided increases. For example, the money spent on medication supply increases as physicians prescribe more of that medication.

When determining the viability of providing a service, it can be helpful for hospital leaders to allocate costs associated with that service line. This can be accomplished using accounting methods that compile costs and ascribe them to a specific service line.⁴

These methods often rely on breaking costs into direct and indirect costs. Direct costs are those that can be explicitly identified for the service provided (e.g., cost of supplies, physician salaries, transportation), while indirect costs comprise those costs that are necessary for the functioning of the hospital and provision of care but are not directly tied to any one service (e.g., facilities rent, technology, maintenance staff). While these costs are known internally, they are often not readily accessible to those outside of hospital leadership.

While hospitals are reluctant to directly disclose costs of services, the Centers for Medicare & Medicaid Services (CMS) requires calculating and reporting of a ratio of cost to charge (RCC) which is used to determine payments for care across hospitals as outlined in the Reimbursement section below.⁵ Hospitals calculate this ratio by aggregating their annual charges and dividing it by their annual costs. If a hospital's RCC = 0.40, then \$0.40 of every \$1.00 charged is cost. This is typically done overall at the hospital level, but also for different departments as required by the CMS. Because most administrative databases capture charges associated with hospital stays, researchers and external entities can use charges and RCC to estimate costs.⁶

Charges

Charges, as used by Synhorst, reflect how much the hospital bills payers (e.g., patients or insurers) for the services that are provided to patients. These are typically captured by the hospital's billing system as services are provided. For example, if a hospital charges a specified amount for a medication, that amount will be added to the running total each time this medication is dispensed for that patient. For hospitals, there will also be a room charge assessed each night the patient stays in a bed that will vary based on the level of care. Each hospital manages a comprehensive charge description master that details services provided along with the associated charge. Charges are typically captured in administrative databases such as the healthcare cost and utilization project's national inpatient sample and kids' inpatient database.⁷

As of January 1, 2021, CMS mandated that hospitals make the charges for the services they provide publicly available to increase price transparency and allow consumers to "shop and compare prices across hospitals and estimate the cost of care before going to the hospital."⁸ Even though hospitals are required to post gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges, this information does not easily allow patients to understand their out-of-pocket expenses, especially for inpatient stays. It is also unclear if consumers will actually use this information to "shop" for hospital services.⁹

Reimbursement

Reimbursement is the amount paid by the patient and/or insurer to the hospital. This sum is a negotiated amount based on one of several

payment methodologies (discussed below). Actual reimbursement is not often captured in hospital administrative data but is available in payer databases such as Medicare & Medicaid.¹⁰ Actual reimbursement is also available through the Children's Hospital Association's Revenue Management Program used by Herndon.

While not always the case, for a hospital to be profitable on any given hospitalization, reimbursement should be higher than cost. However, hospitals may strategically negotiate losses on certain types of services (often referred to as "loss leaders") to maintain referrals and/or higher rates for other services.

One of the complicating factors in healthcare payments is relationships with insurers. Negotiations take place between hospitals and insurers to determine how much will be paid for hospitalizations and other services. Hospitals may have different types of contracts with insurers in their area. Below are detailed several common types of contracts.

1. Fee-for-service (a.k.a. percent of charges, discounted rates): Historically, this was the most common contract whereby insurers would pay an agreed-upon percentage of charges. For example, if the discount rate was 15%, the insurer would pay 85% of the charges accrued by the patient. In this type of arrangement, the provider assumes no risk of financial loss. The more services they provide, the more they are paid. With a renewed focus on value-based care and reducing waste within the healthcare system, these contracts have become less popular with policymakers and insurers. While discounted rates are not as common as they used to be, they continued to be used in special circumstances (see stop loss discussion below).
2. Per-diem: As the name suggests, insurers pay a set amount per day that the patient is hospitalized, regardless of the utilization and charges. Proponents of per-diem payments argue that because hospitals will be paid the same amount regardless of utilization, they will be encouraged to reduce utilization to increase profitability. However, since utilization typically peaks in the initial days of hospitalization, under this system, hospitals may also be incentivized to hold on to patients longer to overcome losses on the initial days. To combat this concern, utilization review teams, both by the hospital and the payer evaluate the ongoing necessity of hospitalization. This process attempts to ensure that providers have clinical justification for ongoing hospitalization and may result in refusal by the payer to reimburse days deemed medically unnecessary.
3. Case rates (a.k.a. prospective payment systems): In what is likely the most common type of contract between insurers and hospitals, hospitals are paid a predefined amount based on the reason the patient is hospitalized regardless of their utilization or length of stay. The conditions are typically defined using diagnosis related groups (DRGs), most commonly the Medicare severity DRGs or all patients refined DRGs.¹¹ Each of these systems tries to put hospitalizations with similar conditions and utilization into groups using the recorded International Classification of Diseases version 10 Clinical Modification diagnoses and procedures.

Medicare, medicaid, and many commercial payers use case rates so the hospital assumes the financial risk and is incentivized to control utilization and length of stay to be profitable.

Regardless of the type of contract, there are special provisions that are commonly specified in each contract, both of which protect the hospital from excessive losses. The first is for carve-outs. Carve-outs take specified high-cost treatments (e.g., high-cost drugs) out of the typical contract and pay for them differently. Second, there are stop-loss provisions. Stop-loss is an agreed-upon threshold beyond which a hospital's losses for a hospitalization are reduced. For example, if a hospital is in a case rate contract with a payer and a hospitalization's charges go beyond \$100,000, the contract will revert to a fee-for-service contract.

DISCUSSION

Understanding the differences between charges, reimbursements, and costs is important for all healthcare providers, especially hospitalists. To provide high-value care, hospitalists must understand how to provide the highest quality of care in the most cost-effective manner.

There are several ways hospitalists can help a hospital improve revenue or reduce costs. On the revenue side, hospitalists can ensure that orders are written for the correct level of care (i.e., inpatient versus observation). It is also critical that the clinical documentation supports the ongoing medical necessity of the care provided, as the documentation drives coding, and the coding ultimately determines the reimbursement. Hospitalists may also be asked to participate in utilization review activities and peer-to-peer discussions with payers to review underpayments or denials.

On the expense side, hospitalists can help the institution control direct costs in several ways. Hospitalists can ensure that only medically necessary care is ordered for the patient while they are in the hospital. Hospitalists can also participate in quality improvement teams to reduce unintended variation in care (e.g., via care pathways) or to improve throughput and efficiency. Reducing hospital variation and improving outcomes can also help hospital systems to avoid financial penalties levied against them by CMS for poor performance in areas such as readmission rates or hospital-acquired conditions. Additionally, hospitalists can help the care team anticipate the timing of discharges and services that may be needed to facilitate discharge (e.g., patient teaching, home care equipment), which may minimize last-minute delays, improve patient and family satisfaction, and decrease the length of stay.

Ultimately, the impact of costs, charges, and reimbursements is far-reaching. Patients and families are often impacted by hospital and payer financial policies and may be left with a significant financial burden on top of a potentially traumatic hospitalization. Those of lower socioeconomic standing are likely to suffer the most harm, as they are also more likely to be uninsured and have fewer cash reserves. As hospitalists, consideration of cost should primarily be driven by what is right for the patient and their goals of care. The consideration of the impact on the hospital is important but should never supersede the need to serve the patient.

Understanding how hospitals are paid and manage their costs can help hospitalists appreciate how what they do every day can impact the financial health of hospitals so that they are able to achieve their missions.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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How to cite this article: Synhorst DC, Gay JC, Harding JP, Hall M. Methods progress note: hospital finances for the hospitalist. *J Hosp Med.* 2022;1-4. doi:10.1002/jhm.13041

APPENDIX A: GLOSSARY OF TERMS

See Table A1.

TABLE A1 Glossary of terms and associated definitions

Glossary of terms	
Costs	Hospital expenditures needed to provide care for patients
Fixed	Costs that do not change based on volume of care provided (i.e., facilities rent)
Variable	Costs that generally increase as more care is provided (i.e., medication costs)
Direct	Cost that can be directly attributed to the service provided
Indirect	Costs that are necessary for the provision of care, but apply to more than one service line
Charges	Amount hospitals submit for payment for services provided
Gross charges	Total amount of charges submitted for reimbursement
Discounted cash prices	Reduced price offered if a submitted charge is paid in cash in full
Payer-specific negotiated charges	Reduced charges that are negotiated between hospital and payer
Reimbursement	Amount paid by the payer to the hospital for services rendered
Loss-leaders	Services resulting in net loss for hospitals, tool used in negotiations with payers
Fee-for-service	Each service provided has its own negotiated fee
Per-diem	Payers agree on a fixed payment per day in the hospital regardless of services provided
Case rate	Payments based on the reason for hospitalization regardless of services provided
Carve-outs	High cost services that are negotiated separately between payers and hospitals
Stop-loss	Threshold beyond which reimbursements increase to prevent excessive hospital losses