

Testimony related to 114.1 CMR 42.00  
Hospital Financial Reports  
From the Massachusetts Council of Community Hospitals  
Jan. 25, 2011

Dear Commissioner Morales:

The Massachusetts Council of Community Hospitals (MCCH) requests the Division delay the implementation of your proposed regulations for 90 days to allow a test group of hospitals to supply the requested information and for your Division to examine the output to determine if significant distortions exist due to the proposed methodology. If such distortions exist you can propose appropriate adjustments. Our reasons are:

1. Cost-to-charge ratios have been used for decades as a simplified means of allocating cost. It is a KISS principle that seemingly allows for a more rapid pointer to a possible issue. As a stand-alone methodology it is rarely used as the basis for decision making since it is so unreliable on a micro basis as opposed to a macro basis. Large hospitals eventually had to adopt sophisticated cost accounting systems just to deal with this issue. Cost-to-charge ratios are more likely to be accurate across the full universe of Massachusetts' hospitals and large-scale payers than accurate at any one hospital at the level of 26 potential payers.
2. Charges become a poor proxy if hospitals choose to use sophisticated rate setting models that play on the degree of charge influence on payment in a particular contract. For example, conceptually a hospital might charge \$1 for a pacemaker since pacemakers are disproportionately implanted into Medicare patients but Medicare pays on a DRG basis. Thus the charge is completely irrelevant in this case of determining the cost of the procedure. Would an accumulation of charges for this service capture the true cost? Likely, no. While charges are uniform across payers at an individual hospital, every hospital will have a different approach to pricing strategy from year to year. To understand just how distorting this can be we suggest you look at the allocation of the Safety Net Assessment on hospitals which use private pay charges to determine financial responsibility, and compare the present assessment method to one based on net private pay revenue, which is seemingly a more accurate tool to allocate the burden. You will likely see an effect of enough significance that the net income could be significantly distorted for some hospitals.
3. Waiting to "get it right" prevents any distortions or inaccuracies from becoming future obstacles to health reform since such inaccuracies, should they exist, in the minds of the media and policymakers may take months or years to correct. Inaccurate margins by payer will likely just be throwing debris on the playing field, especially in contract negotiations. Our community hospitals are in too fragile a financial state to have to deal with misinformation.

MCCH supports this movement towards greater transparency, so there is nothing we see as inherently wrong with asking for such information, but if we are going down this route all players (niche providers, payers, etc.) must be subject to the same degree of scrutiny and accountability at the same time.

Thank you for your consideration of our request.

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