

# Hospital Characteristics and Medicaid Hospital Prices

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## Contents

Overview	3
Background	3
Methods	4
Results	5
Considerations	11
Conclusion	12
Endnotes	13

## Key Takeaways

- Certain types of hospitals have greater market power and can procure higher prices in the negotiating process with insurers.
- This study found that for several routine children’s procedures, Medicaid facility prices were significantly higher at children’s hospitals, critical access hospitals, and hospitals affiliated with a hospital system.
- When designing laws and regulations, policymakers should balance access to providers alongside the ability of Medicaid managed care organizations to negotiate prices with providers.

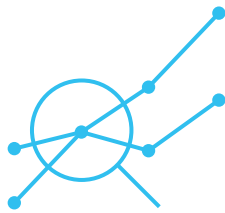
# Overview

**The cost of hospital care in the U.S. continues to be a central concern for health insurers, employers, and policymakers alike.**

Healthcare expenditures now approach 18 percent of the U.S. gross domestic product,<sup>1</sup> with spending growth consistently outpacing inflation over the past two decades.<sup>2</sup> Rising hospital costs, including facility fees at hospitals, are an important driver of increased healthcare costs.<sup>3–6</sup>

Hospital prices vary widely, and hospitals with greater market power may charge higher prices. Certain hospital characteristics, like hospital size, teaching status, and ownership, may be associated with market power and prices.

Using Medicaid claims data across 23 states, this paper analyzes the relationship between various hospital characteristics and hospital-based outpatient or emergency department prices for several common pediatric procedures.



This paper analyzes the relationship between hospital characteristics and prices.

## Background

**For a given procedure, the price of care can vary substantially across different hospital facilities.<sup>7–11</sup>**

Several factors determine a hospital's operating cost and may factor into the prices charged for services, such as labor costs and the cost of technology. However, prior research has shown that hospitals with higher prices are typically associated with higher profits rather than higher operating costs.<sup>12</sup>

Market dynamics also affect hospital prices. For example, the consolidation of hospitals over the last 25 years has reduced competition,<sup>13</sup> and several studies show that hospital prices can increase following mergers.<sup>14–21</sup> In addition, large hospitals or hospital systems often produce direct-to-consumer advertising or use other marketing tactics to create brand awareness and consumer demand, for either their entire system or their specialized services. Furthermore, to remain competitive, insurers must include certain hospitals—particularly large academic centers and children's hospitals—in their networks. These hospitals often provide unique services, advanced care, or pediatric expertise that are not easily substituted. As such, they may wield substantial negotiating power during contract discussions with insurers, even on prices for routine procedures that do not require the facility's unique expertise.

Hospitals' leverage is further amplified in markets governed by network adequacy regulations. For instance, New Jersey's 2021 statute on network adequacy standards (S.3000),<sup>22</sup> which aims to improve access to care for children enrolled in Medicaid, effectively mandates that managed care

organizations include specific children's hospitals, and their rare specialists, in the provider network. State Medicaid agencies often require network access to in-state children's hospitals as well. While well-intentioned, such policies can inadvertently constrain insurers' bargaining ability and facilitate elevated pricing structures at these mandated facilities.

Nevertheless, insurers with significant market share of their own also wield negotiating leverage in a market with multiple hospitals, which can even the playing field, though more so when the insurers have the option to exclude hospitals from their networks.

Despite the influence of hospital characteristics on market dynamics, there remains a notable gap in empirical research examining how hospital prices vary by hospital attributes such as teaching designation or hospital ownership. Some studies look at one or a few hospital characteristics, including children's hospitals,<sup>23–25</sup> government ownership,<sup>26–29</sup> or size.<sup>30–32</sup>

However, there is little research that 1) combines many hospital characteristics into one study, allowing for the identification of unique effects when accounting for other aspects of the hospital; 2) analyzes hospital prices for a Medicaid population; or 3) studies common, routine, procedures in the hospital outpatient or emergency department (ED) setting. Focusing on routine outpatient and ED procedures reduces the likelihood that observed differences in prices are due to patient or procedure complexity, rather than true price differences across hospital characteristics.



Policies that mandate network inclusion of specific providers, while well-intentioned, can inadvertently lead to higher prices.

## Methods

**The objective of this white paper is to examine how hospital prices for children's routine procedures in hospital outpatient or ED settings differ by the following hospital characteristics: children's hospital; critical access hospital (CAH)<sup>33</sup>; rurality; system affiliation; teaching designation; for-profit, religious, or government ownership; and size.**

**Data sources and claim identification.** This study used administrative claims data from 2021 to 2023 from Elevance Health-affiliated Medicaid managed care plans in 23 states. In particular, in-network facility claims for children (aged 0-18) for the following procedures were analyzed: evaluation and management (E/M) in the ED (CPT codes 99282-99285), forearm splint (CPT code 29125), tonsillectomy and adenoidectomy (i.e., surgical removal of tonsils and adenoids, CPT codes 42820 for younger children and 42821 for older children), and tympanostomy (i.e., ear tube insertion, CPT code 69436). Only claims occurring in a hospital outpatient department (HOPD) (CPT codes 42820, 42821, and 69436) or ED (all other procedures) were included; inpatient claims were not included due to the complexities in billing for inpatient services that make direct comparisons more difficult. The final set of claims was linked with data from the American Hospital Directory<sup>34</sup> to obtain hospital characteristics.

**Outcome.** The outcome of interest was the allowed facility cost (i.e., negotiated rate) for the procedure of interest. Costs were inflation-adjusted to 2023 dollars. The cost was calculated at the claim-line level, meaning for the specific procedure only and not for accompanying services. When payments were bundled for the full claim, an allocated cost that covered the specific procedure only was calculated. This process ensured an apples-to-apples comparison for each procedure’s hospital costs, without needing to assess differences in ancillary services provided. Last, to address outliers, we capped costs at the 95th percentile for each procedure.

**Analysis.** Descriptive results and linear regression results are presented. The linear regression results account for all nine hospital characteristics of interest, in addition to hospital referral region<sup>35</sup> and year fixed effects, allowing for identification of the independent association of each hospital characteristic with cost. Children’s hospitals and critical access hospitals are each compared to other acute care hospitals (“other acute care”). For-profit hospitals, government hospitals, and religiously affiliated (nonprofit) hospitals are each compared to other nonprofit hospitals (“other nonprofit”). The other characteristics—rural, system, teaching, and large hospitals (at least 300 beds)—were compared to hospitals that did not fall under each characteristic (e.g., not rural).

## Results

### Sample and Average Costs

The sample size ranged from 32,793 forearm splints to more than 2.6 million ED E/M Level 3 visits. Average costs varied substantially by procedure, with a mean cost of \$85 for a forearm splint to \$1,784 for a tonsillectomy and adenoidectomy. The sample sizes and average facility costs of each procedure are shown in Table 1.

**Table 1**  
**Sample Sizes and Average Facility Costs by Procedure**

Procedure	Number of Procedures	Number of Unique Hospitals	Mean Facility Cost
ED E/M Level 2	832,838	2,381	\$ 153
ED E/M Level 3	2,642,747	2,442	\$ 194
ED E/M Level 4	1,064,674	2,414	\$ 294
ED E/M Level 5	290,007	2,217	\$ 513
Forearm Splinting	32,793	1,843	\$ 85
Tonsillectomy and Adenoidectomy	33,683	902	\$ 1,784
Tympanostomy	39,037	873	\$1,007

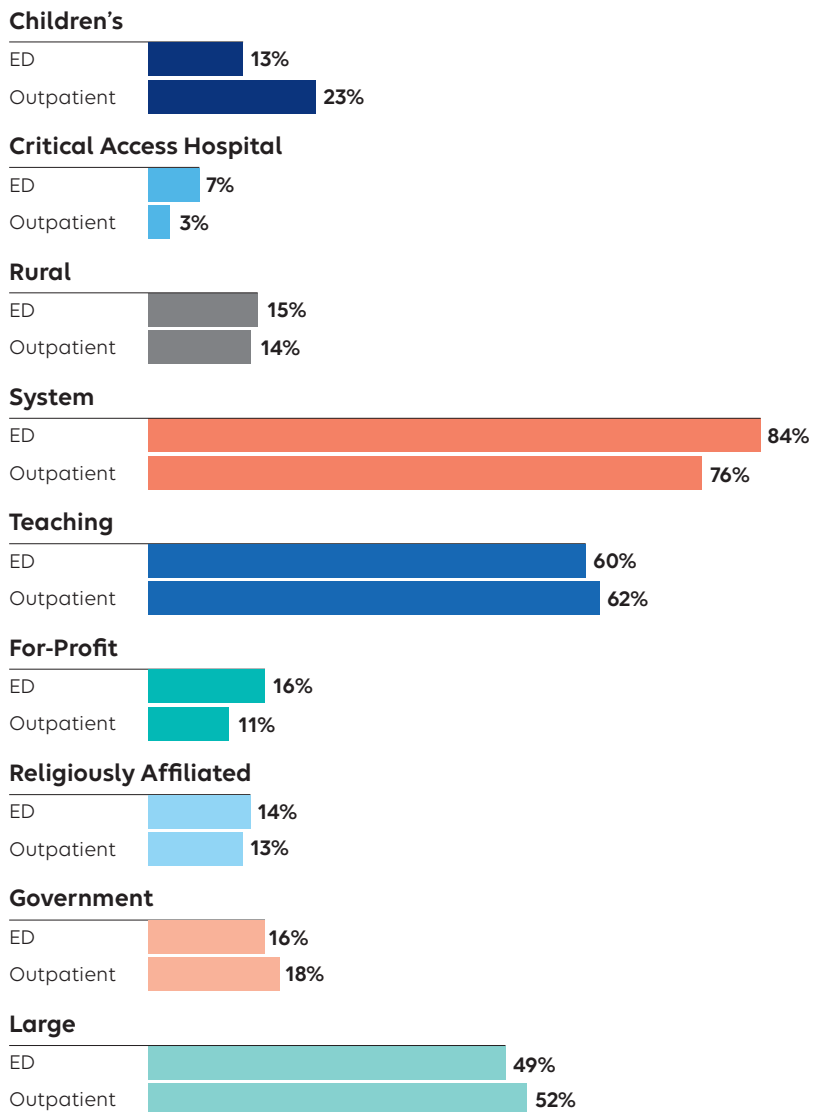
**Note.** ED = Emergency Department; E/M = Evaluation & Management.

## Hospital Characteristics

Most care for the studied procedures occurred in hospitals that are part of a system, and approximately 60 percent occurred in teaching hospitals. Children’s hospitals, teaching hospitals, government hospitals, and large hospitals were more commonly used for the outpatient procedures than for the emergency care, indicating a potential preference for these hospitals when families can schedule the care for their children in advance. Critical access hospitals were not used commonly, especially for the outpatient procedures.

Figure 1 shows the percentage of the seven procedures of interest occurring within each hospital type. Note that a hospital may fall under multiple categories. The two outpatient procedures—which are nonurgent, scheduled procedures—are shown separately from the procedures occurring in the ED (splinting and ED E/M).

**Figure 1**  
**Percentage of Select Children’s Procedures Occurring in Different Hospital Types**



**Note.** Percentages sum to more than 100% for each setting (i.e., ED or outpatient) because hospitals may be characterized as more than one type. Large are hospitals with 300 or more staffed beds.

## Association Between Hospital Characteristics and Facility Costs

Figure 2 below shows the hospital characteristics, when taken all together in a multivariate regression, that have a statistically significant ( $p < .10$ ) association with the facility price of each procedure. For example, for ED E/M Level 2: children's hospitals were on average \$173 more expensive than other acute care hospitals; critical access hospitals were on average \$35 more expensive than other acute care hospitals; system-owned hospitals were on average \$23 more expensive than independent hospitals; for-profit hospitals were on average \$18 more expensive than other nonprofit hospitals; and hospitals with 300 or more beds (large) were on average \$16 more expensive than hospitals with less than 300 beds. The other four hospital characteristics—rural, teaching, religiously affiliated, and government—did not have a statistically significant association with ED E/M Level 2 facility costs after controlling for other characteristics.

The following results provide an overview of the findings across procedures:

**Children's hospitals.** Children's hospitals were substantially more expensive than other acute care hospitals across all seven procedures. All estimates were statistically significant.

**Critical access hospitals.** For most procedures, critical access hospitals were more expensive than other acute care hospitals, though to a lesser degree than children's hospitals.

**Rural hospitals.** Rural hospitals did not have a statistically significant association with price.

**Systems.** Hospitals in a system were more expensive for procedures in the ED setting as compared to independent hospitals.

**Teaching hospitals.** Teaching hospitals did not have a statistically significant association with prices, except for splinting.

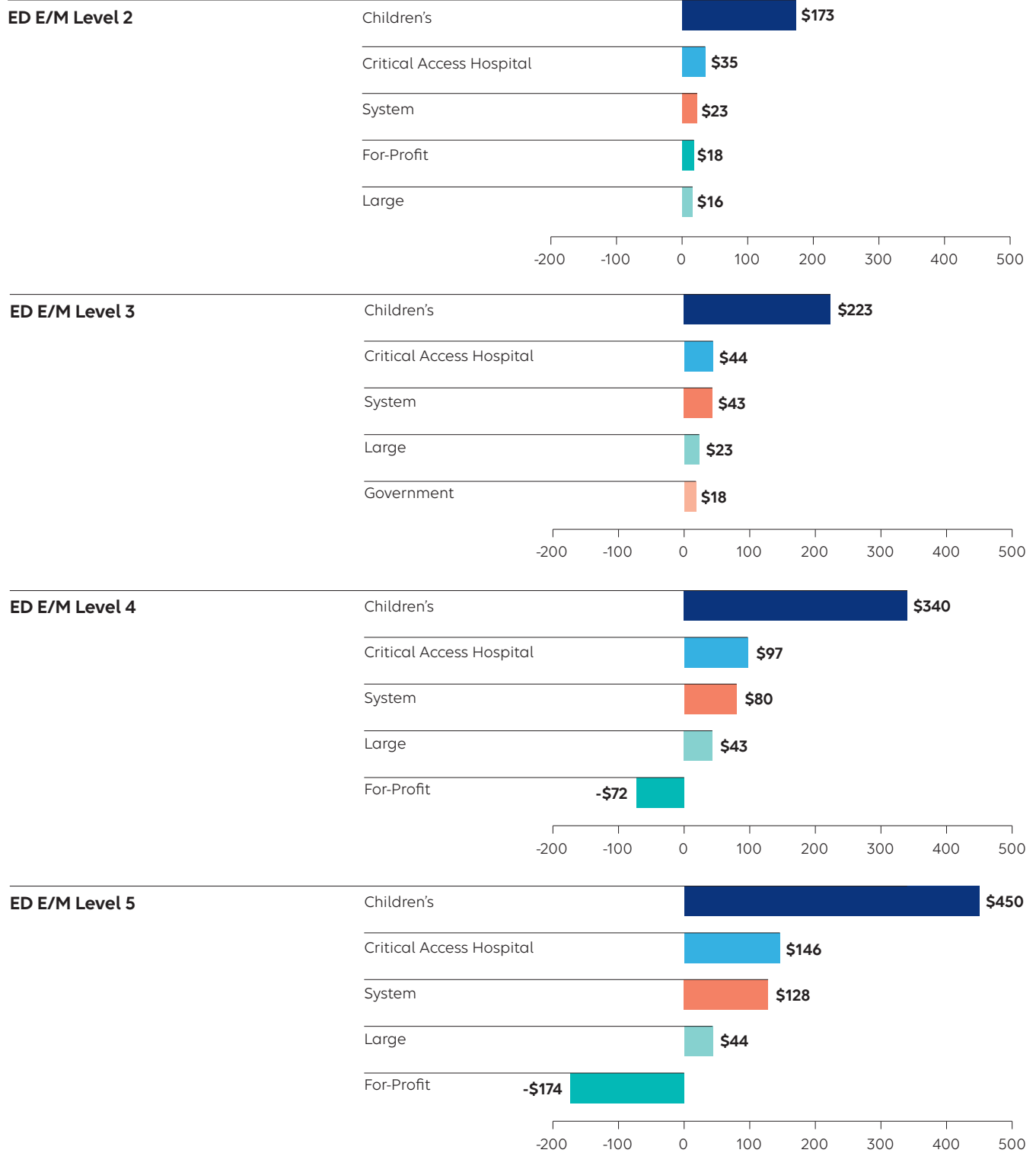
**For-profit hospitals.** For-profit hospitals were less expensive than other nonprofit hospitals for most procedures.

**Religiously affiliated hospitals.** Religiously affiliated hospitals were more expensive than other nonprofit hospitals for the outpatient procedures.

**Government hospitals.** Government hospitals showed mixed results, with lower prices for tonsillectomy and adenoidectomy and higher prices for splinting and ED E/M Level 3.

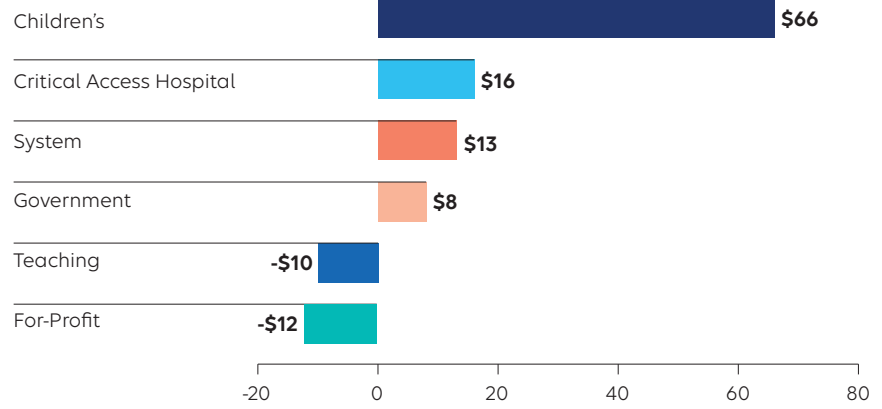
**Size.** Hospitals with 300 or more staffed beds showed higher prices for ED E/M (all levels) and tympanostomy.

**Figure 2**  
**Hospital Characteristics**  
**Associated with Allowed**  
**Facility Costs, by Procedure**

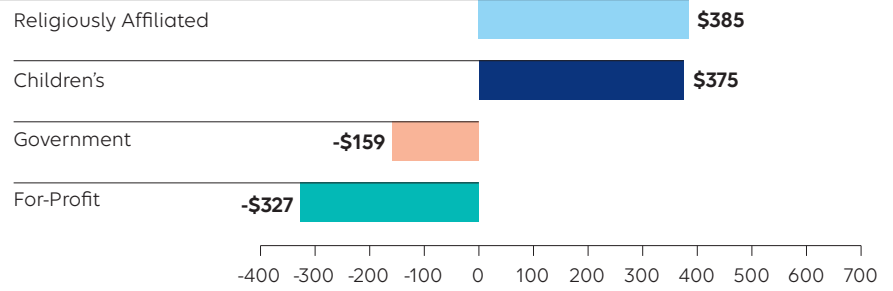


**Note.** Large are hospitals with 300 or more staffed beds. Analysis from Elevance Health claims data. Hospital characteristics not shown did not have a statistically significant association with allowed costs for that procedure. Allowed costs are capped at the 95th percentile.

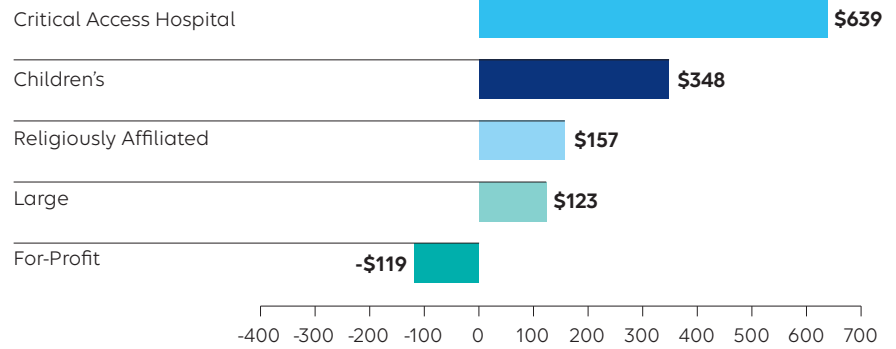
### Forearm Splinting



### Tonsillectomy and Adenoidectomy



### Tympanostomy



**Note.** Large are hospitals with 300 or more staffed beds. Analysis from Elevance Health claims data. Hospital characteristics not shown did not have a statistically significant association with allowed costs for that procedure. Allowed costs are capped at the 95th percentile.

## A Closer Look at Children’s Hospitals and Critical Access Hospitals

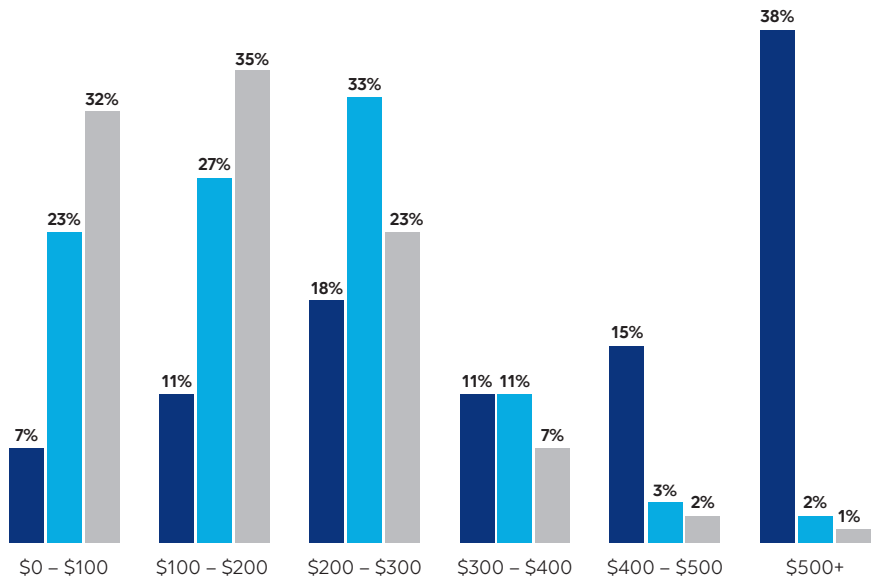
Because children’s hospitals and critical access hospitals were consistently more expensive than other hospitals (except for tonsillectomy and adenoidectomy at critical access hospitals), the following analysis provides additional information about those two hospital characteristics, using ED E/M Level 3 and tympanostomy as examples.

Figure 3 shows distributions of ED E/M Level 3 costs at children’s hospitals, critical access hospitals, and other acute care hospitals. There was a much greater share of high-cost claims at children’s hospitals compared to the two other hospital types. The distribution of costs of claims at critical access hospitals and other acute care hospitals was somewhat similar, though other acute care hospitals had a larger proportion of claims with slightly lower costs.

**Figure 3**

### Distribution of ED E/M Level 3 Claims by Allowed Facility Costs and Hospital Type

■ Children’s Hospitals  
■ Critical Access Hospitals  
■ Other Acute Care Hospitals



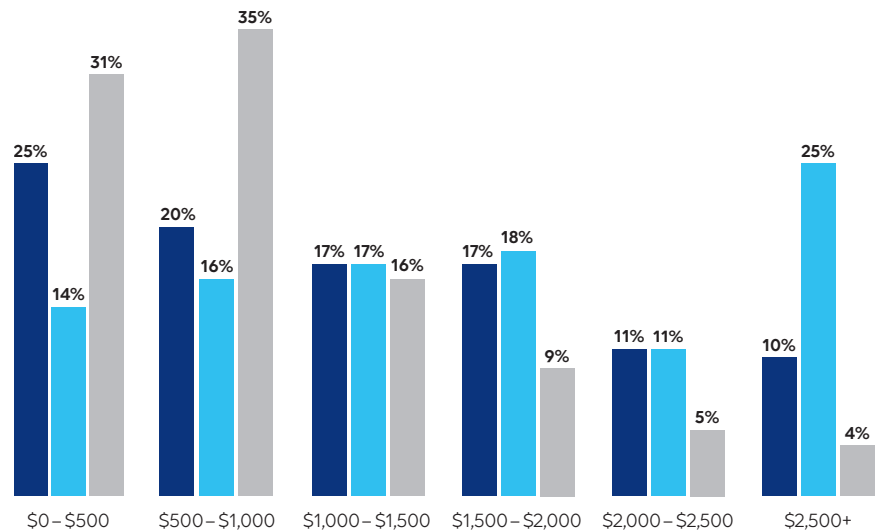
**Note.** Analysis from Elevance Health claims data. Allowed costs are capped at the 95th percentile.

Figure 4 shows distributions of tympanostomy costs at children’s hospitals, critical access hospitals, and other acute care hospitals. There was a greater share of high-cost claims at critical access hospitals compared to the two other hospital types. Additionally, other acute care hospitals tended to have a larger proportion of low-cost claims compared to the two other hospital types.

**Figure 4**

**Distribution of Tympanostomy Claims by Allowed Facility Costs and Hospital Type**

■ Children's Hospitals  
■ Critical Access Hospitals  
■ Other Acute Care Hospitals



**Note.** Analysis from Elevance Health claims data. Allowed costs are capped at the 95th percentile.

## Policy Considerations

**Children's hospitals and critical access hospitals appear to be more successful in negotiating higher prices with Medicaid managed care plans than other types of acute care hospitals.**

This dynamic may be exacerbated by state laws (like NJ S.3000) or other regulations that, in an effort to ensure access to needed specialty care or care across geographic locations, effectively require Medicaid managed care plans to contract with certain hospitals. The insurers' lack of leverage (i.e., inability to keep hospitals out of their networks) may lead to high costs at hospitals, which may affect insurers and taxpayers alike.

Nevertheless, it is important that members who need specialized services can access them. States considering network adequacy laws or regulations similar to New Jersey's may want to consider provisions that encourage or require certain specialty services to be covered in-network, while allowing for routine pediatric care (which is unnecessary to be at a children's hospital or other specific hospitals) to be out-of-network. This would allow the health plans some leverage and presumably lead to lower negotiated prices at these facilities, allowing for a balance of access and cost.

## Conclusion

**This analysis found that children’s hospitals were associated with substantially higher Medicaid prices than other acute care hospitals for several common outpatient and emergency department procedures for children.**

Critical access hospitals, hospitals that were part of systems (rather than independent), and larger hospitals also tended to have higher prices. Religiously affiliated hospitals had higher prices for nonemergent outpatient procedures only, and for-profit hospitals tended to have lower prices. Other factors like rurality and government ownership had a less consistent relationship with prices. State network adequacy laws and regulations should ensure that Medicaid plans provide access to in-network hospitals for all necessary care while still maintaining the ability to effectively negotiate with providers in order to reduce prices for routine services that may be performed at most hospitals.

# Endnotes

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