

Cost-to-Charge Ratio Files:

2003 Kids' Inpatient Database (KID) User Guide

1. Purpose

The purpose of this data file is to provide Healthcare Cost and Utilization Project (HCUP) data users with ratios that will allow the conversion of charge data to cost estimates. The file is constructed using all-payer, inpatient cost and charge information from the detailed reports by hospitals to the Centers for Medicare and Medicaid Services (CMS). It provides an estimate of all-payer inpatient cost-to-charge (CCR) for nearly every HCUP KID hospital in 2003. Where permitted by HCUP State Partners, the data set provides a hospital-specific CCR and a weighted group average. The KID is an all-payer inpatient care database for children ages 20 and younger and contains data drawn from 36 State Inpatient Databases.

The file can be linked to the 2003 file of KID discharges using the HOSPID variable. The HOSPID variable on the CCR CSV text file is enclosed in quotations in order to preserve leading zeros in Excel. As a result, some software applications may interpret HOSPID as a character variable which in turn would not match the numeric version of HOSPID on the KID. This data element should be loaded as numeric or converted to numeric prior to merging with the KID.

The cost of inpatient care for a discharge can then be estimated by multiplying TOTCHG (from the discharge record) by either the hospital-specific cost-to-charge ratio (APICC), or the group weighted average CCR ratio (GAPICC). The KID CCR file differs from other CCR files offered by AHRQ in that long-term care cost centers, such as skilled nursing facilities, are excluded from the calculation of APICC.

2. File Format

The data set contains one record for each of 2965 of 3438 total HCUP KID hospitals in 2003 (unduplicated HOSPIDs). All HCUP hospitals in the file are also in the American Hospital Association (AHA) 2003 survey.

Analysts might want to use the hospital-specific cost-to-charge when available (2243 cases approximating 75%) and the weighted group average when the hospital-specific CCR is not available (722 cases). Alternatively, one might use the group average in all cases.

Four states were dropped from the file (ME, NY, PA and TX). One state, NE, only includes group average CCR. To obtain national cost estimates for a set of cases, users will need to re-weight all discharges to account for cases where cost estimates are missing. The original case weight (DISCWT) should be multiplied by the following: Total weight of original cases divided by total weights, after excluding cases with missing cost. By performing these calculations, the weights for remaining cases are increased.

3. Internal Validation Studies

A regression analysis of the all-payer inpatient CCR was performed this year and in earlier years. This analysis used all clean HCUP and non-HCUP records with both AHA and CMS data. (Clean records are defined as having complete CMS schedules and worksheets, containing key variables within an acceptable range.) This was a weighted OLS regression using acute medical-surgical beds as the weighting variable, with separate state constant terms. Factors leading to significant differences in the CCR were: investor-ownership, rural location, large size (more than 300 beds), and a high ratio of interns and residents per bed (top 5%). Several of the state constant terms were also significant. The results tended to validate the “peer-grouping” method used here to create weighted group averages for each HCUP record.

A second type of validation study was performed for two states. In one case, the state accounting system by department was taken as the “gold standard” for cost estimation. Three alternatives were compared as predictors of differences in cost by DRG: Centers for Medicare and Medicaid Services (CMS) departmental cost-to-charge ratios, CMS hospital-wide inpatient cost-to-charge, and raw charges. The mean-squared-error criterion was used. The CMS departmental cost-to-charge ratios applied to detailed charges are somewhat more accurate in predicting the “gold standard” costs than are the hospital-wide inpatient cost-to-charge. The latter is substantially more accurate as a predictor than the raw charges. Unfortunately, detailed charges are not available for all HCUP states, so we can only use the hospital-wide inpatient cost-to-charge for cost estimation with the KID.

4. Weighted Group Average—GAPICC

The group average CCR (GAPICC) is a weighted average for the hospitals in the group (defined by state, urban/rural, investor-owned/other, and number of beds), using the proportion of group beds as the weight for each hospital. The groups are defined based on all clean HCUP and non-HCUP records for community hospitals with matching AHA 2003 Annual Survey data and CMS accounting database records as of September 30, 2005. Both operating costs and capital-related costs are included.

In cases where a peer group average is not possible, the “group” average is the statewide average.

5. Hospital Type for Grouping—HTYPE

Although HTYPE is not provided on the KID Cost-to-Charge file, it is helpful to know how this variable is defined to create peer groups within each state using all hospitals – not only those selected for the KID. Some researchers will find the information below useful with respect to replicability, and reviewers for journal articles might find this more detailed description especially valuable.

The following are values for the HTYPE variable:

- 1= investor-owned, under 100 beds
- 2= investor-owned, 100 or more beds
- 3= not-for-profit, rural, under 100 beds
- 4= not-for-profit, rural, 100 or more beds
- 5= not-for-profit, urban, under 100 beds
- 6= not-for-profit, urban, 100-299 beds
- 7= not-for-profit, urban, 300 or more beds

Unfortunately, data about the ratio of interns and residents per bed are not available on the AHA survey, so a high value of this indicator of teaching status could not be used for grouping. *Urban* is defined as being part of a Metropolitan Statistical Area (MSA); *beds* are the total hospital beds set up (2003 AHA survey).

6. Area Wage Index—WI_X

The area wage index is computed by CMS for each urban MSA. All rural areas in each state are combined for a state rural wage index. This information is available for download from CMS. For the HCUP hospitals in 2003, all were matched to an area wage index using CMS and the AHA survey. One caution is that some urban hospitals have been allowed higher area wage indexes in federal regulations than found in the file. Sub-MSA special wage indexes were assigned in about 2.5% of urban MSAs.

7. Variable List

There are six variables in the KID Cost-to-Charge data file. The following list summarizes the variables (and their respective labels) included in this file.

HOSPID	HCUP hospital identification number
WI_X	Wage Index, source CMS, edited

Z013	State postal code
APICC	All-payer inpatient CCR, hosp-specific
GAPICC	Group avg. all-payer inpatient CCR
YEAR	Year for linking to HCUP records