Frequently Asked Questions: Average Cost per Procedure

What does Average Cost per Procedure include?
The average procedure cost results account for the professional fees of the physicians conducting the procedure or seeing the patient during an office visit.

The vast majority of the procedures reported by MN Community Measurement occur in ambulatory care clinics; thus, the amount listed on MNHealthScores.org should reflect the full cost of the service. The exceptions are colonoscopy and maternity services, which are most often done in hospitals or surgical centers. Those may have additional facility fees or costs for added services (e.g. anesthesiology).

How many medical groups are included?
The 2015 results include 201 medical groups in Minnesota, as well as neighboring communities in Wisconsin, Iowa, North Dakota and South Dakota. This is an increase from the 153 medical groups that had reportable results in 2013. The increase is due to the expansion of procedures to include mental health and radiology centers, as well as the use of individual campuses for some large medical groups. The latter aligns with the breakout of groups for both our Total Cost of Care and quality measures.

To be included in the results for any given procedure, medical groups had to have at least 50 claims across at least three health plans to ensure accuracy.

All patients are included in the statewide averages, including those who were seen at groups that were not reported by medical group due to having less than 50 claims.

What procedures are included and why?
MNCM publishes statewide and medical group costs for the 85 most common medical procedures. The procedures are separated by CPT codes. They are selected based on claim volume, consumer interest and being conducted largely in ambulatory care clinics. They include office visits, gastrointestinal procedures, imaging, laboratory, medical services, OB/GYN, pathology and surgical procedures.

Seventeen new procedures were added this year, including lumbar spine MRI, Human Papilloma Virus vaccinations, psychotherapy office visits and echocardiogram. Particular emphasis was placed on expanding the cost information available for mental health visits and high-tech imaging.

How do these procedure costs differ from past years?
We last published Average Cost per Procedure in 2013. Since then, the average cost of procedures has risen 6 percent annually.
The cost of doctor’s office visits increased at a higher rate than all other procedures. Office visits jumped 7.7 percent annually, while all other high-volume tests and procedures increased by only 2.5 percent.

**Where are the costs from?**
The information is based on 2014 claims data from the four health plans in Minnesota with the largest commercially insured populations: Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica and PreferredOne.

**How are the costs of medical procedures determined?**
The cost of medical procedures are largely driven by two factors: the amount that the Centers for Medicare and Medicaid Services (CMS) pays for different types of medical services, and the overall price increase negotiated between each medical groups and health plan.

The significant influence of Medicare can be seen in the increase of certain types of costs relative to others – such as the fact that the cost of office visits are increasing more rapidly than lab tests or simple surgical procedures. CMS has increased the amount it will pay providers for office visits with patients enrolled in Medicare or Medicaid. Correspondingly, medical groups want the same type of increase from health plans for their commercially-insured patients. However, health plans and medical groups, through contract negotiations, determine the overall increase in price across all procedure categories.

**What are MNCM’s future plans with Average Cost per Procedure?**
MNCM expects to report the cost reimbursed for Medicare and Medicaid patients for these same procedures in the near future, which will allow analysis of the disparity between what providers are being paid for commercially-insured patients compared to patients insured by government programs.

Additionally, we are evaluating a new measure to look at comparable costs for episodes of care, such as a total knee replacement or a year of care for a patient with diabetes.