Maryland All-Payer Hospital Rate Setting

Regulation vs. Market Power

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The Maryland hospital sector is a regulated utility

- **All-payer** – Medicare, Medicaid, private insurance, and self-payers all pay the same price for a given service at a specific hospital

- **Rates reflect hospital circumstances** – including cost differences, uncompensated care, medical education

- **Federal waiver** – makes all-payer possible (since 1977), with strings attached

- **Independent agency** – Health Services Cost Review Commission (HSCRC), with dedicated career staff and broad regulatory authority

- **Active participation by hospitals and payers**
Now that we have your attention...

Leverage over rates used to promote multiple policy objectives

• Constrain hospital costs
• Ensure access to hospital care
• Improve equity and fairness of hospital financing
• Provide for financial stability
• Require public accountability

Focus on performance of hospitals, not health system
How have we done?

- **Cost** – Lowest rate of growth in cost per case of any state—**not total cost**

- **Equity** – Prohibit price-discrimination/cost-shifting—**but then there’s Medicaid**

- **Access** – Finance nearly $1 billion per year to finance charity care and bad debt

- **Accountability** – Plenty of data—**but far from transparent**

- **Financial stability** – Bond rating agencies consistently refer to the rate system as a “credit enhancer” for bond ratings
Bending a cost curve

• 1976: Maryland cost per case was 25% ABOVE the US average
• 2009: Maryland cost per case 3% BELOW the US average
• Estimated $48 billion savings to the State over the period 1976-2010
Volume matters

Hospital Discharges per 1,000 Medicare Enrollees

Source: Dartmouth Atlas
Maryland still spends more per case

Medicare Reimbursements for Inpatient Short Stays per Enrollee

- Medicare payment/case, 1981: **US = $2,293.09, MD = $2,971.65**
- Cumulative growth rates, 1981-2011: **US = 363.69%, MD = 324.70%**
- Medicare payment/case, 2011: **US = $10,632.73, MD = $12,620.50**
- **TRANSFER TO MD FROM REST OF US ≈ $1.5 BILLION/YEAR**

Source: Dartmouth Atlas
Controlling cost shifting?

- State budget problems forced adoption of Medicaid assessments
  - $413 million in 2013
- Cost shift to hospitals, who cannot raise private rates to compensate
- Cost shift to private payers, who pay the assessment
Other realities

• Maryland not immune to Medicare policies
  • 2008: Value-based purchasing P4P quality initiative
  • 2009: Maryland Hospital Acquired Conditions – reduced complication rates 20% over two years with savings of $105 million
  • 2010: Initiative to reduce one day stay cases
  • 2012: 31 hospitals at risk for all-cause 30 day readmissions

• Good policy is penalized under current waiver
  • Lowering readmits, 1-day stays raises cost/case
  • 2013 inpatient update = -1%

• Remains largely FFS, which promotes volume growth

• Leakage to unregulated sector
  • Regulation creates incentives and opportunities to profit from regulation
Hospital rate setting, an artifact of the past

• **Current waiver test reinforces wrong incentives**
  - Narrow focus on growth in inpatient cost/case, not full cost of care and not patient outcomes

• **HSCRC has adopted new models**
  - Global budget arrangements for rural hospitals
  - Episode-based payment to reduce readmissions
  - Voluntary—hospitals continue to rely on volume, physician employment arrangements perpetuate FFS strategy

• **Move to population-based system**
  - Seeking new per capita cost test through CMS Innovation Center
  - Technical challenge designing capitation-based models for urban, suburban facilities
  - Will provider and insurer support continue with regime change?
  - Is the solution to faulty regulation more regulation?
Maryland Health Services Cost Review Commission  http://www.hscrc.state.md.us/


Anna Sommers, Chapin White, Paul B. Ginsburg, *Addressing Hospital Pricing Leverage through Regulation: State Rate Setting*, National Institute for Health Care Reform, May 2012

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