Maryland All-Payer Hospital Rate Setting
Regulation vs. Market Power

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Maryland's rate setting system

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

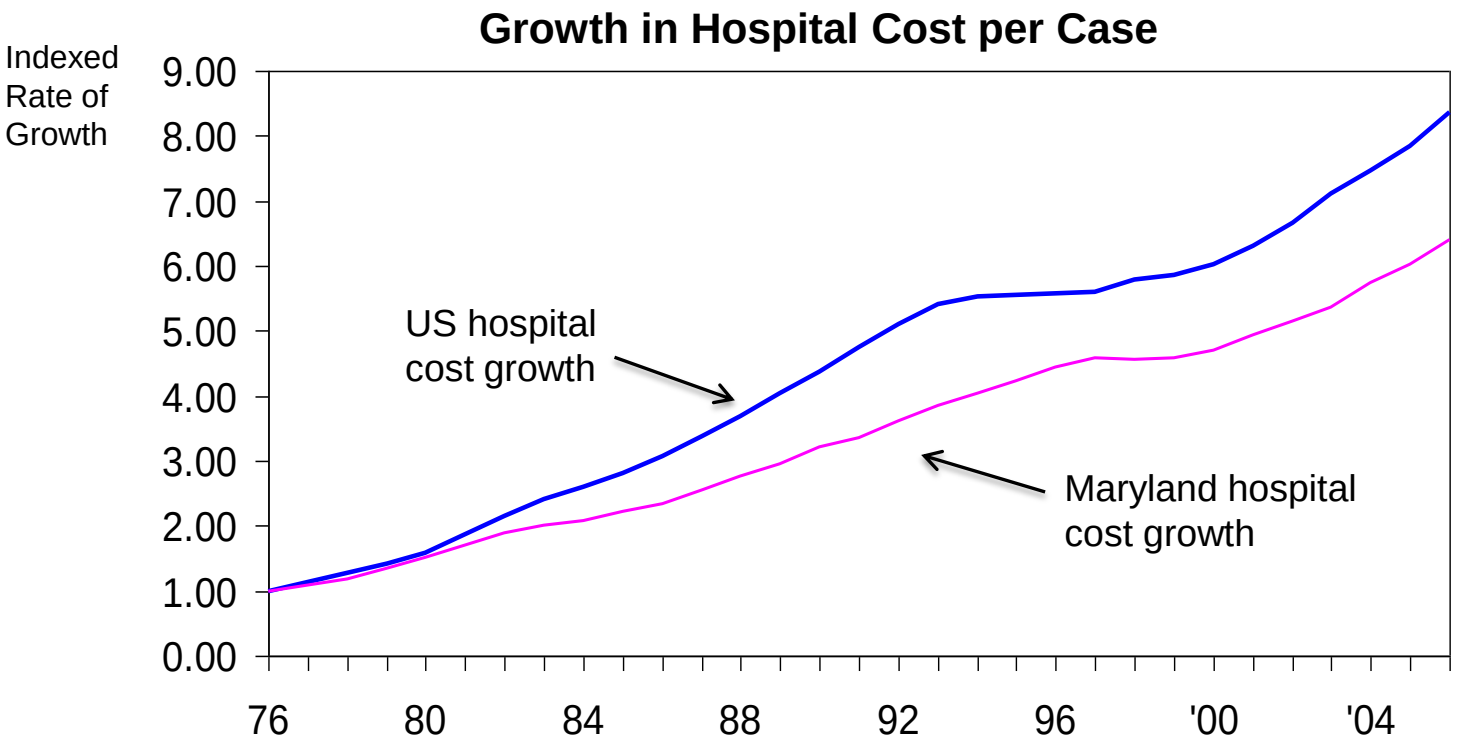
- Constrain hospital costs
- Ensure access to hospital care
- Improve equity and fairness of hospital financing
- Provide for financial stability
- Require public accountability

Focus on performance of hospitals, not health system

How have we done?

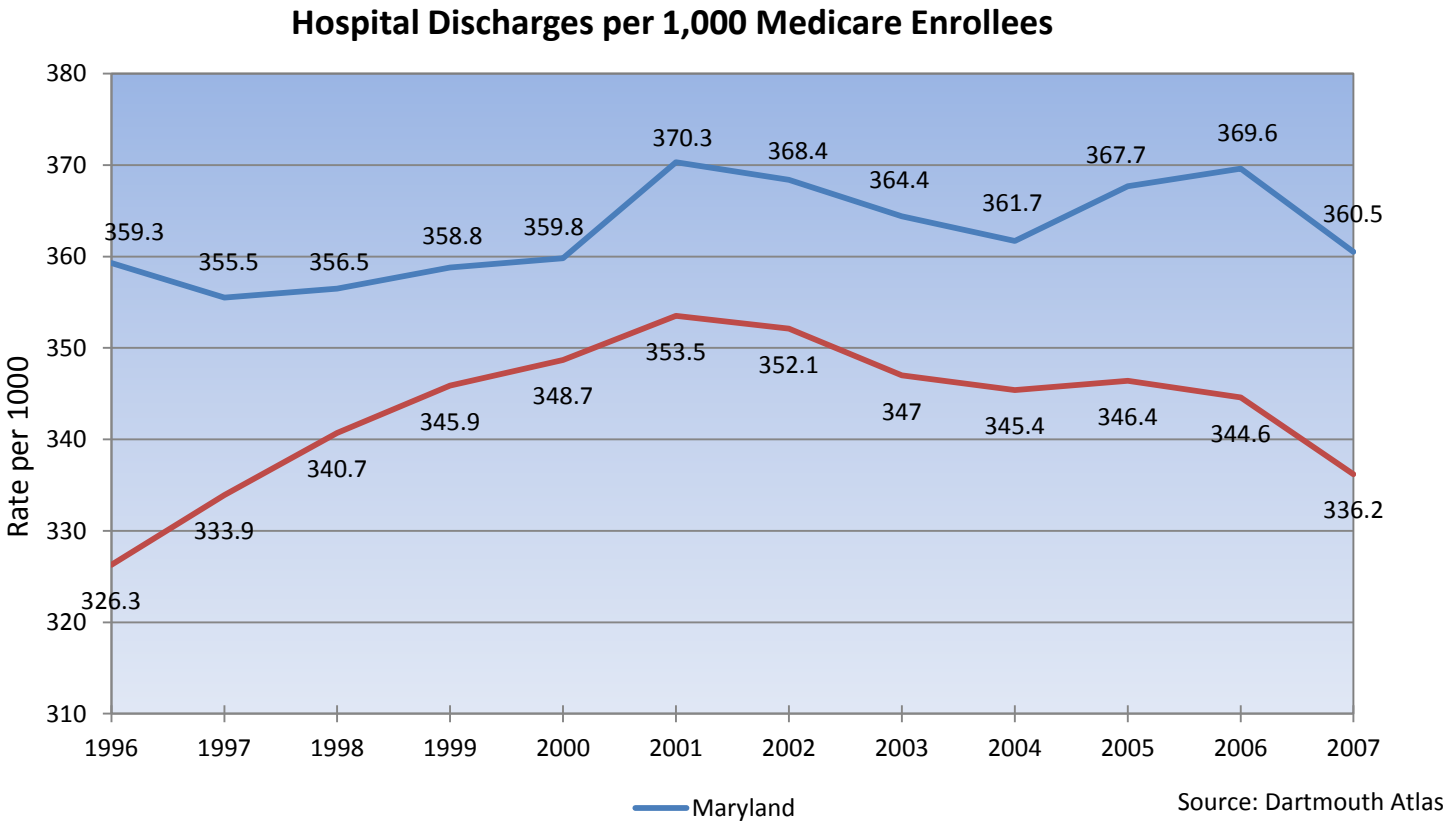
- **Cost** – Lowest rate of growth in cost per case of any state**—not total cost**
- **Equity** – Prohibit price-discrimination/cost-shifting **—but then there's Medicaid**
- **Access** – Finance nearly $1 billion per year to finance charity care and bad debt
- **Accountability** – Plenty of data**—but 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

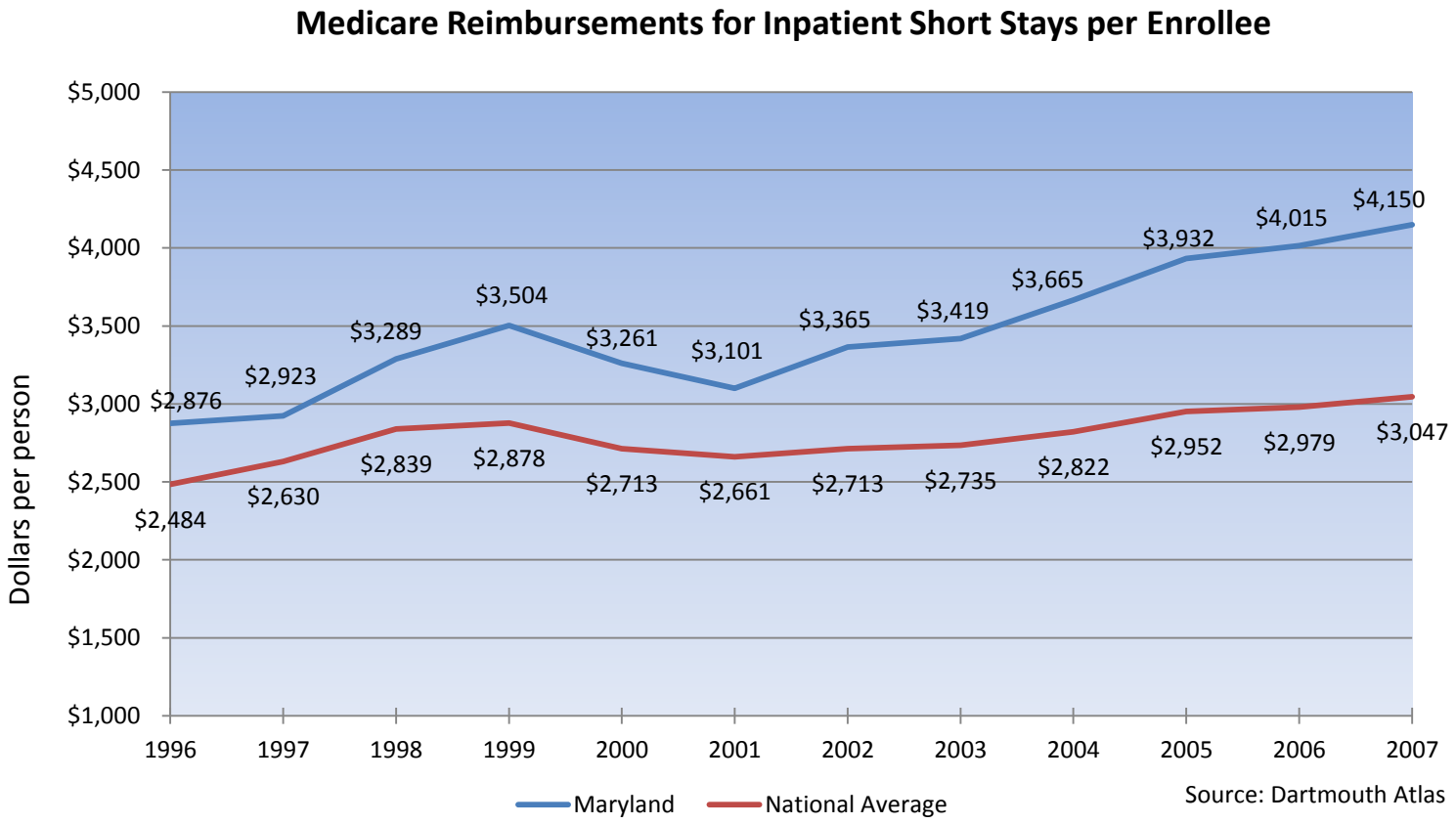


- 1976: Maryland cost per case was 25% ABOVE the US average
- 2009: Maryland cost per case 3% BELOW the US average
- Estimated **$48 billion savings to the State** over the period 1976-2010

Volume matters

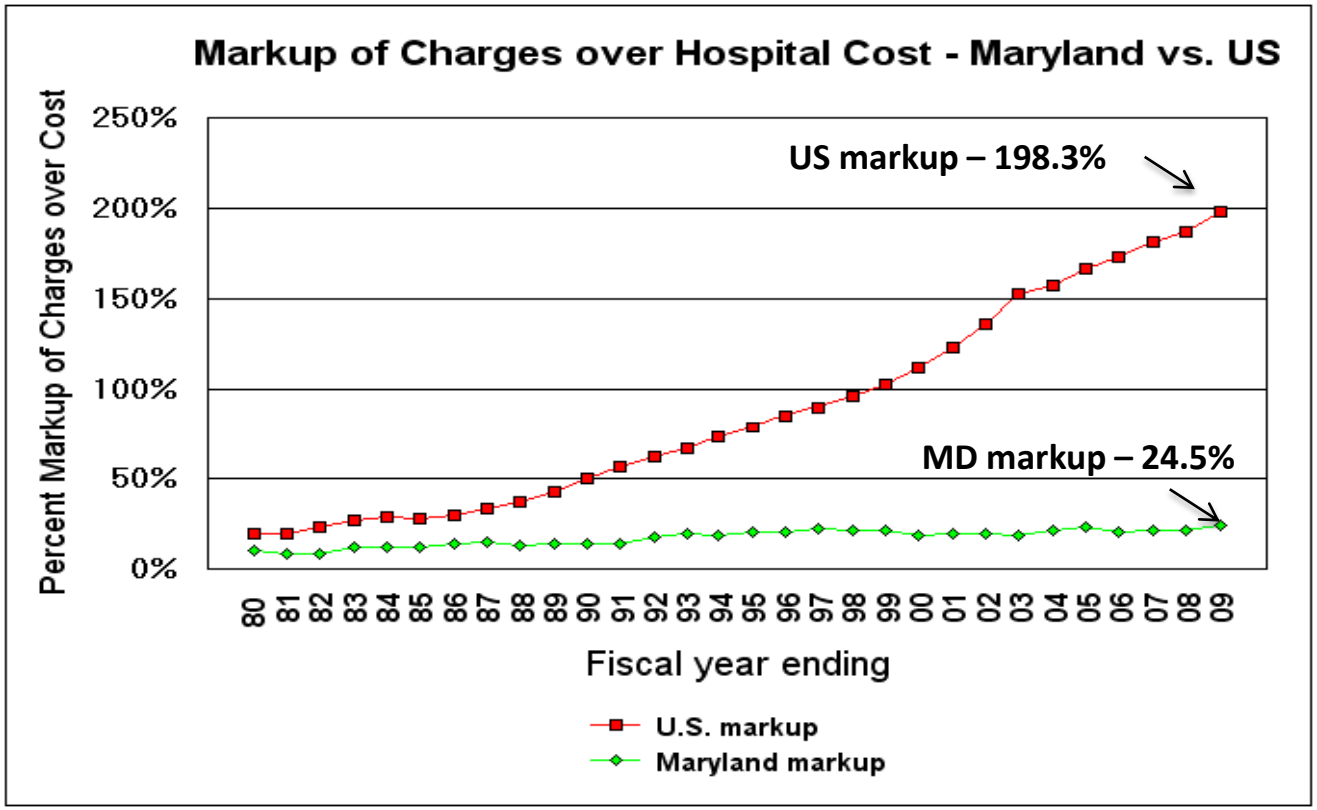


Maryland still spends more per case



- 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**

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?

For more information

Maryland Health Services Cost Review Commission http://www.hscrc.state.md.us/

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