NATIONAL INSTITUTE FOR HEALTH CARE REFORM

ADVANCING HEALTH POLICY RESEARCH

Hospital Rate Setting in Maryland

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CENTER for STUDYING HEALTH SYSTEM CHANGE

History of Hospital Rate Setting in U.S.

- Developed in 1970s to control hospital costs
  - Research showed impact
- Medicare prospective payment (1983) addresses cost control
  - Rate setting focus shifts to supporting charity care
- Growth of managed care in private insurance
  - Increased negotiating clout with hospitals
  - Ability to reduce length of stay through management
- Many states repeal rate setting (early 1990s)
  - Continued in Maryland due to greater success

Conditions Favorable to Rate Setting Have Returned

- Pronounced shift in leverage from health plans to hospitals
- Loss in Medicare ability to control hospital *costs*
- Increasing gaps between “have” and “have not” hospitals
- Need for leadership in provider payment reform

Trends in Provider Leverage

- Origin in backlash against managed care
  - Consumer demands for provider choice
    - "Must have" hospitals
- Shrinkage in capacity in some areas

Hospital Cost Shifting

- Ability to offset constrained public payer rates
- MedPAC analysis of Medicare margins
  - High positive private margins in face of negative Medicare margins
    - Reflects absence of pressure on costs
  - Conclusion of hospital leverage leading to higher costs

Viability of "Have Not" Hospitals

- Hospitals' leverage with providers varies
  - Variation appears to be growing
- Increasing pressure on hospitals who treat lower-income patients
  - Low payments from Medicaid
  - Limited ability to get high private rates

Potential for Provider Payment Reform

- Incorporate quality into payment
- Base payment on broader units
- Payer fragmentation limits options
  - Lack of clout by private payers
- Reform proposals envision leadership from Medicare
  - But limited applicability of reformed incentives

Perspectives on Maryland Rate Setting

- Upshot of previous charts
  - Problems already addressed in Maryland
- HSCRC has been successful over time
- At leading edge of reforming provider payment

National Issues Already Addressed

- Growing provider leverage
- Pattern of cost shifting
- Viability of “have not” hospitals
- Payer uniformity in payment reform

Long-term Success

- Trends in costs per admissions
- Access to care by low-income persons
- Equity among payers
  - Markups in 20 percent range
    - Same charges for uninsured
- Hospital financial stability
  - High proportion rated “investment grade”
- Key factors
  - Guiding principles: simulate efficient markets
  - Strong governance

Role of Strong Governance Model

- Specific authority established in legislation
- Commissioners appointed by Governor
  - Staggered four-year terms
  - Mixture of industry and public policy expertise
- Funding from user fees
- Transparency
- Retained support of key stakeholders over time

Payment Innovation

- Higher degree of sophistication than Medicare
  - Severity-adjusted DRGs
  - Cost-based weights
- Bundled outpatient payments
- Pay for performance

Next Challenges

- Resource for other governments to learn
- Need to incorporate physicians into system