Hospital Rate Setting in Maryland

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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