

MARYLAND'S ALL-PAYOR HOSPITAL PAYMENT SYSTEM

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Executive Summary

This paper describes Maryland's all-payer hospital payment system from a policy perspective. Accordingly, its focus is on the legislative principles that *gave* the system its initial purposes; the rate setting tenets and approaches that were adopted by the HSCRC in its efforts to achieve those purposes; the results achieved by the HSCRC and the hospital industry in controlling costs and meeting various social responsibilities; the key hospital financing issues that remain to be addressed; the remarkable benefits which the regulatory approach has conferred on Maryland as compared to the less desirable effects of competition in California and other states; and, finally, the relevancy of the main ideas of the successful hospital rate setting effort to future health reforms in Maryland and other jurisdictions.

In establishing the HSCRC, the Maryland legislature articulated four key rate setting principles: efficiency, access for all, equity among payers and solvency for all efficient and effective hospitals. The legislature did not prescribe detailed methodologies; instead, it pointed out a clear direction; created a small, independent agency with provider and consumer representation; and insisted on public accountability for all parties. The HSCRC responded by establishing credible, widely-endorsed objectives; by substituting strong financial incentives for traditional administrative sanctions; by involving the hospital industry in the setting of budgetary standards; and by using information, technically sound methodologies and flexible, case-by-case responses to address special needs and circumstances.

The results achieved by the Maryland hospital rate setting system have fulfilled the legislature's original intents. Maryland's costs have gone from 23.6% above to 4.6% below the national average; we have virtually no cost shifting; all Marylanders have access to needed hospital services; solvency has been maintained for all efficient hospitals; and our hospitals have generally retained or enhanced their reputations for clinical and teaching excellence. This performance far exceeds the national standard over the last 15-20 years and is clearly preferable to the rampant cost-shifting and patient dumping that have characterized California's unregulated hospital market during the same period.

The principles established in the Maryland hospital rate setting system are relevant to other health care sectors and provide useful bases for consideration of future health reform strategies. The challenge of solving today's problems is great but no larger than the hospital services issues the Maryland legislature addressed and solved in 1974.

MARYLAND'S ALL-PAYOR HOSPITAL PAYMENT SYSTEM

This paper describes Maryland's all-payer hospital payment system from a policy perspective. Thus, the focus is on the founding policy assumptions and principles behind the all-payer system, the goals of the system, its results and the lessons it offers for future health care reforms in Maryland and in other jurisdictions.

A. BACKGROUND

Hospital rate regulation in Maryland was created by an act of the 1971 Maryland legislature. The law passed with strong support of the Maryland Hospital Association (MHA). It is worth noting that the (MHA) is unique among hospital associations in that it is controlled by hospital trustees rather than by hospital administrators.¹ The law created the Health Services Cost Review Commission (HSCRC), an independent agency with seven members appointed by the Governor. The HSCRC was given broad responsibilities regarding the public disclosure of hospital financial data and trustee relationships and was given the authority, beginning July 1, 1974 to set hospital rates which would apply to all Marylanders.²

The Maryland law gave the HSCRC authority to set hospital rates for all payers. However, federal law, which takes precedence, governed the methods by which Medicare and Medicaid paid hospitals. The HSCRC believed that hospitals should operate under consistent payment incentives and that the payment methods of Medicare and Medicaid, which were cost-based at that time, were contrary to the interests of efficient hospitals and to those of the citizens of Maryland. Therefore, the HSCRC negotiated with representatives of both Medicare and Medicaid and, effective July 1, 1977, obtained a waiver of federal law that required Medicare and Medicaid to begin paying hospitals on the basis of HSCRC-approved rates.^{3,4} Thus, while the HSCRC has been approving hospital rates since 1974, those rates have covered all payers only since the Medicare Waiver was granted in 1977.

B. FOUNDING LEGISLATIVE PRINCIPLES

The creation of the HSCRC grew out of the balancing of two concerns. First, hospital costs had been rising very rapidly in the U.S. since the creation of Medicare and Medicaid in 1965.⁵ Second, hospitals serving large proportions of non-paying patients were threatened with insolvency and the patients who relied upon them for care were threatened with a loss of access. Medicare, Medicaid and Maryland Blue Cross, which represented the vast bulk of Maryland's insured population, did not recognize the costs of providing care to the uninsured as part of the reimbursable cost base. Therefore, the legislature adopted three key goals. These were (1) to constrain hospital cost growth; (2) to ensure that hospitals would have the financial ability to provide efficient, high quality services to all Marylanders; and (3) to increase the equity or fairness of hospital financing.

In pursuit of these overarching goals of cost containment, access, solvency and equity, the legislature embraced certain founding principles. These were:

Principle One: A Maryland Solution

A Maryland solution, rather than a nationally dictated program, was judged to be the preferable route to meeting the legislature's objectives, especially in the area of cost containment. The legislature believed that it was important to have accessible local regulators who would concern themselves with local hospital issues. The Federal bureaucracy was seen as too remote and burdened with national concerns to be able to respond in a timely way to Maryland-specific issues.

Principle Two: Social Mission

The legislature believed that public service, including the provision of medical care to the indigent and the operation of medical education programs, was an essential public duty of the hospital industry. Hospitals were encouraged to serve all patients in need without regard to their ability to pay and the financing of uncompensated care and medical education costs was treated as a responsibility to be shouldered by all payers.

Principle Three: Fairness and Equity

As noted above, the legislature believed that all payers should equitably share the burden of financing the social mission. The HSCRC was given the status of an independent commission to ensure that it would not favor one payer, especially Medicaid, over other payers. Fairness and equity was also supposed to extend to individual patients. Individuals were to be charged for services delivered to them and should not be forced to pay for or be subsidized by other patients. In this context, the equitably spread costs of treating the uninsured were regarded as a form of social insurance that would provide equal protection to any Marylander unable to pay for care at any time.

Principle Four: Solvency Must Be Earned

Hospitals have an obligation to fulfill their mission in an efficient and effective manner. Society has an obligation to maintain the solvency of efficient and effective hospitals.

Principle Five: Regulation

The legislature came to the conclusion that regulation was appropriate in the market for hospital services. The market, left to its own devices, had not and would not produce results consistent with the legislature's goals of cost containment, access, solvency or equity. In particular, the market could not be trusted to finance the social mission.⁶

Principle Six: Public Accountability

Hospitals should be accountable to the public through rate reviews and public access to data, including the extent and nature of all trustee relationships. Information regarding an individual

patient should be confidential. Regulators should be held accountable through open meeting laws, the Administrative Procedures Act, legislative oversight, and comparisons of Maryland results with those of other states.

Principle Seven: Trust and Cooperation

The legislature's commitment to this principle was manifest in many ways. The act did not spell out how the methods by which the HSCRC was to set rates. Instead, it simply required that the rates must be consistent with the goals of solvency, efficiency, equity and access.⁷ The regulators were trusted to respond to individual market and hospital situations. The mixed provider and non-provider makeup of the HSCRC, and the requirement that their deliberations be held in open meetings, engendered a high degree of cooperation. In addition, the act of giving the HSCRC broad authority over the money spent by employers for their employees and the money received by providers indicates a strong degree of trust. Hospitals also contributed to the cooperative effort. For example, some hospitals that, because of their location, did not face a solvency problem accepted limitations on their charges as part of the overall effort to protect the financial viability of hospitals with large uncompensated care burdens. All the hospitals agreed to be efficient in order to make the guarantee of access an affordable social objective.

Principle Eight: Prospective Payment

The legislature did not specify how rates were to be developed, but it did specify that they were to be prospective. This requirement contrasted sharply with the traditional cost-based reimbursement methods employed at that time by Medicare, Medicaid and Blue Cross. The legislature believed that patients and payers should know in advance what hospital charges would be and that hospitals should know in advance what they would be paid.

C. TENETS OF THE ALL-PAYOR SYSTEM

As noted above, the HSCC legislation did not establish the method by which hospital rates were to be set in Maryland. In its initial adoption and ongoing revision of its rate setting methods, the HSCRC has attempted to be faithful to the legislative principles that were enumerated in the previous section. The HSCRC has tried to design payment systems and to use rate setting techniques that are the technical expressions of the legislature's founding vision.

Several of the key tenets of payment system design adopted by the HSCRC follow directly from the legislative finding that the market, left to its own devices, would not produce cost containment, access, equity or solvency for efficient and effective hospitals. The legislature set in place a public utility model of regulation for hospitals, but the causes of failure in the hospital market differed substantially from those that usually afflict public utility markets. Although there are many such differences, the most important was probably the ubiquity of health care (especially hospital) insurance.⁸ The availability of insurance coverage with small deductibles and coinsurance costs, coupled with employer payment of all or a large proportion of the associated premiums, removed the usual cost sensitivity of consumers from the hospital economic system.

It is useful to consider what the restaurant business might look like if most people had pre-paid food insurance (or unlimited expense accounts). Menus would surely be replete with all the latest gastronomic inventions if chefs and servers were paid more when fully insured diners ate more expensive meals. We would probably have graduated by now to a “le Cirque” standard of culinary excellence (with solid golden arches!) whereby low cost meals would be dismissed by restaurateurs and the public as low quality threats to community health status.

In response to the lack of normal market forces that could be relied upon to produce efficiency, and in order to promote the achievements of the goals of access, equity and solvency, the HSCRC developed its own philosophy of regulation. The key tenets the HSCRC injected into its All-Payor regulatory system were as follows.

Control versus Profit Control

The HSCRC adopted the view that there is nothing wrong when an efficient provider is earning profits. However, there is something wrong with financing virtually unlimited increases in cost. The need to maintain affordability requires the regulator to contain payments to hospitals but does not require limits on profits.

Prospective Establishment of Attainable and Predictable Targets

If regulation is to work, hospitals must know what is expected of them and the targets must not be arbitrary. The paying community must accept the targets as reasonable and affordable.⁹ While markets may work through Adam Smith’s “Invisible Hand,” the HSCRC's approach was to provide a “visible hand.”

No Cost-Shifting

All patients, and their payers, should be charged according to the resources consumed in treating them. Markets work best if prices reflect costs. This view is consistent with the equity principle. The most important corollary of this principle is that payers should save money by reducing hospital costs rather than by shifting costs to other payers.

Minimize Market Intrusions

The HSCRC believed that the ancient medical dictum of “Above all else, do no harm,” could be applied to regulators as well as doctors. The HSCRC endeavored to design the least intrusive payment system that would accomplish social goals.

Use Incentives

People respond to incentives. The major problem with the hospital services market in the early 1970s in Maryland was that appropriate incentives were not in place.¹⁰ The HSCRC saw its job as adopting, through a cooperative rule-making process, the appropriate incentives. People are most likely to respond appropriately to incentives and targets they believe are reasonable. This fact is a

very important aspect of the principle of cooperation and trust. It is very hard to design a payment system that does not have unforeseen and unanticipated incentives. The HSCRC believed the industry was more likely to respond to the anticipated incentives and to work cooperatively to achieve the legislature's objectives, if it was part of the incentive setting process and accepted the reasonableness of the incentives and targets.¹¹ Finally, the HSCRC believed that the incentives should be applied consistently over time so people are encouraged to learn how to respond to them rather than that today's encouraged behavior will be tomorrow's discouraged behavior.

Information

It does not help to set up the right incentives if the providers do not have the information needed to respond to those incentives. Fairness in identifying inefficient hospitals requires detailed data.¹² Buyers require detailed data to make informed decisions.

Medical Practice

The most important cost issue is medical practice. Hospitals and their trustees are responsible for the efficiency of the medicine is practiced in their hospital. The payment system does influence the way medicine is practiced. Thus, the HSCRC's role was to create a system with incentives for both hospitals and payers to make me practice more efficient.¹³ While several hospitals felt that their physicians and not their Boards were responsible for medical practice, on balance, the industry accepted this formulation. The industry did not accept that were responsible for the state's admission rate but they accept responsibility for the way patients were treated after they were admitted.

Focus on Outliers

All hospitals were part of the inefficiency problem, but some hospitals were considerably more inefficient than others. The HSCRC determined to constrain the cost increases of the least efficient hospitals more than the cost increases of other hospitals. Hospitals which did not attain their targeted level of efficiency were expected to lose money and eventually go out of business.

Long Term View

The HSCRC believed that Maryland's cost problems could be solved via a long term approach that did not destroy the existing hospital delivery system.. The HSCRC tried to act deliberately without causing short-term havoc. The most important application of this principle and the reasonable target principle was the HSCRC's decision that hospital cost increases in Maryland could be held to levels approximately three percentage points below the national average rate of increase. Since the historical performance in the hospital industry had been inflation plus approximately 4.5%, the HSCRC set a target of inflation plus 1.5%.¹⁴ The industry accepted this initial level of financing as reasonable. Flexibility has allowed for changes in targets and methods as the market and other factors have changed. Annual disclosures allowed for public review of performance.

Appropriate Capacity Incentives

An unnecessary empty bed wastes far fewer resources than an unnecessarily filled bed. This observation was an important consideration in designing the payment system and the measures of efficiency. The HSCRC did not want to encourage hospitals to unnecessarily fill beds in order to lower their unit costs. Nevertheless, the HSCRC wanted units of service to be produced in an efficient manner. Long term policy should lead to elimination of excess capacity while short term policy must not encourage the filling up of existing capacity.

D. RESULTS OF THE ALL-PAYOR SYSTEM¹⁵

Cost Containment

In 1974, the year before the HSCRC began setting rates, hospital costs per admission in Maryland were 23.6% above the national average. By 2005, the most recent year for which data are available, hospital casts per case in Maryland had fallen to 5.1% below the national average. Despite less favorable performance versus the U.S. in the period 1994-1998 (a period of heavy use of managed care cost containment nationally), the long term performance of Maryland has been impressive. Over this period (1975-2005) Maryland has experienced the absolute lowest rate of increase of cost per admission of any state.¹⁶ Hospital expenditures per capita by state compiled by the Office of the Actuary at the Health Care Financing Administration (HCFA). That analysis covered the 1980 to 1991 period. Maryland's annual rate of increase over the period was 7.6% compared to the national rate of 8.9%. During the period, Maryland's per capita hospital expenditures dropped from 92% of the national average to 81% of the national average.^{17, 18}

The HSCRC reached a compact with the hospital industry that the most inefficient hospitals would have to bear more of the burden of cost containment. That agreement has been honored by both sides over the last twenty years. The first year the HSCRC published hospital-specific costs per adjusted admission data was 1977. The eight hospitals with costs per admission more than 25% above the statewide average in 1977 either exhibited lower than average cost increases or were out of business by 1993.¹⁹

Equity and Cost Shifting

The Medicare waiver has allowed Maryland to achieve what is by far the most equitable hospital payment system in the U.S. The most recent national data available on payment equity is for 2005. The average mark-up of charges over cost at a hospital in the United States is over 150% per the American Hospital Association Annual Hospital Statistical Guide. This means that hospitals nationally mark-up their posted charges by 1.5 times the underlying costs. Charges are posted at such artificially high levels to recoup un-recovered from uninsured patients (who pay only about 20-30% of cost), Medicare (who pays about 98% of cost) and state Medicaid (which pays on average 80% of cost). Private insurers face these dramatically marked-up charges and then attempt to negotiate steep discounts. Only the largest private insurers (those with the most market leverage) are successful in these attempts however. Smaller insurers, faced with the monopoly power of large

hospitals or hospital systems must pay these unreasonable posted charges.

In Maryland, because of the All-Payer system (which prevents this type of “cost-shifting”), all payers pay the HSCRC established rates for hospital services. These rates reflect a mark-up of approximately 18%. This mark-up has been uniform and steady over the life of the Rate Setting System. It includes a provision for financing of uncompensated care in the system. Thus, all payers are contributing equitably to the financing of care to the uninsured. There is no cost-shifting in Maryland. Patients and payers pay for the care they receive and also their fair share of social costs in the system.

Access to Care and Other Social Objectives

There are no longer any public government-operated acute care hospitals in Maryland. The indigent and uninsured have access to all hospitals. At a hearing on the possible sunset of the HSCRC, the Legal Aid Bureau testified that they had no cases of patient dumping in Maryland while in neighboring states such cases were common. The uninsured tend to go to hospitals located near where they live and hospitals with a history of welcoming them. As a result, the burden of uncompensated care is not evenly distributed. However, while nationally uncompensated care has tended to concentrate in public government-owned hospitals and teaching hospitals over time, Maryland's system, while still concentrated, is actually less so now than it was in 1979, the first time the HSCRC published uncompensated care data for all hospitals.^{24, 25} This increased sharing of the burden of uncompensated care represents the broad acceptance of social responsibility by Maryland's hospitals. Under the current rate setting system, the burden of financing uncompensated care falls inequitably upon payers at hospitals with high percentages of uncompensated care in their rates. Between 1979 and 2005, uncompensated care in Maryland rose from 5.8% of revenue to 8.0% of revenue and from \$70,000,000 to \$ 800,000,000. Many of the year to year dramatic increases have been associated with reductions in eligibility and coverage of the State's Medicaid program. The HSCRC system financed hospital access for patients previously insured by that program.

While the provision of uncompensated care is concentrated, the provision of medical education to physicians in training is even more so, with the top two hospitals incurring approximately 73% of the cost. Unlike the uncompensated care, the costs of medical education are not spread throughout the hospital system.²⁶ The financing of medical education falls inequitably upon the patients and payers who use teaching hospitals.

Solvency of Efficient and Effective Hospitals

Seven Maryland hospitals have closed since the HSCRC began setting and one other hospital went through a bankruptcy procedure. All were identified as higher cost hospitals. The hospital closure rate in Maryland has been at approximately the national average. Maryland's hospitals showed profits of 4.5% of revenue in 2006. This profit level was higher than average for the previous rate setting or pre-rate setting periods. Maryland hospital profits had been approximately 1% annually in the pre-rate setting period and afterwards were generally below 1.5% through 1982. Profits have exceeded 2.5% most years in the period 1982 - 1994. Since 1994 profits have been in the 3-5%

range Nationally, hospital profits have been closer to 5-6% over that period. Many economists familiar with the Maryland system believe that the rate setting system provides the hospitals with a far greater degree of financial predictability and stability. This has proven to be a benefit to Maryland hospitals in terms of their access to the municipal bond markets and their bond ratings. Because of this financial stability it has been argued that Maryland hospitals face less financial risk than hospitals nationally. It is not unexpected that their profit levels have averaged about a 1% less than hospitals nationally. Profits are generally reflect rewards for the level of financial risk faced by institutions in a particular market. Where there is less risk – there may be less long term economic need for higher rewards. We believe the Maryland hospital market reflect this general economic result. Thus far, efficient hospitals, including those with significant social missions, have remained solvent in Maryland.

Public Accountability Through Information

It is difficult for people who are used to Maryland's magnificent public data to understand how little hospital data is typically available in other states. Maryland's data is very current. For example, in early January of 2005, discharge data is already available through September 30, 2004. Maryland's hospital data bases include accounting do a uniform reporting format; wage, salary and fringe benefit data; case mix or hospital discharge data; outpatient surgery, emergency room, clinic charge data; and monthly charging and compliance data. The HSCRC maintains public records involving trustee dealings, approved rates, and audited financial statements. Much of the data in this paper is reported in the HSCRC's annual disclosure report.

E. UNRESOLVED HOSPITAL FINANCING ISSUES AND CURRENT PROJECTS

While the results of the all-payer system have been impressive, several steps need to be taken:

Incentives and Targets for Outpatient Services

Develop Quality Measures

As the market becomes more price sensitive, it is important for consumers and their sponsors to make decisions based both on relative efficiency and on relative quality of care. The HSCRC is implementing the nation's first All-Payor hospital pay for performance system. It is based on Nationally endorsed process measures and will be correlated to outcomes measures on a risk adjusted basis. The rewards and incentive payments built into the system will be substantial and seek to increase the quality of care of all Maryland hospitals.

Stimulate Investment in Health Information Technology and Electronic Medical Record

In order to continue the benefits realized by the Maryland system in the areas of efficiency and quality improvement, it is crucial that the system move rapidly toward the adoption of beneficial health information technologies and the establishment and use of a global electronic medical record

(EMR). The HSCRC is promoting the adoption of these technologies and is spearheading the development of the interoperable exchange of important clinical and administrative data on all patients across all sites of care in the State. The implementation of a full fledged interoperable medical record system will confer substantial additional benefits to the citizens of Maryland in the form of improved efficiency, quality of care, and patient safety.

F. RELEVANCY OF THESE FINDINGS TO FUTURE HEALTH REFORMS

The lesson of Maryland's approach is that good results will follow if the incentives in the insurance market encourage carriers to target all people equally and reward carriers and clinicians who develop more efficient ways to manage the care of the very ill. The concepts and methods are applicable to different financing mechanisms and different jurisdictions. Maryland's experience in hospitals rate regulation suggests that the cooperative establishment of appropriate incentives can yield enormous social and economic benefits to other jurisdictions.