# How the US Uses Prices to Affect Expenditures of Hospital Services

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# The Presentation Will:

- Discuss unique aspects of US hospital payment
- The Medicare (social insurance) experience setting hospital prices
- The challenge of rising hospital prices for private insurers
- Lessons from Maryland – the only all-payer rate-setting model in the US

# Unique US issues making knowledge transfer challenging

- Multiple payers with resulting price discrimination (although not necessarily cost-shifting)
- No global budgets for health or hospitals
- Active managed care with spillover effects on the Medicare experience

# Recent research shows that prices are the leading reason for high US spending

- Prices, not volume (although US does lead in use of some discretionary procedures, e.g. cardiac stents, joint replacements)
- Overall, prices drive spending directly
- There have been mixed volume responses to price constraints. In some areas, price reductions reduce volume, e.g., imaging
- Medicare hospital prices are related to costs. For private insurance mostly a function of market negotiations and use of market power.

# The Medicare experience

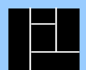
- For those >65 and disabled, Medicare functions like a broad, social insurance program, although 28% of beneficiaries opt to get care from a private insurer in a form of managed competition
- Interestingly, Medicare-equivalent hospital prices are used by Medicare Advantage insurers even if not paying DRGs. (Insurers more commonly pay *per diems*).

# How Medicare pays hospitals

- Inpatient payments based on 2007 MS-DRGs (Medicare Severity), which were adopted to provide more clinical nuance and better predict costs and shift payment from surgical to medical DRGs
- Hospitals submit cost reports as the basis for estimating overall hospital costs and for allocation of costs into specific DRGs
- But all sorts of adjustments for individual hospitals – geographic wage adjustments, graduate education, serving poor and rural, etc. A recent government analysis found that 90% of hospitals receive a "payment adjustment."

# Setting the annual price update is the key policy tool for controlling spending

- Generally is tied to the hospital “market basket” of input price increases
- Hospitals and Congress made a deal as part of the Affordable Care Act (ObamaCare) -- the annual update for 10 years will be market basket increase – an estimate national productivity gain. (In essence, a trade-off between more hospital revenues from newly insured and reduced but predetermined Medicare payment rates)



# Hospital responses to pricing pressure in Medicare

- Have not seen consistent volume increases
- Rather, “code creep” initially and periodically with an increased case-mix index. But the Centers for Medicare & Medicaid Services can adjust prices for upcoding and audits
- Surely some spillover from managed care’s prior authorization approaches – hard to tailor behavior to a single, even large, payer
- Long-standing assumption of “cost-shifting” to private insurers – a payment “hydraulic”

# Cost-shifting?

- Research and policy based on the belief that hospital costs are exogenous – immutable – a given
- Recent research has found it mostly works the other way – high prices from private insurers permit a higher hospital cost structure producing negative Medicare margins (except for the hospitals that don't get high prices, so they must be leaner)
- Is moving policy discussions from paying for the average hospital to paying for the efficient hospital
- While not cost-shifting, price discrimination provides hospitals a safety valve re costs

# Further,

- Research performed over 25 years has found that hospitals actually respond to pricing pressure in Medicare by reducing their overall costs, although where possible, they may also “game” the incentives or find revenues elsewhere to support cost structure.
  - Varies by market characteristics. Hospitals in concentrated markets with pricing power may raise prices to private payers to offset Medicare shortfalls.

# Trends in negotiating leverage between private insurers and hospitals over price

- Aggregate hospital payment-to-cost ratios for private payers has increased from about 115% in 2000 to about 135% in 2010
- Private payments to hospitals exceed Medicare payments by about 40% on average -- with major variations
- The major determinant of relative prices are market concentration of hospitals – there has been a lot merger and acquisition activity to form multi-hospital systems – although even single hospitals serving a unique area can have market power if they become "must have" hospitals for insurance networks

# US is starting a debate about “Big Medicine” – Mega hospital systems employing doctors .

- Advocates say: provides economies of scale; spreads managerial expertise; permits greater access to capital for HIT; offers the potential of a community-based orientation, recognizes that younger physicians want “shift work” that is possible from employment
- Detractors argue: creates non-responsive monopolies that undermine competition; beyond a threshold bigness is inefficient; most new capital supports a “medical arms race” – non-price competition; hospitals are not the engine of change – ambulatory care-based medical groups might be

# All of this has re-kindled discussion of all-payer rate setting

- Under either scenario, need to address hospital pricing power over private insurers, price discrimination, focus on negotiating strategies rather than care, etc.
- The State of Maryland has regulated hospital prices for all payers since 1977. (3 other states had such systems but abandoned them in the 1980s after Reagan won and promoted competition, and managed care plans were able to obtain deep discounts from hospitals.

# The Maryland Health Services Cost Review Commission

- Politically and legally independent
- Funded through user fees, not government funding
- Sets, with some negotiation, service-specific rates for all inpatient, hospital-based outpatient, and emergency services at 47 acute, 3 specialty, and 3 psychiatric hospitals. Includes Medicare payments – so is an all-payer system
- Regulated revenue about $15 billion
- Unlike Medicare, HSCRC pays on service-specific unit rates, while constraining revenues using DRG-based limits on inpatient and ambulatory patient groups (APGs) for outpatient services.

# Also:

- Unlike Medicare, rewards and penalties from performance are aggregated and realized through adjustments to *hospital-approved revenue* each year
- It reflects actual resources used
- It aligns the incentives across payers and hospitals – both want to control utilization per case
- Annual price inflation updates like Medicare
- Basic objectives: constrain hospital costs, ensure access for all citizens through the front door rather than ER, improve equity and fairness of hospital financing, and financial stability even if less profit potential

# HSCRC Performance

- Good control over rate of increase in hospital costs per admission – 2nd lowest of any state
- But hospital admissions and days increased much more than national average. From 2001-2008, admissions grew an annual average of 2.5% in Maryland vs. 1 percent nationally. Had second highest rate of all states for readmissions of Medicare patients.
- Note the all-payer system doesn't have the safety valves hospitals otherwise enjoy – so not surprising to see more of a volume response to price constraints than in Medicare

# Maryland attempts to address volume response

- From 1978 to 2001, changes in volume triggered application of fixed/variable cost adjustment to payment rates. Paid 85% of the case rate for patients above a volume benchmark (and 15% for volume decrease). Did not measure actual variable costs
- Succumbed to hospital pressure to eliminate the reduced rate. Immediately, admission rates began to increase, quickly outpacing national rates. The 85% payment rate, was put back in 2007 based on the observed regrowth of volume and costs – with desired results on volume. Volume is now growing about the same as national, although from a higher base.

# Recent Maryland innovations

- Global budgeting, "total patient revenue," for 10 rural hospitals with defined service areas and limited competition – fixed global (and guaranteed) revenue for hospitals regardless of volumes.
- Admissions/Readmission Revenue Structure – per episode payment to include **all** admissions and readmissions within 30 days of discharge. Allowable revenue per case is the average payment associated with index admission and the all-cause readmissions.
- Quality/Payment programs –
  - P4P – starting with 0.5% of inpatient revenue at risk
  - Hospital Acquired Conditions penalties – 2, then 3%, at risk

# New Maryland proposals

- Maryland is in danger of losing its Medicare waiver – in essence, because Medicare always loses money because it is subsidizing the uninsured and eliminating price discrimination. (? Why now just when coverage expansion will be implemented?)
- So the state recently has made a proposal to the Department of Health and Human Services to raise the policy and political stakes by suggesting dramatically new approaches in all-payer rate setting.

# Proposals

- Expand current initiatives
- “Gainsharing” between hospitals and physicians
- All-payer Accountable Care Organizations as the engine of change – based around hospitals
- “Population-based budgeting for suburban and urban hospitals, shifting from fee-for-service to accountability for outcomes and cost”

# Population-based budgeting

- Currently aspirational with many of the details to follow – called “virtual capitation”
- Will apply to hospitals that have a majority of market share for specific services????????
- One element seems to be expansion of the variable cost determination for payment – so discusses reducing variable cost factor to 60% from 85% and to consider “asymmetric” and “discontinuous” volume adjustments
- Little detail on the virtual capitation approach