

Public Health Practice Grand Rounds
Johns Hopkins School of Public Health

**Improving Health Care:
Incentives, Cost-Effectiveness, and Public Policy**

*The Health Services Cost Review Commission -
Baltimore, Maryland*

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Overview

- Review of policy development process
- Applying the principles of Cost-Effectiveness Analysis (CEA) and other Cost Studies to Policy Development
- Role for Government to address Market Failure
- Background on Maryland's Health Services Cost Review Commission (HSCRC) – Public Policy to promote Cost-Effective Behavior & Achieve other Goals
- The Maryland All-Payer Hospital Payment System – uniquely positioned to promote “Value-based” decision-making

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General Policy Development Process

- Identify market distortions, and other economically and socially less desirable outcomes in a “system”
- Develop policy objectives
- Identify behaviors that need to be changed
- Construct financial incentives necessary to change behavior and achieve identified objectives
- Develop sufficient metrics and adjustments to measure current performance and changes in relative performance over time
- Strengthen, broaden and align incentives to improve performance

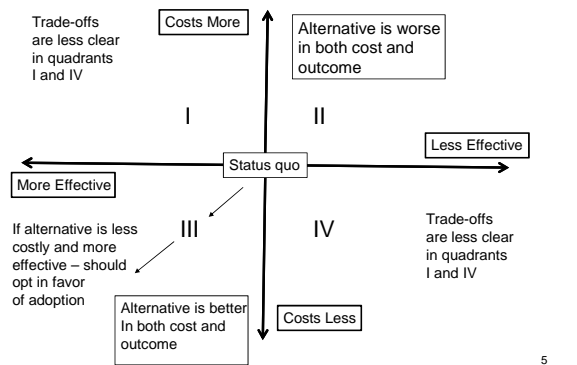
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Principles Implicit in the use of Cost-Studies Can Guide Policy Development

- Cost-Effectiveness Analysis (CEA), Incremental Cost-Effectiveness Ratio (ICER), and other Cost-Studies accepted tools to guide decision-making in optimizing use of scarce resources
- CEA first applied to health care in mid-1960s
- Championed by Weinstein and Stason NEJM 1977:
“Limits on health-care resources mandate that resource-allocation decisions be guided by considerations of cost in relation to expected benefits.”
- Concept of adopting interventions that provide additional “Value” (incremental gain in health per \$ spent) can help guide policy making process

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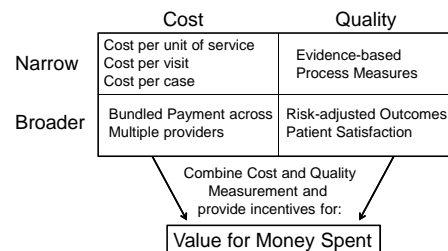
Promoting Value for \$ by Intervention



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Framework for Policy Application

- Promoting “Value” for dollars spent also applicable to Policy Development Process
- Generally the broader the framework for policy development and the use of financial incentives – the better



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The Maryland All-Payer Hospital Rate Setting System

Uniquely Positioned to Promote “Value for Money”

HSCRC Background

- Only All-Payer Hospital Rate Regulatory System in US
- Established in 1970s to address “Market Failure” in health care market
- Identified policy goals relating to current problems:
 - Cost Containment
 - Expanded Access to Care (Uninsured)
 - Equity and Fairness
 - Higher Levels of Accountability and Transparency
 - Financial Stability
 - Improved Clinical Effectiveness
- HSCRC establishes payment levels for all inpatient (per case) and outpatient hospital services (per visit)
- Use of financial incentives (payment per case) across all payers - to change behavior and meet policy goals

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Using “Price” to Send Better Signals

- In competitive markets, prices send “signals” that induce behaviors resulting in economically efficient/effective outcomes
- In health care markets, however, prices do not send the proper “signals” for efficient allocation of resources
- Thus, HSCRC uses “price” to influence behavior, allocate health care resources and achieve other policy goals
- These prices are applied across all payers for all hospital services in the State (broad application)
- Historical focus has been relatively narrow - establishing a “price per inpatient case” or a “price per outpatient visit”
- So – like Medicare – HSCRC is a “*dumb price-fixer*”

Tom Scully – former Medicare Administrator under Bush

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Dumb and Dumber

- In creating the HSCRC – Maryland legislature recognized Health Care Market characterized by massive market failure:
 - Suboptimal Market Structures (Hospitals as virtual monopolies)
 - Highly fragmented payer and provider industries
 - Dominance of Physicians and Hospitals in Purchase decision
 - Uncertainty and absence of consistent, accurate and timely data
 - Presence of risk and insurance
 - Nature of the product (hard to shop ERs after major trauma)
- These and other factors contribute to price distortions
- “*So while rate-setting may be dumb price-fixing, the market has been even less effective in setting prices*”

Paul Ginsburg, Center for Health System Change, 2009

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All-Payer made Possible by Maryland’s Medicare Waiver

- Only State to retain a waiver
- Enables the “all-payer” system – Medicare/Medicaid in
- All payers pay the rates established by the HSCRC
- Allows for uniform financial incentives (prices)
- All payers contribute equitably toward financing social costs (Uncompensated Care and Med. Education)
- Broader base for other initiatives – Quality of Care
- Brings in considerable federal dollars
- Waiver Test – cumulative rate of growth test

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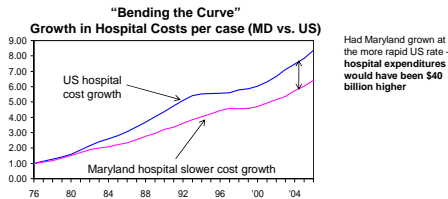
Maryland has Outperformed the Market

- HSCRC role – intervene to “correct” for Market Failure – by structuring payment (financial incentives) to change provider behavior
- Rate Setting Tenets are consistent with competition:
 - Philosophy of Macro-Regulation (avoid unnecessary intervention)
 - Emphasis on providing accurate data and information on performance
 - Prices (rates) should reflect costs
 - Rates set prospectively
 - Hospitals held “at-risk” for things they can control
 - Otherwise managers given maximum flexibility in decision making
 - Focus on cost control – not profit control
 - Prohibit so-called “cost-shifting”
 - Support of hospitals’ “Social Mission”
- Achieved some positive results – despite narrow focus

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Bending the Cost Curve

- 2nd Lowest Rate of Cost Growth of any State 1976-2007
 - 1976: Maryland Cost per case was 25% ABOVE the US average
 - 2007: Maryland Hospital cost per case 2% BELOW the US average
 - Estimated \$40 billion savings to the State over the period 1976-2007



- Had the US grown at the slower Maryland rate of growth - hospital spending would have been \$1.8 trillion lower

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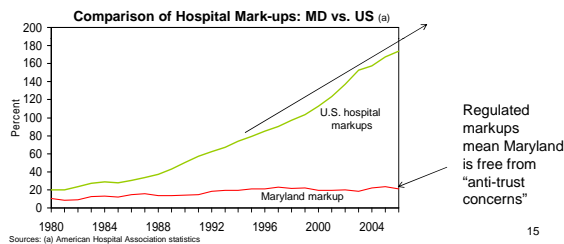
Access to Care

- Primary Goal of Maryland Legislature: improve access to care
- HSCRC developed a unique mechanism for financing hospital "uncompensated care" (UC)
- Hospital rates contain an extra "provision" (mark-up) that allows them to generate funds sufficient to pay for care to the uninsured
- Implications:
 - Hospitals receive funding for \$1 billion of care to the uninsured annually
 - This "mark-up" is in the rates applied to All-Payers, so everyone contributes equitably to the funding of this care
 - Uninsured are charged same prices as fully insured patients
 - There has never been "Patient-Dumping" in Maryland

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Far Superior Payment Equity

- HSCRC controls the "Markup" of rates over costs (prohibits cost-shifting)
- Nationally hospitals use their market leverage to "cost-shift" drives up their "list-prices" to private insurers
- Dynamic that completely undermines incentives to contain costs



Sources: (a) American Hospital Association statistics

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Accountability

- In addition to its Rate Setting duties, the HSCRC has broad powers of data collection and disclosure
- Maryland has the best data on hospital performance of any state
- All data are publicly available
- Hospitals & Payers – biggest users of the data
- Hospital prices are readily available
- Virtually all Commission discussion done in public meetings

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Financial Stability

- High degree of predictability & stability in the system
- Rates set prospectively (in advance) – facilitates budgeting
- Uncompensated care "paid for" in the rates charged to all payers
- Maryland recognized by municipal bond rating agencies for year to year stability (given "credit +" in evaluations)
- Maryland has the highest percentage of hospitals rated "Investment Grade" by bond rating agencies (stability)
- Profits are slightly below U.S. Hospital profits – but follow general U.S. trend year-to-year
- Less risk in Maryland (implies less need for reward)

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Observations re: Quality

- HSCRC has statutory mandate to promote Effective Operation
- HSCRC: Uniquely position to lead the nation in Hospital Quality
 - Comprehensive payment system (link to quality measures)
 - Most sophisticated Risk Adjustment system
 - Most extensive administrative data in the country (Quality measures)
 - Ability to structure incentives (to improve quality) across all payers
- Not much progress in measuring "Quality of Care" until recently
- **HSCRC now leading the nation in linking Payment to Quality**
 - Evidence based process of care measure
 - Hospital Complication Rates
 - Development of a Method to reduce Preventable Hospital Readmissions
- Also a "Cost" component to improving Quality

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Quality of Care Initiatives

- **Phase I:** Pay for Performance (VBP) – 19 process measures; 4 core measures HF, AMI, PN, SIP – measures performance – linked to payment (2008)
- **Phase II:** Maryland Hospital Acquired Conditions – Uses 49 Potentially Preventable Complication (PPC) categories – linked to payment (2009) – potential \$522 million in savings
- **Phase III:** Potentially Preventable Re-Admissions (PPR) – link rates of re-admissions to payment (2010) – potential \$700 million in savings
- **Phase IV:** Patient Experience of Care Measures (patient satisfaction surveys – will link to payment)

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Phases II & III: PPCs and PPRs

- **Potentially Preventable Complications (PPCs)**
 - Harmful events (accidental laceration during a procedure) or negative outcomes (hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease
- **Potentially Preventable Readmissions (PPRs)**
 - Return hospitalizations that may result from deficiencies in the process of care and treatment (readmission for a surgical wound infection) or lack of post discharge follow-up (prescription not filled) rather than unrelated events that occur post discharge (broken leg due to trauma).

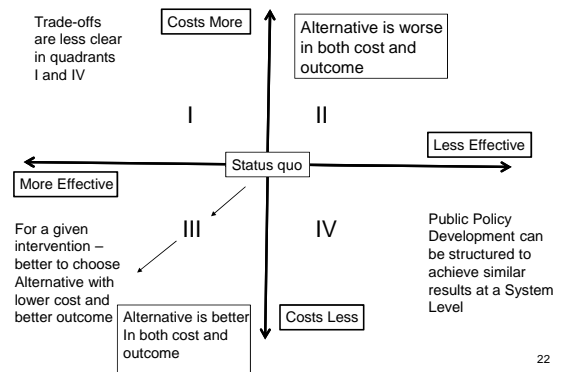
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Selected PPCs (35 of the Most Significant PPCs)

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| <p>Extreme Complications</p> <ul style="list-style-type: none"> • Extreme CNS Complications • Acute Pulmonary Edema & Respiratory Failure w Ventilation • Shock • Ventricular Fibrillation, Cardiac Arrest • Renal Failure with Dialysis • Post-Operative Respiratory Failure w Tracheostomy <p>Cardiovascular/Respiratory Complications</p> <ul style="list-style-type: none"> • Stroke & Intracranial Hemorrhage • Pneumonia, Lung Infection • Aspiration Pneumonia • Pulmonary Embolism • Congestive Heart Failure • Acute Myocardial Infarct • Peripheral Vascular Complications Except VT • Venous Thrombosis <p>Gastrointestinal Complications</p> <ul style="list-style-type: none"> • Major GI Complications w Transfusion or Significant Bleeding • Major Liver Complications <p>Infectious Complications</p> <ul style="list-style-type: none"> • Clostridium Difficile Colitis • Urinary Tract Infection • Septicemia & Severe Infection | <p>Perioperative Complications</p> <ul style="list-style-type: none"> • Post-Op Wound Infection & Deep Wound Disruption w Procedure • Reopening of Surgical Site • Post-Op Hemorrhage & Hematoma w Hemorrhage Control Proc or I&D Proc • Accidental Puncture/Laceration During Invasive Procedure • Post-Op Foreign Body <p>Malfunctions, Reactions Etc.</p> <ul style="list-style-type: none"> • Iatrogenic Pneumothorax • Mechanical Complication of Device, Implant & Graft • Inflammation, & Other Complications of Devices, Implants or Grafts Except Vascular Infection • Infections due to Central Venous Catheters <p>Obstetrical Complications</p> <ul style="list-style-type: none"> • Obstetrical Hemorrhage w Transfusion • Obstetrical Laceration & Other Trauma w/o Instrumentation • Obstetrical Laceration & Other Trauma w Instrumentation • Major Puerperal Infection and Other Major Obstetrical Complications <p>Other Medical and Surgical Complications</p> <ul style="list-style-type: none"> • Post-Hemorrhagic & Other Acute Anemia w Transfusion • Decubitus Ulcer • Encephalopathy |
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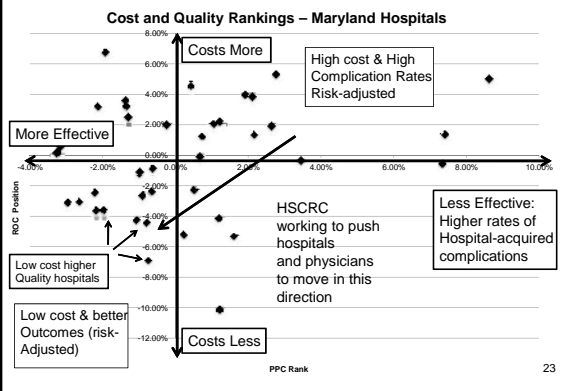
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Back to Concept of Promoting Value per Health \$ Spent



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HSCRC Value Index – Cost/Case & Complications



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Broaden, Strengthen and Align Incentives

- HSCRC successes achieved in narrow framework – Cost per Case growth & achieving social objectives
- Broader Policy Framework can improve performance with an emphasis on promoting overall “Value”
- Current focus: broadening the “unit” of payment to include more services and more providers
- Case-rates bundling hospital and physician payment
- Align incentives across hospital & physicians (gain-sharing)
- Global budgets for sole-county hospitals
- Expanding and Strengthening incentives around Quality

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Back to CEA and Policy Development

- Broadening the Policy Framework should allow for higher levels of overall cost and quality effectiveness (Value per \$ spent)
- Induce broader cost-effective initiatives – Electronic Medical Records & Better Care Coordination
- Should also incentivize hospitals and physicians to employ CEA and other Cost Studies
- Still may be a need for a Cost-Assessment Agency similar to U.K.'s National Institute for Health and Clinical Excellence (NICE) agency
- Not to explicitly make health care rationing decisions (US not ready for that) – but to help guide and promote CEA and ICER activities

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Back to the Future

- Principles associated with CEA been around a while
- Concept of promoting improved efficiency and health outcomes - increasing the overall Value of Health \$s
- We seem to have gone full circle after 33 years
- Weinstein and Skinner, NEJM 2009
"If we can induce hospitals and health plans to improve efficiency and not just cut costs, then health costs in the United States will come down and outcomes will improve."
- Role for Government to apply stronger and broader financial incentives to move us in this direction
- Maryland better positioned to do this than any other State

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