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

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

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

Promoting Value for $ by Intervention

- Costs More
- Costs Less
- More Effective
- Less Effective
- Status quo

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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Combine Cost and Quality Measurement and provide incentives for:

Value for Money Spent
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

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”

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

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

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
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

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8.00
9.00 Had Maryland grown at the more rapid US rate –
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- Had the US grown at the slower Maryland rate of growth -
  hospital spending would have been $40 billion higher

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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

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

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)

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

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
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 $322 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 Re-admissions (PPRs)**
  - Return hospitalizations that may result from deficiencies in the process of care and treatment (readmission for 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).
### 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

### 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