

Rate Setting for Health Services: A “Radical” Proposal or A Proven Way to Control Healthcare Costs?

On February 16, 2018, California State Assembly Member Ash Kalra introduced Assembly Bill 3087 – The Health Care Price Relief Act, which calls for a commission to set uniform rates for medical providers, including hospitals and physicians, for the private-insurance market. The bill sets the floor for payment at the Medicare rate and places the onus on providers to apply for adjustments to the base amount.[\[1\]](#) AB 3087 advanced out of committee on April 25, 2018, but faces fierce opposition from doctors and hospitals, among other groups.[\[2\]](#) In this post, The Source explores whether the bill is as “radical” as the California Medical Association (CMA) [claims](#) or built upon an existing rate-setting program in Maryland. This post further details how California could adopt a program similar to Maryland’s using lessons from that state’s long experience in rate setting for hospital services.

Maryland’s All-Payer Approach Sets Rates for All Hospital Services

For more than forty years, Maryland has set a standardized reimbursement rate for all hospitals in the state. In 1971, the Maryland legislature established the Maryland All-Payer Model. Under the Model, a state agency sets a single rate that all health care payers –public and private– pay for inpatient and outpatient hospital services.[\[3\]](#) Beginning in 1974, the year the law took effect, the Health Services Cost Review Commission (HSCRC) of Maryland, an independent state agency, set reimbursement rates for all inpatient, hospital-based outpatient, and emergency services at all forty-seven of Maryland’s general acute hospitals.[\[4\]](#)

When establishing the HSCRC, the legislature “articulated four key rate-setting principles: efficiency, access for all, equity among payers and solvency for all efficient and effective hospitals.”[\[5\]](#) The legislature also recognized that the free market failed to meet those four principles and instructed the commission to

approve rates that reflect underlying costs and facilitate more-efficient and equitable resource allocation. The legislature, however, did not specify how the commission was to set rates and gave the HSCRC flexibility in setting rates that were consistent with the legislature's intent. As a result, the HSCRC created financial incentives (bundled payment structures, variable and fixed cost adjustments, and incentives for improved quality) to follow that mandate.

The results of the first decades of the Maryland all-payer system were impressive. Before the implementation of the rate-setting system, Maryland's hospital costs per admission were 23.6% above the national average. By 2005, it had fallen significantly to 5.1% below the national average. In a Health Affairs Blog in 2009, Robert Murray called Maryland's rate-setting system "one of the most enduring and successful cost containment programs in the United States."[\[6\]](#) Furthermore, Maryland's system nearly eliminated cost-shifting, whereby hospitals charge privately insured patients more than their care costs, in order to cover the cost of caring for uninsured persons or persons covered by public programs. A 2006 report by the HSCRC claimed the performance of the all-payer program "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."⁵

Revisions to Maryland's Program: All-Payer Global Hospital Budgeting

Most experts agreed on the success of Maryland's all-payer rate setting model, but many still recognized that its reliance on a fee-for-service reimbursement model still forced hospitals to keep their beds filled in order to generate revenue. Rural hospitals felt this pressure most acutely, so in 2010, Maryland launched a pilot program to give 10 rural hospitals a global budget. Under this program, hospitals receive guaranteed revenue for the coming year regardless of the number of inpatients or emergency room visits in that year. As a result, hospitals can invest in community and preventative services for which they could not be reimbursed under the previous system.[\[7\]](#)

The success of this program led Maryland to negotiate a waiver with the Centers for Medicaid and Medicare Services (CMS) Innovation Center to revise its all-payer rate setting system to include global budgets for all hospitals in the state beginning in 2014.[\[8\]](#) Together, they set quality goals and capped the increase in hospital revenues, setting a population-based (per capita) budget limit for hospital services for all state residents and all payers.[\[9\]](#) Under the agreement with CMS, Maryland must limit per-capita hospital expenditure growth to below 3.58% per year[\[10\]](#) and annual growth of Medicare's per capita hospital costs to 0.5%, with the goal of saving Medicare at least \$330 million over 5 years.[\[11\]](#)

Success of Maryland's Global Budgeting Program

As a result of the CMS waiver, every hospital in Maryland now operates with a global budget that covers, at the minimum, all state residents.[\[12\]](#) Although patients and payers still receive a bill for services provided, the total revenue a hospital receives does not depend on the volume of care. As a result, hospitals have a strong incentive to reduce unnecessary hospitalizations and many have invested in care coordination and management with additional support for patients with chronic conditions. Global budgets further allow hospitals to benefit financially from investments in preventative care and in programs that improve the health of the community. As a result, Maryland has taken an active role in supporting the transformation of the delivery system. For example, hospitals can use information collected by Maryland's health information exchange, the Chesapeake Regional Information System for Our Patients (CRISP), to better track and manage patients. Real-time information and alerts allow hospitals and primary care physicians to better understand how patients utilize hospitals, including emergency departments, and allow providers to adopt cost-effective alternatives and focus on preventing expensive hospitalizations when possible.[\[13\]](#)

In the first two years of the global budgeting program, an independent evaluation paid for by CMS estimated that the program saved Medicare \$679 million during the first 3 years of the program.[\[14\]](#) Based on the early success of the program, Maryland submitted a progression plan to CMS that details the state's intention to

expand its value-based incentives beyond hospitals to all providers, with a specific emphasis on the delivery of primary care including a Maryland Comprehensive Primary Care Model.[\[15\]](#) The progression plan includes geographic value-based incentives that give providers local accountability and control over individual health outcomes and population health. For example, if total costs in the service area are below the target, the hospital would receive a financial bonus, but if total costs in the service area are above the target, the additional costs would come from the hospital's global budget revenue. The details of the program are still under consideration, including how Maryland will serve dual-eligible individuals – those that are eligible for both Medicare and Medicaid. Nonetheless, the plan signifies Maryland's commitment to expanding and refining its all-payer program to provide quality care to all state residents.

California's Proposed Adoption of an All-Payer Model

In light of Maryland's success, it is reasonable to ask why Maryland remains the only state with an all-payer rate setting model.[\[16\]](#) Politics and intense lobbying by providers against rate-setting dictated that, until recently, no state could adopt a similar program. In 2017, however, Vermont began an All-Payer ACO model with CMS.[\[17\]](#) The Vermont ACO will be voluntary, but the state will encourage participation so that it includes 70 percent of all Vermont insured residents, including 90 percent of Vermont Medicare beneficiaries. Also in 2017, Pennsylvania obtained a CMS waiver to implement global budgeting, similar to the Maryland program, for 30 rural hospitals.[\[18\]](#) In the 2018 legislative session, California also moved down the path toward all-payer reimbursement with AB 3087.

Three major differences between the proposed system in California and the existing one in Maryland, however, mean that if AB 3087 is passed, it is unlikely to enjoy the success of Maryland's program. First, the California proposal includes all provider services from "an allergy test to heart bypass surgery,"[\[19\]](#) not just hospital services. Consequently, the bill would set rates on a fee-for-service basis instead of value-based reimbursement, which is becoming more popular with private insurance. Maryland addressed this problem with global budgets for hospital

services, but it is difficult to see how California could adopt global budgets for all providers. Through the Progression Plan submitted to CMS, Maryland is exploring options to expand global budgets to more providers, but details of these plans are still being determined.[\[20\]](#) California's proposal lacks any value-based incentives like the ones used in Maryland. By ignoring the experience in Maryland, AB 3087 is unlikely to lower healthcare costs because it incentivizes providers to provide more services to compensate for income lost from lower reimbursement rates.

The second significant difference between the California proposal and the Maryland model is that California's rate setting program would apply only to private insurance. As a result, the California program does not require Medicaid waivers or integration with the Medicare program. In addition, California's program does not address cost-shifting problems because, unlike in Maryland, the reimbursement rate for patients covered by public programs would differ from those with private insurance. One of the core tenets of Maryland's system was equity for payers and patients, and any system that values such equity must ensure that all payers are included in the rate-setting program.

Finally, the two systems differ in the intent of the regulation. Maryland's all-payer model arose from the insolvency of some hospitals, especially rural ones, that provided a large amount of uncompensated care. The Maryland legislature had three stated goals: to constrain hospital cost growth, to ensure that hospitals would have the financial ability to provide efficient, high quality services to all Marylanders, and to increase the equity of hospital financing.[\[21\]](#) In California, however, AB 3087 states that "the chief cause of high health care spending in the United States is high prices" and seeks "to regulate the cost of health care by regulating health care prices for health plans, hospitals, physicians, physician groups, and other health care cost drivers." [\[22\]](#) Although AB 3087 says that it will ensure "fair reimbursement rates ...reducing health disparities among Californians," [\[23\]](#) it appears to prioritize cost containment over ensuring hospital solvency, especially for safety-net hospitals. As a result, the California Hospital Association projects that the legislation, which would base prices on what Medicare pays, would cost the state's hospitals at least \$18 billion a year in revenue, and about 175,000 health care workers could lose their jobs.[\[24\]](#)

What California Should Learn From Maryland's Experience

California's Health Care Price Relief Act, AB 3087, reflects the desire of California legislators to provide its residents with lower health care costs. While AB 3087 represents a valiant attempt by lawmakers to address rising health care costs in California, it has significant limitations and challenges. Legislators face [strong opposition](#) to the bill from providers, including 92 percent of the California physicians surveyed.[\[25\]](#) Beyond political difficulties, AB 3087 likely threatens safety-net hospitals. Because the bill does not include MediCal (California's Medicaid) and caps the amount that private insurers will pay, hospitals that serve many MediCal beneficiaries will likely see their revenue drop. California needs to learn from Maryland's program to more equitably distribute the cost of uncompensated care and medical training among hospitals.

Furthermore, any state attempts to control costs needs to recognize the shortage of primary care physicians, especially in rural and poorer communities. Only 36 percent of California's physicians practice primary care, and a [2017 report](#) by researchers at the University of California, San Francisco details how California is likely to face a state-wide shortage of primary care providers in the next 15 years, especially in the Central Valley and Central Coast region and the Southern Border region.[\[26\]](#) If Californian legislators want to consider an all-payer rate setting model, they need to work with providers to acknowledge the difficulties primary care providers face and find ways to include them in the rate-setting process.

Maryland's experience with the all-payer rate setting model over the last forty years has demonstrated that all-payer models can be an effective tool in addressing health care costs. When considering policies to control costs, however, states must address more fundamental issues of access to primary care and fee-for-service versus population-based or value-based reimbursement. Maryland's state legislature gave the HSCRC flexibility in setting rates when it first created the all-payer model and then modified the program when it recognized that its reliance on fee-for-service should be revised to incorporate global budgeting for hospitals. As more states seek legislative solutions to rising health care costs, California has the potential to

become a leader in this movement, but it must incorporate lessons from states like Maryland and more closely model its legislation after Maryland's programs to ensure that it doesn't unintentionally decrease access for the state's most vulnerable populations.

[1] AB 3087 § 100625.

[2] California Medical Association. **California Health Care Community Condemns AB 3087**. Press Release April 24, 2018. Available from: <http://www.cmanet.org/news/press-detail/?article=california-health-care-community-condemns-ab>.

[3] Rajkumar R, Patel A, Murphy K, Colmers JM, Blum JD, Conway PH, et al. **Maryland's All-Payer Approach to Delivery-System Reform**. *New Engl. J. Med.* 2014;370(6):493-5.

[4] HSCRC also sets rates for three specialty, and three private psychiatric hospitals in Maryland with regulated revenue in excess of \$13 billion annually. See Murray 2009.

[5] Cohen HA. **Maryland's All-Payer Hospital Payment System**. Available from the HSCRC website at: <http://www.hscrc.state.md.us/Documents/pdr/GeneralInformation/MarylandAll-PayerHospitalSystem.pdf>.

[6] Murray R. **Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience**. *Health Affairs (Millwood)* 2009; 28:1395-1405. Available from: <https://www.healthaffairs-org.ucsf.idm.oclc.org/doi/full/10.1377/hlthaff.28.5.1395>

[7] Sharfstein JM, Gerovich S, Moriarty E, and Chin D. **An Emerging Approach to Payment Reform: All-Payer Global Budgets for Large Safety-Net Hospital Systems**. *The Commonwealth Fund*. August 2017. Available

from: <http://www.commonwealthfund.org/publications/fund-reports/2017/aug/payme nt-reform-all-payer-global-budgets-hospital>.

[8] Murray R. **Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience.** *Health Affairs (Millwood)* 2009; 28:1395-1405. Available from: <https://www.healthaffairs-org.ucsf.idm.oclc.org/doi/full/10.1377/hlthaff.28.5.1395>.

[9] Sharfstein JM, Kinzer D, Colmers JM. **An Update on Maryland's All-Payer Approach to Reforming the Delivery of Health Care.** *JAMA Intern Med.* 2015;175(7):1083-1084. doi:10.1001/jamainternmed.2015.1616.

[10] The 10-year compound annual growth rate of the per capita gross state product.

[11] Rajkumar 2014.

[12] Many hospitals have global budgets that also include out-of-state residents (approximately 1 in 10 patients in MD hospitals), but that is not required. See Sharfstein 2015.

[13] Sharfstein 2015.

[14] Haber S, Beil H, Amico P, et al. **Evaluation of the Maryland all-payer model: third annual report.** Marv h 2018. Available from the HSCRC website at: <http://www.hscrc.state.md.us/Documents/Modernization/md-all-payer-thirdannrpt.pdf>.

[15] Maryland Department of Health and Mental Hygiene. **The Maryland All-Payer Model Progression Plan.** December 16, 2016. Available from the HSCRC website at: <http://www.hscrc.state.md.us/documents/md-maphs/pr/Maryland-All-Payer-Model-Progression-Plan.pdf>.

[16] Dayen D. **Single Payer, Meet All Payer: The Surprising State That Is Quietly Revolutionizing Health Care.** *The Intercept.* July 24, 2017. <https://theintercept.com/2017/07/24/single-payer-meet-all-payer-the-surprising-state-that-is-quietly-revolutionizing-healthcare/>

[17] **Vermont All-Payer ACO Model.** CMS.gov. <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/index.html>.

[18] **Pennsylvania Rural Health Model.** CMS.gov, <https://innovation.cms.gov/initiatives/pa-rural-health-model>.

[19] Associated Press. **California Bill Would Create Healthcare Price Controls.** *Modern Healthcare*. April 10, 2018. Available from: http://www.modernhealthcare.com/article/20180410/NEWS/180419998?utm_source=modernhealthcare&utm_medium=email&utm_content=20180410-NEWS-180419998&utm_campaign=am.

[20] Maryland Department of Health and Mental Hygiene. **The Maryland All-Payer Model Progression Plan.** December 16, 2016. Available from the HSCRC website at: <http://www.hscrc.state.md.us/documents/md-maphs/pr/Maryland-All-Payer-Model-Progression-Plan.pdf>.

[21] Cohen HA.

[22] AB 3087 §100600(c).

[23] AB 3087 §100600(e).

[24] California Hospital Association. **California Hospitals Overwhelmingly Oppose AB 3087.** Media statement. April 10, 2018. Available from: <https://www.calhospital.org/cha-news-article/california-hospitals-overwhelmingly-oppose-ab-3087>.

[25] California Medical Association. **California Health Care Community Condemns AB 3087.** Press Release April 24, 2018. Available from: <http://www.cmanet.org/news/press-detail/?article=california-health-care-community-condemns-ab>.

[26] Spetz J, Coffman J, Geyn I. **California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030.** August 15, 2017. Available

from: <https://healthforce.ucsf.edu/publications/californias-primary-care-workforce-forecasted-supply-demand-and-pipeline-trainees-2016>.