

Rate-Setting

Potential Recommendation for the Colorado Commission on Affordable Health Care

APRIL 11, 2016

Defining Rate-Setting and Global Budgets

Rate-setting: Rate-setting programs are operated by established commissions that set limits on the rates paid to hospitals. Rate setting programs can include all payers or a subset of payers.

Global budgets: These are one variation of rate-setting that set an annual and prospective budget that hospitals receive from payers. The budget can be adjusted annually to take into account population and demographic changes.

Potential Recommendations

Two options:

1. Conduct a study on traditional rate-setting.
2. Conduct a study on global budgets for all payers (Maryland).

Original Commission Recommendation

Presentation from Carmela Coyle of Maryland.

Evidence Basis

Hospital rate-setting started in the late 1960s and early 1970s with at least 27 states implementing programs to either review or directly regulate hospital rates and budgets. Results from a study of the states that implemented rate-setting in the 1970s found that state rate-setting was successful in controlling the rate of increase in per-admission costs in most of the states where it was implemented.¹ However, many states have faced challenges in controlling the volume of services rendered.

State Examples

Maryland and West Virginia are the two remaining states that implement rate-setting. West Virginia sets

rates for all nongovernmental payers. Maryland began rate-setting for all payers in 1974 and ran the program in that way until 2014. In 2014, the program was at risk of losing its Medicare waiver because it had loosened volume controls and was in danger of exceeding the requirements of the waiver. In order to maintain its waiver, Maryland implemented a new methodology beginning on January 1, 2014.

In this new phase of rate-setting, Maryland prospectively sets the budgets for hospitals every year. Because that budget is not affected by the volume of services provided during a given year, there is no incentive for hospitals to provide more volume to bring in more money. As part of the waiver it negotiated with CMS, per capita hospital revenue cannot increase by more than 3.58 percent a year, and per capita Medicare hospital spending must be at least 0.5 percent below the national growth rate.

According to the Maryland Hospital Association, during 2014 all-payer hospital spending growth per capita stood at 1.47 percent, lower than the targeted 3.58 percent. The hospital acquired conditions rate also improved at a better than anticipated rate. However, the hospitals did not meet their Medicare readmissions rate target. The target was a decrease of 0.95 percent or more, but the 2014 decrease came in at 0.70 percent.²

Notes

- 1 http://www.commonwealthfund.org/~media/files/publications/issue-brief/2009/oct/1332_atkinson_state_hospital_ratesetting_revisited_1015.pdf
- 2 <https://www.colorado.gov/pacific/sites/default/files/Colorado%20Commission%20on%20Affordable%20Health%20Care%20-%20February%208%202016.pdf>