Case Study on the Maryland Hospital Regulatory Experience – Looking Beyond DRGs

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Background

In the United States, there are three major categories of health care payers: 1) the Medicare program, which is a federal governmental program that insures elderly patients (age greater than 64) and pays hospitals based on a pre-set fee schedule (using fixed DRG rates for inpatient care); 2) State-based Medicaid programs which insure poor citizens and are administered by each state's Medicaid department and financed partly by state and federal revenues. Medicaid programs also pay hospitals based on a pre-set fee schedule (also largely on a DRG basis for inpatient care); and 3) Commercial Insurers, who insure the beneficiaries who work at large and medium-sized companies and also individuals insured on the recently developed health insurance exchanges (Obama Care), must negotiate the rates they pay hospitals each year.

Health care providers in the U.S. are generally consolidated into large health systems that own a number of hospitals and many physicians. These health systems use their market leverage to negotiate relatively high payment rates from commercial insurers.

Because of these market dynamics (i.e., two large governmental payers paying a pre-set fee schedule and negotiated rates paid by commercial payers) each of these major payers pays hospitals at different levels (e.g., Medicare pays about 88% of hospital costs, Medicaid pays about 90% of hospital costs and commercial insurers pay about 140% of hospital costs). Clearly, this system is highly inequitable.

State-Based Rate Setting

State-based hospital rate setting was popular in the United States in the 1970s and 1980s. Maryland was one of five states (and the only remaining state) to implement what is referred to as an All Payer hospital rate setting system (i.e., applicable to Medicare, Medicaid and Commercial Insurers). In order to implement an All Payer system, a state needed to receive a "Waiver" (exemption) from the Medicare and Medicaid payment systems and a state law that required commercial insurers to pay the rates established by the rate setting agency. Maryland implemented this system in an effort to develop local solutions to the problems of the health care sector, with the following policy goals: 1) control costs; 2) improve access to care; 3) improve payment equity across payers; 4) improve transparency and accountability; and 5) ensure the solvency of efficient and effective hospitals.

The state of Maryland has 50 acute care hospitals. These include two large urban Academic Medical Centers, 17 rural hospitals, 18 suburban hospitals and 13 additional urban hospitals with about $16 billion in annual revenue. Sixty percent of this revenue is for inpatient services and forty percent is for outpatient services. Hospital revenues account for about 36% of total health care spending in the state.

The hospital rate setting agency in Maryland, the Health Services Cost Review Commission (HSCRC), is a small governmental body, with approximately 30 professional staff (health executives, health economists, accountants and researchers), with broad legal authority to set and enforce hospital rates, collect data and experiment with payment design. Maryland was the first jurisdiction to use DRGs to set hospital rates in 1977. This system also included the use of a "Volume Adjustment System" which adjusted DRG rates to remove excess marginal revenues over marginal cost, when volumes were growing. This system also covered

hospital fixed costs as volumes declined. The HSCRC implemented this system to offset financial incentives for hospitals to unnecessarily grow volumes.

Removal of the Volume Adjustment System and Large Volume Increases

This system operated very effectively to constrain the growth in hospital cost per case and also neutralize hospital incentives to unnecessarily grow volumes over the period 1977-1990. After 1990, the HSCRC weakened and eventually eliminated the incentives of the Volume Adjustment System. In response to these changes, Maryland hospitals greatly increased their admissions and outpatient volumes (2001-2008). This growth in volumes greatly undermined the overall cost effectiveness of the Maryland system (i.e., Maryland hospital cost per capita increased rapidly).

In response, the HSCRC implemented a series of payment reforms that emphasized more bundled and fixed payment structures. Payment structures that bundle more services transfer more financial risk from payers to providers and create stronger incentives for cost control. Starting in 2008 the HSCRC implemented the following payment reforms: 1) pilot Global Budgets for 10 isolated rural hospitals; 2) bundled admission-readmission payment for other hospitals; 3) reinstitution of the Volume Adjustment System; 4) the implementation of a number of Pay-for-Performance initiatives that provided incremental incentives to improve quality of care.

New Model Waiver Agreement with the Federal Government – Global Budgets

Following the passage of health reform nationally, Maryland persuaded the US Department of Health and Human Services (HHS) to approve a new Medicare Waiver agreement, but one based on controlling the growth of per capita hospital expenditures, instead of the old waiver which was based on controlling growth in the cost per hospital case. Per this new agreement, Maryland was required to place all 50 hospitals under Global Budgets and meet various per capita spending and quality targets. The first phase of this new Model started in Calendar Year (CY) 2014 and is scheduled to end in CY 2018.

Hospital Global Budgets have the following key features and characteristics: 1) they provide a hospital with a fixed amount of revenue for a year regardless of the number of patients treated; 2) they are associated with an identified "Reference Population" (for rural and isolated hospitals it is easy to identify this population; they are the patients that reside in the patient service are and primarily use the Global Budget hospital for care); 3) the base year budget is usually based on a hospital's historical costs and revenue; 4) these base year budgets are trend by an inflation factor to the first Performance year of the Global Budget; 5) a hospital's Global Budget is subsequently adjusted forward year to year based on an inflation proxy of hospital input costs and for any demographic change of its patient population (i.e., change in the number of residents or the aging of residents – both circumstances impact the demand for hospital services of the reference population); 6) the rate agency must have the authority to enforce Compliance with the Global Budget; and 7) the rate agency may wish to exclude certain services from the Global Budget and/or apply an aggregate stop loss for a hospital if there is concern that the hospital is too small to assume the financial risk under a Global Budget.

Global Budgets are relatively easy for a rate agency to administer. They provide hospitals with a fixed guaranteed revenue stream. They also contain very strong incentives for cost control. They usually apply only to hospital facility charges, however, can be extended to hospital-based physicians or other non-hospital services if these services fall under the umbrella of a hospital's ownership or control. Global Budgets also create incentives for hospitals to reduce the quality of care or "stint" on care. Thus, it is important for the

rate agency to supplement Global Budgets with a series of Pay-for-Performance programs that provide incremental incentives for the hospital to improve or maintain quality of care and patient satisfaction.

Results and Implications of the Maryland Hospital Global Budget Model 2014-2018

Over the five years of the New Global Budget Model, Maryland has been meeting most all of its financial and quality related targets and requirements during this first phase of the Model. However, the model did not produce significant savings for the federal government (only 1.7% savings over five years). Also, there was some evidence that care migrated out of the hospital to non-hospital setting so that while the state met it's targets on hospital cost growth, it missed its targets on the growth of "Total Cost of Care" (which includes both hospital and non-hospital care).

Performance on quality and utilization was mixed. The State met its reduction targets for its rate of readmissions and frequency of Hospital Acquired Conditions. However, overall hospital utilization did not decline (it merely remained flat), emergency department wait times increased and patient satisfaction eroded during the course of the Model. The results of other quality metrics (clinical care and patient safety measures) were also mixed.

Additionally, some hospitals in urban and suburban areas (with overlapping service areas and reference populations) became dissatisfied with the Global Budget Model because the Global Budgets were too rigid and did not adjust adequately for shifts in patients from one hospital to another. The largest commercial insurers in the area (Blue Cross of Maryland and Kaiser Permanente) but provided incentives to primary care physicians to shift volumes from high cost, low quality hospitals to low cost, high quality hospitals. These higher "value" hospitals thus were disadvantaged under their fixed Global Budgets when they received more patients. The two large Academic Medical Centers in the state also because dissatisfied with Global Budgets because they found these fixed Budgets restricted their ability to adopt new medical technologies.

Finally, there was disappointment regarding the inability of Maryland hospitals to substantially reduce volumes of care. The U.S. and Maryland health care sectors are characterized by between 20-30% of unnecessary or marginal care. Thus, it was thought that when facing the very strong incentives implicit in Global Budgets to cut volumes, Maryland hospitals would respond aggressively by implementing initiatives to reduce admissions, unnecessary tests, imaging and procedures. This reduction in volume did not materialize, however. The absence of concerted efforts to reduce unnecessary volumes may have been a function of two circumstances: 1) the rate setting agency provided hospitals with very generous annual revenue updates to their Global Budgets and hospital profitability increased greatly from 2014 - 2018. It could be that hospital managers had little reason to reduce cost and volumes (in order to improve their financial situation) when profit margins were already at all-time high levels; and 2) hospital managers appeared reluctant to aggressively cut unnecessary or marginal admissions, tests and procedures because this would tend to erode the incomes of specialists practicing at the hospital, who were still paid on a fee-for-service basis.

Implications from the Maryland Experience for Other Jurisdictions

Based on this experience, we put forth the following potential implications for jurisdictions considering the observations and implementation of Hospital Global Budgets:

- Global Budgets are best administered by some regional or governmental entity with enforcement authority;

- They contain very strong incentives to reduce unnecessary volumes and eliminate waste and are easy to administer (particularly relative to a DRG payment system which requires more detailed and extensive data collection, monitoring and compliance activity);
- However, it is important to keep overall system revenue restricted in order to meet overall cost goals of the jurisdiction and to provide strong incentives for hospitals to manage care and reduce waste;
- Global Budgets are most effective and easiest to administer if they apply to an identified "Reference Population" (i.e., they work best in Isolated regions);
- Global Budgets for hospitals with overlapping service areas may create problems when patients move (or are shifted by payers) from hospital to hospital; However, a Global Budget was applied successfully Regionally in Rochester NY for a group of Urban/Suburban hospitals;
- Strong Quality-Based Incremental Incentive (P4P) Programs are required to offset tendency to reduce quality or restrict care;
- One alternative approach is a Hybrid System of Global Budgets for rural hospitals and DRGs with a Volume Adjustment System for other hospitals, until regional Global Budgets can be developed;
- Jurisdictions may also face challenges in extending Global Budgets to non-hospital services unless hospitals are able to control most non-hospital services in their area. Another Demonstration in the U.S. in the State of Vermont is attempting to place hospitals under Global Budgets that cover the "Total Cost of Care" (i.e., both hospital and non-hospital services). This Demonstration could provide additional lessons for jurisdictions looking to implement more expanded Global Budgets.