

Maryland's New Global Budgets for Hospitals: Testing the Incentive Effect of Volume Controls

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How does Maryland's new global budget model for hospitals incentivize lower expenditure growth and higher quality of care?

- Hospital global budgets provide rewards for meeting annual expenditure benchmarks and penalties for not meeting the benchmarks.
- Quality programs offer rewards for meeting quality of care standards and penalties for not meeting the standards.
- Future iterations of the global budget model will include physician payment.

In 2014, Maryland established global budgets for all hospitals in the state, building on the state's 40-year tradition of stimulating continued interest among health care policymakers and researchers by operating the nation's only all-payer rate setting health care system. In contrast, hospital Medicare payments in all other U.S. states are governed by the national Inpatient Prospective Payment System (IPPS).

Maryland's new global budgets are designed to shift hospitals' incentives away from volume-based revenue growth and toward a system in which hospitals are penalized or rewarded, respectively, for overall expenditure growth above or below a set statutory rate. The model also provides incentives to maintain or improve quality of care, health outcomes, and population health. (For detail on Maryland's new model, see Rajkumar et al.¹) This shift in incentives aims to create healthier communities while slowing the overall growth rate of health care expenditures.

Slowing the health care expenditure growth rate is a major condition of Maryland's exemption from the IPPS, which is granted by the Centers for Medicare & Medicaid Services (CMS). Under the exemption, the state is required to keep cumulative per capita total hospital cost growth in Medicare below the national growth level; consequently returning \$330 million in savings to Medicare over 5 years. Maryland's immediate policy expectation is to reduce the provision of unnecessary hospital care and to shift the focus away from increasing volume and toward improving the general health of the population.

To understand the effects of Maryland's new payment incentive model, RTI is conducting a rigorous evaluation of this CMS-funded 5-year demonstration program. This issue brief examines Maryland's incentives for decreasing cost and improving the quality of care, provides an overview of RTI's evaluation, and looks at the planned future extensions of the Maryland model.

Controlling Costs

Designed to control costs through prospectively defined constraints on per-admission spending, the Medicare IPPS is a prospective payment mechanism intended to limit the financial incentive for hospitals to increase testing, procedures, length of stay, and overall intensity of services where unwarranted for a particular patient. However, the IPPS places no limits on the total revenue a hospital can generate from Medicare patients, giving hospitals an unintended incentive to increase their revenue stream by, for example, increasing admissions among patients who could potentially be treated in a less intensive setting.

The Maryland model, in contrast, seeks to reverse the trend of volume-driven growth—which is occurring not only in Maryland but nationwide—by incorporating direct limits on hospitals' overall revenues through annually established global budgets. Global budgets are established for each hospital based on a fixed rate per unit of service (such as patient days) for a wide range of services (such as medical-surgical acute services) using the hospital's historic utilization and expenditures. These budgets include adjustments for inflation, changes in market share and population demographics, quality performance, uncompensated care trends, and expected reductions in unnecessary utilization. Hospitals bill all payers on a per-service basis using their assigned rates.

Future year budgets for hospitals will be reduced if their revenues in the current year are more than one half of 1% over their established budget. To protect quality of care, future hospital budgets will also be reduced if total revenues fall below their global budgets by more than one half of 1%.

Clinical and administrative responses by hospitals to these incentives may vary. Some hospitals may decrease the need for hospital services by working to improve the general health of their specified communities. Other hospitals may work to achieve global budget targets more directly through increased care coordination and case management, improved patient education, and shifting care, where appropriate, to less expensive settings such as outpatient clinics.

Because Maryland's hospital growth targets are set for all payers, hospitals are incentivized to limit volume and expenditure growth not only for Medicare patients but also for Medicaid and privately insured patients. Consequently, policymakers can expect to see two major differences between Maryland and the rest of the country:

- In addition to changes anticipated for Medicare beneficiaries, per-admission cost trends for Medicaid and privately insured beneficiaries may diverge substantially from their respective national trends.
- Although hospitals under the IPPS have incentives to increase overall volume, they have a stronger incentive than hospitals under Maryland's new payment system to control admission-level intensity. This could result in admitted patients being sicker, on average, in Maryland than elsewhere in the nation, given the incentives to lower global costs by reducing lower-acuity hospital admissions. This, in turn, could lead to an increase in per-admission expenditures in Maryland compared with those nationwide, even if hospitals stay within their established budgets.

The impact of the global budget constraint also depends on the level at which budgets are set. The intent of the policy is to set the budgets at levels where hospitals can maintain quality of care while implementing cost-saving strategies. If the budgets are set too high, overall hospital expenditure growth may be no less than, and could be more than, growth under the IPPS. Conversely, budget limits set too low may force restrictions in hospital services that lead to lower quality of care.

Maintaining Quality

As part of the Affordable Care Act, the Medicare IPPS incorporated incentives for hospitals to meet quality benchmarks defined under CMS' value-based purchasing (VBP) program beginning in October 2012. These incentives include payments for reducing hospital readmissions and hospital-acquired conditions, among others.

Maryland is still required to meet national Medicare performance standards; however, its IPPS waiver grants the state flexibility to experiment with alternative designs. The IPPS relies mostly on penalties if hospitals do not achieve designated quality-of-care standards, whereas Maryland has adopted an approach that also enables hospitals to earn savings. Maryland's quality improvement incentives also apply to all payers rather than solely to Medicare patients, broadening the impact of the incentives across the entire health system. This could prove to be a key differentiator determining the success or failure of the Maryland model.

Reducing Readmissions

The IPPS readmissions provision is condition-specific and applies only to Medicare patients. CMS penalizes

hospitals up to 3% of Medicare revenues for excess readmissions. Providers cannot earn a bonus for reducing readmissions.

The Maryland Readmissions Reduction Incentive Program, in contrast, is not condition-specific and applies to all payers. Maryland hospitals that achieve the specified annual reduction are eligible for a bonus, whereas those that do not meet the goal receive a revenue cut. For fiscal year 2017, for example, hospitals can receive up to a 1% revenue increase or up to a 2% revenue reduction.²

Although the possible percentage of revenue at risk is less under the Maryland program than under the IPPS, the IPPS applies only to Medicare patients. Consequently, the Maryland system allows for the aggregate impact of the losses to be greater for hospitals when considering all payers. The combined incentives of the Maryland system's rewards for achieving the readmissions targets and the smaller potential loss exposure may lead Maryland hospitals to focus on reducing readmissions for all patients rather than just for Medicare patients under the IPPS.

Quality-Based Reimbursement

Under the IPPS, value-based purchasing links Medicare payments to improving hospital quality of care based on measures of care processes, outcomes, patient experience, and efficiency of care. In contrast, the Maryland system focuses on improving care processes, patient experience, and mortality. The state's quality-based reimbursement program implements a smaller set of measures than the IPPS VBP program and assigns different weights to specific measure domains, such as placing greater emphasis on patient experience of care. Maryland's payment incentives under the quality-based reimbursement program are similar to the payment incentives in Medicare's VBP program in that both offer hospitals the potential to earn additional payments or to be penalized. Although in principle the two sets of measures may present differing incentives, in reality hospitals are unlikely to differentiate care based solely on different measures while faced with similar financial incentives.

Hospital-Acquired Conditions

The IPPS imposes a payment reduction on hospitals with high rates of hospital-acquired conditions, such as hospital-acquired infections, pressure ulcers, and objects left in the patient during surgery. Under the

IPPS hospital-acquired conditions reduction program, hospitals that fall in the lowest national quartile on four risk-adjusted quality and patient safety measures are paid 99% of what they would have been paid under the IPPS, with no incentives for rates that are better than the national benchmark.

The overarching goal of the Maryland model is to reduce potentially preventable complications by 30% by the end of 2018. The Maryland hospital-acquired conditions program measures performance on a much larger set of potentially preventable complications than the IPPS hospital-acquired conditions reduction program. Low-performing hospitals receive financial penalties, and high-performing hospitals receive financial rewards. As a group, low-performing Maryland hospitals are at risk for up to 3% of revenues in 2015 and 4% of revenues in 2016-2017; high-performing hospitals can receive incentive payments of up to 1% of revenues.³

Evaluating Maryland's Global Budget Model

RTI is in the early phases of a rigorous evaluation of the 5-year demonstration of Maryland's statewide global budget model. The evaluation will assess the impact of the model's incentives on hospital costs and quality of care, comparing Maryland's model against the Medicare IPPS operating in other states, as well as any unintended or spillover effects, such as changes in out-of-state hospitalizations or referral patterns. The evaluation will cover the 5 years of the demonstration period, with interim findings reported to CMS.

Two factors add substantially to the complexity of this impact evaluation: the demonstration is statewide, and Maryland hospitals have never operated under the IPPS. Both factors complicate the analytic task of developing an appropriate method to construct a comparison group to represent how Maryland hospitals would have behaved if the state had been operating under the Medicare IPPS during the evaluation period. To address this challenge, RTI developed a synthetic comparison state based on hospital and market area data in multiple states.

The Maryland model is intended to be an intermediate step to move the state's entire health care delivery system toward a total cost of care payment model with two goals: to stem rising health care costs and to provide patients with the best care by the right provider in the most appropriate setting. One major element lacking in Maryland's current model is that physician

expenditures are not currently covered by the global budget. This creates a misalignment between physician and hospital incentives, which will be addressed under future state plans to incorporate incentives for physicians as well as for hospitals and eventually to bring physician revenues under the global budget cap. The timeline for the inclusion of physicians under the global budget remains unclear; consequently, this will not be examined in the current evaluation.

Overall, the evaluation of these recent policy changes in Maryland will help inform efforts to improve the U.S. health care system as policymakers observe the effect of the incentives and the resulting success or failure of the Maryland model. More broadly, Maryland's experience with this new policy will provide valuable guidance in the nation's continuing effort to control health care costs while achieving better quality of care and healthier people.

References

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RTI10152-062016



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