Cost Containment—Global Budget Caps

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Nelson Sabatini, Joseph Antos, Howard Haft & Donna Kinzer, *Maryland's All-Payer Model—Achievements, Challenges, And Next Steps*, Health Affairs Blog (Jan. 31, 2017).

While the Affordable Care Act has done much to improve access to care—20 million more Americans carry health care insurance as a result of ACA—the Act's ability to contain health care spending is less clear. Accordingly, efforts to identify effective policies for limiting health care costs are critical.

Unfortunately, the experience with many cost-containment strategies has been disappointing. What seems promising in theory may not pan out in practice. That makes a recent review by Nelson Sabatini and colleagues especially worth reading. They highlight a model in Maryland that has shown very encouraging results so far.

As observers have long noted, fee-for-service reimbursement leads physicians and hospitals to provide excessive care. When insurers base pay on the amount of care provided, lots of care will be provided, and much of it will be unnecessary. Public and private insurers have implemented quality-based measures, bundled payments, and other strategies to counter the incentives from fee-for-service reimbursement. As Sabatini et al. discuss, Maryland draws on an important approach common in other countries—global budget caps.

Three years ago, Maryland modified its already innovative policy for payment of hospital bills. For a long time, Maryland had set hospital reimbursement rates that were the same for all payers. Private insurers, Medicare, and Medicaid paid for services at the same rates. While much good came from this approach, hospitals still pushed spending higher by increasing the quantity of services provided. In response, Maryland instituted more quality-based measures for payment. More importantly, Maryland is in the midst of a five-year trial of caps on the total reimbursement each year for the state's hospitals. With a global budget cap, hospitals are forced to become more efficient. If they run up the tab, they'll hit or exceed their budget cap, and will have to eat any losses.

As Sabatini et al. report, hospitals have responded to their new limits in desirable ways. For example, they have worked to prevent the need for hospitalization by expanding their chronic care management programs for diabetes, heart disease, lung disease, and other conditions. They also have provided more support for patients after discharge to smooth the transition to less acute health care facilities or to home and reduce the need to return to the hospital for additional care. Though readmission rates still are higher in Maryland than the national average, the gap has narrowed considerably, to less than half of its previous size.

With the improvements in quality of care have come reductions in costs of care. Maryland's global budget policy caps the growth in hospital revenues to no more than the long-term growth rate of the state's economy, which is 3.58 % per year. Hospitals have come in comfortably below their target each of the three years during which the global budget caps have been in effect, with revenue growing only 0.35 % in 2016, 2.31 % in 2015, and 1.47 % in 2014. (The data for 2016 are partial-year to date, through September 2016.) Thus, while Maryland hoped to save $330 million in Medicare hospital costs over five years, it has already saved Medicare $429 million in spending for inpatient care.

Of course, reducing inpatient spending need not lead to a reduction in overall spending. Care that used to be provided in a hospital might shift to an outpatient setting. Hence, as Sabatini et al. observe, Maryland monitors overall health care spending to make sure its budget caps are truly effective. To some extent, savings in hospital-based care have been offset by increased spending on home health care, the chronic care management that the hospitals provide, and

care at rehabilitation facilities. This increased spending for Medicare patients has totaled $110 million, for a net reduction in Medicare hospital spending of $319 million. To fully judge the effectiveness of Maryland's budget caps, we would need to see data for spending on patients insured privately or by Medicaid.

Global budget caps have much to offer. They bring more predictability to budget planning, they make it harder for providers to evade efforts to contain spending, and they give providers the freedom to decide how they will lower their costs.

There also is good reason to think that budget caps can be implemented without compromising care. Not only is that the experience in Maryland to date, it also is the experience in the European countries that employ budget caps and are able to deliver good quality care at much lower cost than in the United States. It seems that physicians, hospitals and other providers can adjust their manner of practice to their fiscal environment and preserve quality of care even as they reduce the quantity of care delivered.

Since policies that promise much in theory need not pan out in practice, it is critical for policymakers to test their ideas on a trial basis and move forward only after they have been able to demonstrate effectiveness. As Sabatini et al. indicate in their important analysis, the evidence from Maryland's use of hospital budget caps supports more trials with global budget caps in the U.S. health care system. Indeed, Maryland is planning to expand global budgeting beyond the hospital setting.

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