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Market-Share Adjustments Under the New All Payer Demonstration Model

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Introduction: Incentives in Maryland's new hospital payment system

Market-share adjustments are part of a much broader system of incentives under the state's new hospital payment system that seek to encourage some but not all reductions in hospital utilization. The touchstone for distinguishing between reductions that should be encouraged and those that should be discouraged is the Triple Aim. The very first sentence of Governor O'Malley's cover letter to Secretary Sebelius accompanying the state's October 2013 waiver proposal emphasized the Triple Aim. It described Maryland's proposal as:

> "an unprecedented and innovative model to ***improve health care outcomes, enhance patient experiences, and control costs***…"[1]

The state's hospital payment system should thus do the following:

- ***Encourage reductions in hospital utilization that help achieve the Triple Aim.*** Examples include utilization reductions that result from—
  - Fewer hospital-acquired conditions;
  - Fewer rehospitalizations;
  - Fewer initial hospitalizations for ambulatory-care-sensitive conditions;
  - Fewer initial hospitalizations for conditions that can be treated equally effectively in other settings at lower cost; and
  - Providing hospital services at lower cost without compromising patient care.
- ***Discourage reductions in hospital utilization that undermine achievement of the Triple Aim***. Examples include utilization reductions that result from—
  - Prompting low-income and other high-cost patients to seek care elsewhere through marketing strategies, restructuring clinical service lines, inducements in physician contracts, limiting availability of emergency room care, or other measures;
  - Reducing volume or capacity to the point of creating long waiting lists or delays;
  - Underinvesting in new technology or modes of care proven to improve patient health, safety, or quality, some of which could also lower overall health care spending;
  - Structuring a hospital's overall service mix to reduce the volume of high-cost services below the amount needed by patients within the hospital's service area;
  - Reducing total levels of a hospital's medical staff or the quality of affiliated providers to the point of compromising patient care; or
  - Undermining patient care by providing care in settings outside the hospital, when patients would be better served within the hospital; providing lower-cost services within the hospital, when more costly services would better meet patient needs; or delaying the onset of hospitalization for particular patients in ways that place health at risk.

Of course, ethical hospital executives would not condone actions in the latter category. But payment systems should be structured so hospitals that provide good patient care to all in need can do as well or better than their competitors financially. If excellent patient care relies on values trumping financial incentives, achieving the Triple Aim will become unsustainable.

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[1] Letter from Governor Martin O'Malley to the Honorable Kathleen Sebelius, October 11, 2013.

Market-share adjustments within that broader incentive system

A key function of market-share adjustments is to discourage reductions in utilization that harm patient care so clearly that consumers take their business to other hospitals. It is one of several mechanisms for deterring hospitals from reducing utilization in ways that undermine the Triple Aim; other necessary mechanisms include vigorous oversight from HSCRC, publication of data that indicates potential underservice, and channels for effective consumer engagement and redress. But market-share adjustments remain an essential tool for using market forces to encourage hospitals to do a good job serving their customers, lest consumers take their business elsewhere, and hospitals soon find their global budgets diminished.

This analysis has several implications:

- Market share adjustments should be done retrospectively, based on a showing that, within a shared service area, one hospital has lost business to another.
- If one hospital increases production without another losing production, the former does not get a market share adjustment. Put differently, these adjustments involve demand moving from one hospital to another, not a hospital creating or addressing new demand for care.

Of course, market share analysis must take into account demographic changes. The following hypothetical illustrates one way this could be done:

- Last year the only hospitals in their area, A and B, served 40 and 60 patients, respectively.
- If they retained the same market share, demographic changes would increase each hospital's caseload by 25 percent, to 50 and 75 patients for this year—125 patients in total.
- In fact, this year A and B serve 45 and 90 patients, respectively. B's increase from 60 to 90 patients can thus be divided into three parts:
    - B's increase from 60 patients last year to 75 this year reflects demographic changes in B's service area and so is presumably included within B's rebased global budget.
    - Based on demographic changes, 125 patients would have been hospitalized in the area. A served 45, so B would have served 80. A's increase from 75 to 80 patients thus reflects a market shift from hospital A and so can lead to a market-share adjustment for B.
    - B's final increase from 80 to 90 patients results from new demand for hospital care, not a market shift from A. This increase cannot qualify for a market-share adjustment.

Calculating market-share adjustments

Avoiding incentives for overutilization that undermines the Triple Aim

Structured poorly, market-share adjustments could penalize rather than reward hospitals for reducing utilization in ways that achieve the Triple Aim. For example, a hospital that cut the prevalence of hospital-acquired conditions could see some of its global budget redirected towards nearby hospitals where similar conditions became more frequent. To prevent such untoward results, market-share adjustments should be based on utilization calculated without considering hospital-acquired conditions.

With rehospitalization, this issue is more complex. Unlike hospital-acquired conditions, rehospitalization levels are not entirely within a hospital's control. Socioeconomic status also

plays an important role. As a result, simply subtracting rehospitalization levels from utilization could let a hospital qualify for upward market-share adjustments by keeping total caseload constant and taking steps to improve the socioeconomic status of its patients. As noted by a recent draft report from the National Quality Forum:

> "Readmissions are difficult to avoid, for example, in patients who can't afford post-discharge medications, have no social support to help with recovery at home, have no way to get to follow-up doctor appointments, or are homeless…. [F]ailing to account for the greater difficulty in achieving good outcomes in socially and economically disadvantaged populations could set up a series of adverse feedback loops that result in a 'downward spiral' of access and quality for those populations…. [P]roviders will have a strong incentive to avoid serving disadvantaged populations, so as to avoid being labeled as a 'bad performer.' This could happen based on where physicians and other individual providers choose to work, where facilities are opened or closed, or expanded or contracted, and through more subtle ways of 'cherry picking.'"[2]

A three-part policy could address these mixed causes of rehospitalization. First, because a hospital's clinical interventions with its patients, both before and after discharge, can influence rehospitalization rates, rehospitalizations should be subtracted from utilization in determining market-share adjustments. Second, rehospitalization incentives should be risk-adjusted for socioeconomic status, as suggested by the broad consensus of expert opinion reflected in the draft report from the National Quality Forum, referenced above. Third, hospitals should be deterred from using improvements in their patients' socioeconomic mix to lower their rehospitalization rates and qualifying for market-share increases. As one approach to this goal, reductions in a hospital's combined Medicaid and uninsured caseload could be subtracted from any market-share increase otherwise claimable by a hospital.

Another issue to consider in defining market-share adjustments involves efficiency. Changed hospital expenditures that reflect efficiency losses or gains should not be confused with alterations to market share. Market-share changes should be analyzed based on the *number of consumers* seeking a certain level of hospital care—perhaps using APR-DRGs as the unit of measurement in the case of inpatient care, for example—rather than *expenditure* changes. Otherwise, hospitals could be rewarded for inefficiency that increases expenditures and punished for efficiency gains that trim spending. Further, it is a hospital's loss of *patients*, not a drop in *expenditures*, that signals potential damage to patient care undermining the Triple Aim.

Finally, we do not suggest excluding from market-share calculations hospitalizations for ambulatory-care sensitive conditions. Almost entirely outside the control of an individual hospital, such hospitalization rates vary greatly based on socioeconomic status. Making such conditions the basis of market-share adjustments would simply encourage hospitals to avoid low-income patients, without providing meaningful incentives to improve care. We will suggest in a forthcoming White Paper another strategy for addressing these conditions.

Calculating the percentage shift in global budgets

HSCRC must also decide how to translate changes in a hospital's market share into modifications to the hospital's global budget. This issue is less straightforward than one might at

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[2] National Quality Forum. "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," March 18, 2014 Draft, *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=75398*.

first imagine. Suppose all shifts in patient caseload from one hospital to another (except for hospital-acquired conditions and rehospitalizations) resulted in dollar-for-dollar movement of global budget amounts between hospitals. That would encourage hospitals to provide their patients with good care, rather than risk losing them to other hospitals. But it could also lead hospitals to lure profitable lines of business from other hospitals—for example, by recruiting physician specialty groups—without any overall effect on patient care, other than a potential increase in cost that could ultimately result from the higher payments needed to bring physicians from one hospital system to the other.

The latter result could be avoided by translating only some of the market shift into a global-budget transfer. For example, suppose that HSCRC adopted a uniform policy of translating 50 percent of market-shift changes into global-budget transfers. If hospital A lost 10 percent of an area's orthopedic market share to hospital B, amounting to $20 million, then $10 million of hospital A's global budget would transfer to hospital B.

That 50 percent translation percentage would reduce hospitals' incentive to take away lucrative business from one another in ways that might not benefit the public. But it could also lessen hospitals' incentive to retain patients' loyalty by providing high-quality services, particularly when less lucrative lines of care are involved.

Fortunately, nothing requires HSCRC to use the same translation percentage for all service lines. The percentage could be higher with less profitable lines and lower with more profitable ones. That way, market-share adjustments would be unlikely to induce competitive bidding motivated by a desire to increase a particular hospital's margins without necessarily improving overall patient care or increasing efficiency. At the same time, market-share adjustments would be more likely to deter hospitals from neglecting lines of care that patients may need but contribute relatively little to hospital margins.

Summary and Conclusion

Market-share adjustments can play an important role discouraging hospitals from providing poor customer service and low-quality care. If consumers take their business elsewhere, a market-share adjustment should mean that hospitals soon find themselves with smaller global budgets.

To achieve that goal, one hospital must lose market share when another gains it. If, rather than take patients from another hospital, a hospital generates new business within a shared service area, the resulting utilization boost should not qualify for a market-share adjustment.

Unless it is structured properly, a market-share adjustment could inadvertently encourage inappropriate, inefficient, or even harmful utilization. Accordingly, hospital-acquired conditions and rehospitalizations should be excluded from patient demand in defining market share, which would be based on the number of consumers seeking care, rather than hospital expenditures. However, to prevent hospitals from reducing their nominal rehospitalization rates by simply avoiding low-income patients, rehospitalization incentives should be risk-adjusted for socioeconomic status, and any reduction in the combined percentage of a hospital's patients who are uninsured or covered by Medicaid should be subtracted from increased market share in determining whether a hospital receives an upward market-share adjustment.

As HSCRC calculates the relationship between changes in hospital market share and the resulting changes to global budgets, two important objectives are in tension. If each dollar shift

in market share translated into a dollar change in global budgets, hospitals would be deterred from degrading patient care and customer service. However, hospitals might attempt to take lucrative lines of business from one another by, for example, recruiting away key physician groups—steps that neither benefit patient care nor yield net cost savings for payors and, in fact, may increase overall costs as hospitals compete for ownership of profitable service lines.

One approach to navigating this tension would vary the percentage by which shifts in market share translate into global budget changes. More lucrative service lines would have lower percentages, and less profitable service lines would have higher percentages. As a result, degraded patient care, even in unprofitable lines of service, might lead to meaningful reductions to future global budgets. At the same time, hospitals could be deterred from investing significant amounts to lure away profitable service lines from other hospitals, since no more than modest increases to future global budgets could result, potentially causing net financial setbacks rather than gains. This general approach to market-share adjustments could prove effective in helping such adjustments play their proper role within the broader hospital payment system.

Stan Dorn, consultant to Health Care for All and the Maryland Citizens Health Care Initiative Education Fund, Inc., was the primary author of this White Paper.