

## **Understanding the Success behind Maryland's Model**

Madeline Jackson-Fowl and Willem Daniel

While state governments are increasingly engaged in developing new ways to control health care spending and deliver more valuable care to their citizens, the State of Maryland began pioneering its approach years ago. With its innovative All-Payer system, the state has committed to improving hospital financing with an eye towards stability and equity. From this foundation, the state has systematically worked to encourage system transformation through formative model agreements with the federal government. Maryland's experience illustrates the opportunities available to states when system financing, quality improvement, and valuable-based care are prioritized equally.

### **Landscape of Hospital Financing in Maryland**

The State of Maryland's history of policy innovation dates back to the creation of a hospital rate regulation system in the late 1970s. From its inception, Maryland's regulatory approach had three main objectives for hospitals and the health system. The first was to ensure costs between both public and private payers were equitable and hospitals with different payer mixes had the same financial security. Second, the system needed to establish a growth rate for hospital costs that ensured sustainable spending. Lastly, Maryland sought to secure the financial viability of its acute care and specialty hospitals.

Over the history of the state's regulatory system, the second objective of ensuring sustainable cost growth has occasionally been at odds with the third objective of ensuring that hospital finances remain viable. Simply constraining hospital costs or cutting the prices of services means that hospitals and providers feel a financial strain that diminishes their ability to prioritize comprehensive patient care.

Utilizing its rate-setting authority, Maryland previously balanced objectives two and three by paying hospitals using a hybrid cost-based approach and traditional fee-for-service system. The system paid hospitals on the basis of a variable cost factor (VCF), meaning that when a hospital's volume grew, its revenue would only grow by the amount of the variable costs of that volume. Fixed costs would be financed through a negotiation between regulators and hospitals. Variable cost factor financing was intended to ensure that hospital revenues were sustainable, while limiting the incentive for hospitals to increase volumes and costs, i.e. balance objectives two and three.

For a while, Maryland balanced competing objectives, though it was not immune to national trends of a growing, aging, and sicker population along with rapidly rising costs of care. However, identifying the true variable costs for a unit of volume is an inexact science. The state adjusted the VCF – sometimes raising it and other times lowering it – with the intention of ensuring that hospital revenues were sustainable, while limiting the incentive for hospitals to increase volumes and costs. But by 2010, hospitals were experiencing higher total operating costs and lower marginal payment rates, resulting in diminished margins. The system ultimately put strain on both hospital finances and the state's goal of keeping hospital cost growth at a reasonable level. Simultaneously, national attention and reform was focusing on improving the value of health care and constraining cost growth. The strain of balancing the system's original

objectives, coupled with the opportunity offered by national reform efforts, incentivized Maryland to revamp its policies.

## **The Maryland All-Payer Model and Global Budget Revenues**

Through an agreement with the Centers for Medicare and Medicaid Services (CMS), Maryland established a Global Budget Revenue (GBR) system, known as Maryland's All-Payer Model, in order to balance both hospital cost containment and financial stability. The GBR is a prospective guaranteed revenue amount, based on annual population growth and inflation. The state sets the annual inflation factor in order to ensure that cost growth remains sustainable for payers. While overall revenues decline, the GBR allows hospitals to retain revenues by reducing utilization. By restructuring the link between hospital profits and volume, hospitals have an incentive to reduce unnecessary utilization with assurance that their financial security will be maintained.

The 2014 Maryland All-Payer Model agreement contained a number of tests and guardrails established to define the state's success, including:

- Cap all-payer hospital revenue growth at 3.58 percent annually.
- Achieve \$330 million in cumulative savings to Medicare over five years.
- Maintain lower overall growth in total Medicare costs (parts A and B).
- Reduce potentially preventable complications by 30 percent.
- Bring Maryland Medicare readmissions to under the national rate.
- Move 80 percent of hospital revenue to a population-based reimbursement agreement by the fifth year.

By implementing GBRs, the State realigned the hospital payment system so that it could once again focus on its initial three objectives: payer equity, financial stability, and constraining the growth of hospital costs. However, the GBR eliminates the tension between financial stability for hospitals and constraining the growth of hospitals costs by allowing hospitals to reduce unnecessary utilization.

## **Results of the All-Payer Model<sup>1</sup>**

By all metrics of the All-Payer Model tests, Maryland met or exceeded expectations. Overall, the state was able to constrain the growth of all-payer hospital expenditures to an average of 1.9 percent annual growth. Additionally, the flexibility afforded to the state and incentives to transform care produced innovative programs and tools for hospitals and policymakers.

### **Savings to Medicare**

Maryland's Model saved money for the federal government by constraining the rate of growth of both hospital and Medicare Parts A and B services (total costs of care) more than the nation. In hospital expenditures, the state saved Medicare \$1.4 billion over five years with an expenditure growth rate 8.74 percent below the nation since 2013. In total cost of care, including all nonhospital costs, savings reached \$869 million over five years with a growth rate 2.74 percent below the nation. Savings achieved in both hospital and total cost to Medicare indicate that constraining cost growth for hospitals did not result in a shift to alternative, unregulated settings.

## **Reductions in Avoidable Hospital Utilization**

Maryland achieved system savings under GBR through a systematic effort to reduce unnecessary utilization in hospitals and improve programs that incent hospitals to invest in care management. Compared to the nation, Maryland accrues savings if lower acuity care is provided in less-intensive settings, with more focus on prevention and management. In comparison to a statistically matched control group, the state has seen inpatient admissions decline significantly.<sup>2</sup>

## **Hospital Financial Performance**

In any other state, a substantial reduction in payments to hospitals likely would have resulted in financial hardship for those hospitals. However, under the GBR system, hospitals revenues are fixed regardless of their volume. As hospitals reduce unnecessary utilization, they retain the revenue from the avoided utilization to support their underlying margin, even while their overall revenues decrease. With this benefit, hospitals can more predictably contract, invest and plan for future performance in a manner detached from volume growth. Over the course of the model, the state has seen per capita savings of approximately three percent of total revenues *and* an average marginal growth of 1-2 percent. Thus, the GBR has created a win-win scenario for both payers and hospitals, aligning objectives two and three.

## **Improvements in Quality of Hospital Care**

Savings of the hospital system and implementing a GBR approach were achieved without degradation in the quality of care. In fact, Maryland hospitals saw improved quality through Maryland's All-Payer approach, with the progression of national quality programs like the Hospital Readmissions Reduction Program and Hospital Acquired Conditions Program. The strength of these quality incentives may in fact be stronger in Maryland because these programs provide incentives on total hospital revenues, not just Medicare revenues. Through these programs the system reduced potentially preventable conditions (PPCs), such as sepsis and hospital acquired pneumonia, by 51 percent. Additionally, the Medicare readmission rate reduced at a rate more rapidly than the nation, surpassing the nation in the final year of the model.

## **Opportunities for Innovation and Care Transformation**

Maryland's system also created space for providers and policymakers to collaborate on tools and programs to further transform the provision of health care. The rate setting system allows for collective investment in infrastructure, such as the State's Health Information Exchange (HIE). This important resource has helped to connect all acute-care hospitals in the state and enable data analytics to further progress transformation and improve the coordination of care statewide. From this investment, the state has been able to further implement public health improvements such as a Prescription Drug Monitoring Program (PDMP) population health reporting, and a vehicle for better data to drive research.

The state also has the flexibility to build alignment programs between physicians and hospitals through the Maryland Care Redesign Program (CRP). The state can create ACO-like and bundles-like programs that allow hospitals to gain share with physicians in exchange for partnership on care transformation activities. With this new capability, the state has begun to expand value-based incentives across the spectrum of care and beyond hospital walls. As hospital's become more sophisticated in reducing unnecessary and avoidable utilization, policies

such as CRP begin to focus Maryland on what is next, systematically improving the management of disease and population health statewide.

## **Progression to the Total Cost of Care Model**

Maryland's success under the All-Payer Model has created a chassis from which the state can build. The original objectives of the rate system, to create equity among payers, ensure hospital financial viability, and control the growth of costs, are currently being met. The state now has the opportunity to address the upstream socio-economic drivers of health care utilization. Starting January 1, 2019, the state embarked on a larger Total Cost of Care Model (TCOC Model) to not only control the growth of hospital costs, but also to focus on total costs of care and bending the growth of costs across the entire continuum of health care.

The TCOC Model will not be without its challenges for the state. Regulatory rate-setting authority has not changed to include other providers beyond hospitals, though now the state is responsible for the total costs of care. Hospitals will need to change their focus fundamentally from operating as acute-inpatient care providers to a structure more analogous to managed care. The traditional scope of care for hospitals is now expanded; however, as hospitals are the largest single component to total health spending, the responsibility should follow suit. The state will remain a strong partner to the hospital and health system in this transition by developing new payment methodologies and programs that ensure payments are connected to valuable care across all health care providers.

Lastly, as Maryland focuses its system on bending the health care cost curve, it will need to look further upstream to impact health spending in the most sustainable way, a healthy population. The state is setting a series of population health improvement goals that will focus the system on population improvements in key areas that ultimately lower spending. Tools and methodologies are important components to Maryland's success, but what started as only a hospital financing structure cannot continue without systematic integration of public health policies and expertise. In the coming years, Maryland will invest in the relationship between the public health community and the health system in a manner that prioritizes health and sustainable provider finances for long-term improvements. While not a simple effort, the state is confident that a history of innovation and collective goals across industries to improve the cost and quality of health care will once again produce success.

## **References**

1. Maryland Health Services Cost Review Commission. (2018). All-payer model results, CY 2014- 2018. Retrieved from: <https://hsrc.maryland.gov/Documents/Updated%20APM%20results%20through%20PY5.pdf>
2. International, R. T. I. (2018). Evaluation of the Maryland All-Payer Model: Third Annual Report. (RTI Project Number 0212790.013.000.001). Baltimore, MD: Centers for Medicare & Medicaid Services Center for Medicare and Medicaid Innovation. Retrieved from: <https://downloads.cms.gov/files/cmimi/md-all-payer-thirdannrpt.pdf>

---

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<https://creativecommons.org/licenses/by-nc-nd/4.0/>) which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.