TheZetemaProject

Case Study: The Maryland Model

Can All-Payer Rate Setting and a Global Budget Contain Costs and Promote Value?

Key Takeaways:
The Maryland Model uses a CMS waiver to conduct all-payer rate setting and global budgeting in hospitals to achieve positive cost and quality outcomes.

In 2019, Maryland will invite physicians and non-hospital providers to participate in the model through incentive-based payment programs that encourage value-based care (VBC).

The Model requires significant administrative investment from hospitals and an independent state agency (the HSCRC) to set annual rates and budgets, implement reform programs, and report on quality and cost metrics.

Maryland's hospitals are incentivized to provide VBC, but physicians largely remain fee-for-service, even in the 2019 Model. This results in misaligned incentives when providing care.

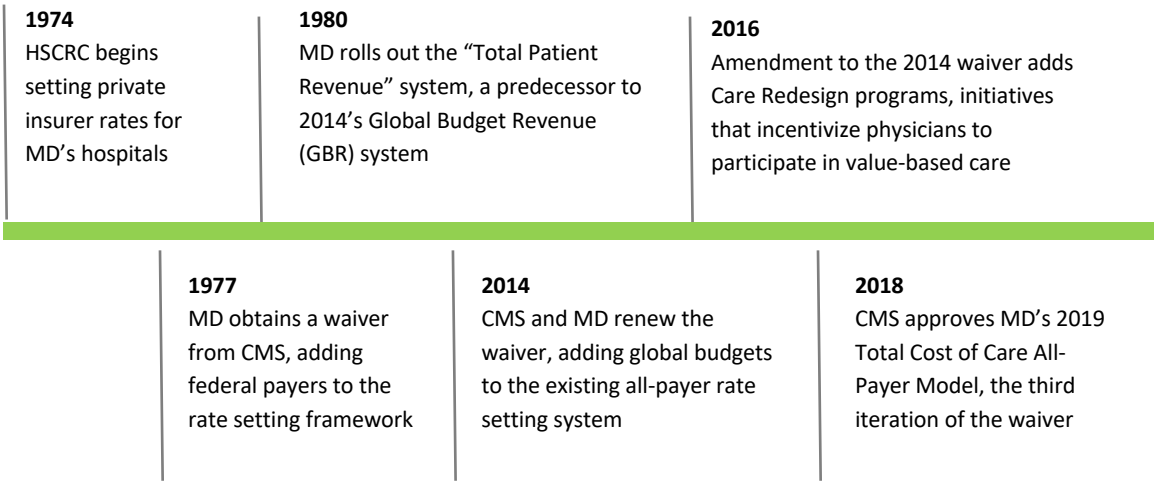
All-payer rate setting and global budgeting can serve as a model for other states with the political and stakeholder appetite to reform healthcare payment.

Background on the Maryland Model

The Maryland (MD) Model is a unique payment agreement between Maryland's hospitals, CMS, and private insurers that offers hospitals stable, predictable revenue in exchange for meeting aggressive quality and cost metrics. The program is administered by the Health Services Cost Review Commission (HSCRC), an independent state agency.

The Maryland Model was developed in 1971 following years of delivery system inefficiency, overutilization, and a per capita hospital case rate 25% above the national average.[1] Initially, the system did all-payer rate setting (APR) for private insurers only, reviewing a hospital's cost data, patient population, and uncompensated care burden to set line-item rates. Every hospital has its own set of rates, which all private payers agreed to pay. In 1977, the state secured a waiver from CMS that expanded APR to government payers, making Maryland the first and only all-payer state in the country.[2]

Figure 1: Maryland's Payment Reform Timeline[2]



Phase 1: 1974-2013

With the 1977 waiver, CMS agreed to pay Maryland hospitals higher rates than non-Maryland hospitals for Medicare and Medicaid patients. In exchange, the state agreed to keep healthcare cost growth below the national average for Medicare case payments and instituted a system to manage volume growth.[3]

From the 1970s to early 2000s, the system continued iterating to improve, refining its rate-setting methodology, implementing a global budget program for rural MD hospitals, and launching pay-for-performance quality standards.[2]

Figure 2. The Maryland Model: 1974-2013

Scope and Methodology	Requirements of Waiver	Results
All Maryland hospitals agreed to participate in all-payer rate setting, starting with private insurers from 1974-1976 and then adding government payers in 1977.	Maintain a payment growth rate lower than the national average, measured on Medicare case payments	Achieved. From 1976-2007, average cost-per-admission dropped from 26% above the national average to 2% below it. This resulted in approximately $40B in savings.[3]

Phase 2: 2014-2018

In 2012, seeing a rise in inpatient-to-outpatient care shifts and subsequent risks to meeting the waiver's standards, CMS and Maryland negotiated a new payment waiver. This version, in effect from January 2014 through December 2018, introduced a per-hospital global budget on top of the existing all-payer rate setting. The 2014 Model shifted performance evaluation from reducing per-case/episode spending to reducing overall per-capita hospital expenditures. This program evaluation shift came out of Maryland's rising inpatient admissions rate (per-case rates were lower than average, but utilization was higher than average) and pushed hospitals to manage volume while controlling costs.

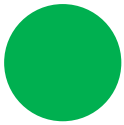
As part of the new waiver, Maryland hospitals were held to new performance standards. The standards required meeting rigorous quality metrics, shifting costs to population-based payment systems, generating savings for Medicare, and continuing to reduce hospital cost growth rates. Maryland's performance against these metrics are detailed in the table below.

Figure 3. The Maryland Model: 2014-2018

The 2014 model includes all Maryland hospitals and imposes a hospital-specific global budget, in addition to the existing all-payer rate setting system.

Requirements of Waiver[8]	Results[5,8]	Progress on Goal
Inpatient and Outpatient Hospital Per Capita Cost Growth: limit all-payer per capita revenue growth to 3.58%	Achieved. All-Payer per capita revenue growth: CY '13-14: 1.47% CY '14-15: 2.31% CY '15-16: 0.80% CY '16-17: 3.54%	

Requirements of Waiver[4]	Results[4]	Progress on Goal
Aggregate Medicare Savings: Achieve $330M or more in savings to Medicare from 2014-2018	Achieved. Medicare Savings: CY '14: $120M CY '15: $155M CY '16: $311M CY '17: $330M	
Shifting from a Per-Case Rate System to a Global Budget: Shift at least 80% of hospital revenue to a global budget system	Achieved. As of May 2017, 100% of regulated hospital revenue is under a global budget.	
Reducing the Readmission Rate among Medicare Beneficiaries: Inpatient admissions must be below the national average admission rate	In Progress. Medicare Readmissions:[6] CY '14: 0.98% above average CY '15: 0.51% above average CY '16: 0.25% above average '17 (latest data through September): 0.17% **below** average	

Requirements of Waiver[4]	Results[4]	Progress on Goal
Reducing Hospital-Acquired Conditions (HACs): Reduce HACs by 30% by the end of 2018	Achieved. 45.84% reduction in HACs between 2014 and June 2017	
Monitoring Total Cost of Care (TCOC): cost of care growth for Medicare beneficiaries cannot exceed the national growth rate by more than 1% in a given year. The MD growth rate cannot exceed national growth in any two consecutive years.	Achieved. CY '14: 1.62% below average CY '15: 1.31% below average CY '16: 2.08% below average CY '17: 1.36% below average	

Another provision of the 2014 Maryland Model required the state to submit a "Total Cost of Care Model" proposal to CMS by January 2017. This proposal, following clearance and approval by CMS, would serve as a third iteration of the model and be in effect from 2019-2023.

Phase 3: Begins 2019

On May 14, 2018, Maryland Governor Larry Hogan announced that the 2019 Total Cost of Care (TCOC) All-Payer Model was approved by CMS.[7] The TCOC Model will go beyond hospitals to improve healthcare outcomes while slowing per capita spending growth. The model also provides flexibility to promote private sector initiatives.

To keep the waiver, Maryland must:

- Reach $300M in annual savings to Medicare by reducing per capita total cost of care spending growth
    - In comparison, the 2014 Model required $330M in savings over 5 years
- Continue limiting hospital all-payer per capita revenue growth to 3.58% or below

In addition to achieving these measures, Maryland must invest in primary care and delivery system innovations to improve chronic care and population health. The model will also help

physicians and other providers use existing programs (state-run initiatives and federal APMs) to better align with hospital goals of cost reduction and quality improvement. These programs are voluntary, and Maryland will not set private insurance or Medicare rates for physicians or non-hospital providers. The state is also expected to set aggressive quality goals and a range of population health goals.[9]

To engage physicians and other providers, the Model will actively support Care Redesign programs and roll out the Maryland Primary Care Program (MDPCP) in 2019. Care Redesign programs are hospital-led initiatives that provide hospital-based and community physicians with financial incentives to engage in care coordination, lower total cost of care, and provide high quality care. These programs operate like CMMI APMs and were made possible through a 2016 amendment to the 2014 Model- the 2019 Model will maintain and elevate the Hospital Care Improvement Plan program (HCIP, 33 participating hospitals) and Complex and Chronic Care Improvement Program (CCIP, 9 participating hospitals). A third track, the Episode Care Improvement Program (ECIP) will launch in 2019.[10]

The Maryland Primary Care Program (MDPCP) is a key element of the 2019 Model to engage physicians. The voluntary program gives community physicians incentive dollars upfront to perform preventative services, work to manage chronic illness, and prevent unnecessary hospital utilization. MDPCP and the Care Redesign programs work to shift physician priorities from volume to value-based care through financial incentives.[11]

Stakeholder Impact

The Maryland Model relies on collaboration between hospitals, CMS, private insurers, and (with the 2019 Model), physicians and other providers.

Hospitals

With all-payer rate setting, hospital patient access, business office, and managed care departments have a lighter administrative lift- there is no need to negotiate individual payer contracts on consult a rate schedule to determine an insurer-specific rate for a procedure. All rates across all payers in a single hospital are the same. Because of APR, Maryland hospitals do

not have to worry about maintaining a payer mix with favorable cross-subsidization (private plans subsidizing lower-paying public plans).

When the Global Budget Revenue (GBR) model was added to APR in 2014, hospitals were given an expected revenue figure for the year. With the Maryland Model, hospitals must financially plan around the given budget, incentivizing lower-cost care, increased care coordination, and preventing unnecessary admissions.

While there are administrative savings from APR, Maryland hospitals have had to hire staff, and for larger facilities, establish departments, that ensure the hospital is staying on budget and meeting CMS's quality metrics. Directors and managers of "payment reform programs" are common titles in MD facilities, responsible for staying up to date on rate/budget changes and methodology updates and relaying that information to hospital executives and staff. These positions are also responsible for advocating on behalf of their hospitals to the Health Services Cost Review Commission (the group that sets rates, budgets, and calculation methodologies), protecting budgets from unexpected utilization. A common example of hospital-HSCRC negotiation is on transfer rates: a small hospital may admit a high acuity patient, decide the patient needs specialized care from an academic medical center (AMC), and transfer them there. Hospitals may transfer patients for better care, but also to avoid the high cost of caring for the patient. Advocates at AMCs, therefore, must ensure they are not penalized by HSCRC for exceeding their budget from taking on transfers. The Transfer Case Adjustment Policy in 2016 addressed this concern and continues to be updated as needed.[4]

The Maryland Model offers hospitals stable rates and revenue but requires cost-conscious decision-making when it comes to care and significant administrative investment.

CMS

The Center for Medicare and Medicaid Services (CMS) has been invested in the Maryland Model since 1977. To accommodate APR, CMS pays Maryland hospitals higher rates than

providers outside the state. In exchange for this higher rate, CMS expects on Maryland to find cost-savings in how it provides care while simultaneously improving quality (increasing the "bang for buck").

Compared to federal models like those administered by the Center for Medicare and Medicaid Innovation (CMMI), The Maryland Model requires less administrative support from CMS. The HSCRC sets rates and budgets and provides CMS with regular updates on how the model is performing. Near the end of a model's term, CMS is involved in assessing quality metrics and negotiating the model's renewal (or replacement with a new model) with the state.

CMS has maintained its support of the Maryland Model across a variety of Administrations because the outcomes have met expected goals. Maryland has regularly reduced per capita case costs, reduced HACs, and generated savings for Medicare. Politically, Maryland fits the current Administration's desire for states to use waivers and take the lead in healthcare innovation.

Private Insurers

APR is a boon for large private insurers as they no longer must cross-subsidize lower-payer payers by reimbursing at higher rates. Smaller, regional plans which may have operated a narrower network at lower rates in a non-APR state may be paying higher rates under APR than desired.

APR also means insurers can afford to have hospitals with strong reputations in their network. In other states, large AMCs and well-regarded hospitals will use their "brand name" to negotiate higher reimbursement rates from insurers. Insurers understand the value of having such a hospital in their network and often feel compelled to pay the higher rate. In Maryland, this is not a concern.

Physicians and Non-Hospital Providers

Before the 2019 Model, physicians and non-hospital providers were only indirectly impacted by the Maryland Model. These stakeholders may have observed higher volumes as hospitals shift patients and procedures to other settings where care can be administered just as effectively (and outside a hospital global budget). Hospitalists will have encountered the model: while the Model pays hospitals set rates and encourages value-based care, physicians are paid according to separate fee schedules for every insurer and fee-for-service. This has resulted in mismatched, and even times conflicting, incentives.

While the 2019 Model includes physicians and non-hospital providers, participation is voluntary. Inclusion in the program will also not have as many guardrails as hospitals face: HSCRC will not be setting rates or a budget for non-hospital participants. Programs coming out of the model, like Care Redesign initiatives and the Maryland Primary Care Program (MDPCP), may provide enough incentive to align physician and hospital priorities.

Analysis

The Maryland Model is an innovative method of payment reform that encourages cost containment and value-based care. The model works well for Maryland and the state consistently achieves all or most of CMS's expectations the waiver.

However, the Maryland Model is not a panacea to our country's healthcare problems. The system is largely confined to hospitals and does not align incentives for all providers and practitioners in the same way. While achieving significant cost savings and quality outcomes, the model is not without tension. Hospitalists remain fee-for-service and must adjust care decisions to fit a global budget, even when their payments are handled separately. Hospitals may feel moved to transfer patients to other sites of care or hospitals to avoid high costs or attempt to reduce admissions from SNF/LTCs. Patient preference may cause volume shifts from

standalone hospitals to AMCs, reducing volume for those smaller facilities, which threatens global budget allocation for the following year.

The Maryland Model, like any other system, is not a silver bullet for payment reform. However, the cost savings and outcomes observed thus far position Maryland as a state to watch when developing payment models.

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Replicability: Could the Maryland Model Work in Other States?

The Maryland Model is an extremely customized system and requires constant update and maintenance by the HSCRC. The model was also designed for a state with very few exceedingly rural areas, zero critical access hospitals, a high population density, and a sizeable number of community hospitals and AMCs.

While a state's geographic and demographic makeup may impact how a Maryland-like model is created and administered, the key aspects – all-payer rate setting and global budgets – are potentially replicable.

Although it may be possible to expand parts of the Maryland Model, certain political and infrastructural elements must be present.

In the 1970s, 10 states (including Maryland) implemented APR models. The nine other states succumbed to pressures from HMO industry, which did not want to be tied by APR and lobbied for the ability to negotiate lower payment rates. Wanting to encourage HMO growth, hospitals and state legislatures allowed the industry the exemption. As HMO prevalence grew, rate negotiation re-entered these states and the APR system was effectively deregulated. Now, only Maryland remains.[12]

Today, there are similar pressures that would preclude a state from implementing APR and GBR. When California attempted a version of APR earlier this year, the California Hospital Association (CHA) and California Medical Association (CMA) lobbied heavily against it. Similarly,

the California Association of Health Plans pushed the state legislature to consider access reform instead of cost control.[13] The bill was quickly shelved.

Conclusion

The Maryland Model has provided the country with an innovative approach to payment reform for 44 years. With APR and GBR, Maryland has achieved impressive cost control and quality outcomes in its hospitals. While the system does pose an administrative burden for the state, the savings and efficiencies indicate that the approach is worthwhile for Maryland.

To improve on the model, both in Maryland and for other states considering the APR+GBR approach, incentives must be aligned across providers and practitioners. Maryland has a mixture of value-based care (hospitals) and FFS (non-hospital providers and practitioners). When incentives clash, the model's efficacy is reduced. Maryland is working towards universal alignment in incentives through its 2019 Model, but the incremental approach with voluntary programs means robust data on the model's effectiveness may take time.

The Maryland Model shows that there are options when it comes to healthcare cost containment and value-based care. From APR to CMMI's alternate payment models (APMs) to GBR and physician payment programs, proposed solutions and choice exists for states and/or healthcare systems with the appetite for payment reform.

Discussion Questions

- Is the Maryland Model (APR and global budget) a replicable model for other states? For the country as a whole?
- Which elements of the Maryland Model were most critical to its success?
- Is it necessary for a state to implement APR prior to GBR?
- How can states/healthcare systems create payment structures that align facility and practitioner incentives to move towards value-based care?
- What alternatives are there to the Maryland Model that states can leverage?
- Which groups stand to lose from value-based care (VBC)? Should widespread VBC be the next step for the U.S. healthcare system?

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