

# Maryland's All-Payer Global Budget Cap Model and Its Implications for Providers

May 16, 2016

# Advisory Board Health Policy

## Project Directors

Eric Cragun  
[CragunE@advisory.com](mailto:CragunE@advisory.com)  
202-266-6249

Kathryn Martucci  
[MartuccK@advisory.com](mailto:MartuccK@advisory.com)  
202-266-6701

## Project Editor

Piper Nieters Su  
[SuP@advisory.com](mailto:SuP@advisory.com)  
202-568-7860

### LEGAL CAVEAT

The Advisory Board Company has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and The Advisory Board Company cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, The Advisory Board Company is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member's situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither The Advisory Board Company nor its officers, directors, trustees, employees, and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by The Advisory Board Company or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by The Advisory Board Company, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

The Advisory Board Company is a registered trademark of The Advisory Board Company in the United States and other countries. Members are not permitted to use this trademark, or any other trademark, product name, service name, trade name, and logo of The Advisory Board Company without prior written consent of The Advisory Board Company. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names, and logos or images of the same does not necessarily constitute (a) an endorsement by such company of The Advisory Board Company and its products and services, or (b) an endorsement of the company or its products or services by The Advisory Board Company. The Advisory Board Company is not affiliated with any such company.

# Maryland's All-Payer Global Budget Cap Model and Its Implications for Providers

---

For the past forty years, the state of Maryland has pioneered a unique approach to financing hospital payments as a means of limiting spending growth. The state launched a statewide hospital rate-setting system across all payers in the 1970s and, beginning in 2014, implemented a global budget cap for hospital services while adding robust quality goals. While other states also adopted various forms of all-payer rate-setting models in the 1970s, Maryland's system is the only one that remains in place today.<sup>1</sup> And although the state's efforts have produced mixed results and undergone adjustments over the years, state officials recently announced that the latest iteration produced nearly \$116 million in Medicare savings in its first year of operation.<sup>2</sup>

## I. Introduction

The all-payer model Maryland is now utilizing was developed in partnership with the Centers for Medicare and Medicaid Services (CMS) as a state-driven initiative to accelerate payment and delivery transformation. Although it is technically a new model, it is nonetheless important to understand the history of Maryland's rate approach because this iteration builds upon the existing hospital all-payer rate-setting mechanisms through the addition of a global hospital budget cap along with several pay-for-performance programs. Historically in Maryland's rate-setting system, a state agency sets reimbursement rates for each hospital and all public and private payers are required to pay those rates for hospital inpatient and outpatient services. Under the global budget model, while hospitals continue to claim fee-for-service reimbursement at these rates, they must also ensure compliance with a prospectively established total budget or face penalties in the following year's budget. By holding hospitals accountable to a population-based financial target while measuring performance, the global budget model seeks to provide better incentives for reducing spending growth, ensuring appropriate service utilization, and improving overall quality of care. Based upon the data available from the first year, the model appears to be achieving some of these goals, but longer-term experience is needed to judge the ultimate success of the effort.

While Maryland's particular approach is unique among states, the health care industry as a whole has seen similar shifting of greater accountability to care providers for quality of care and per capita health care spending. In the midst of this trend, Maryland's model stands out as one of the most comprehensive approaches by impacting hospital performance across payers. The stability and transparency of Maryland's model have accelerated the pace of change in the state. Notably, by synchronizing incentives across payers and laying out a multi-year plan for the model, the state and CMS have provided hospitals with aligned goals and confidence to move forward in efforts to transform care. In addition, the focus on overall population spending has led to greater collaboration among the state's health care stakeholders. However, as policy experts and

1) McDonough 1997.

2) Patel et al. 2015.

stakeholders closely monitor the state's experience, they should remember that attempts to replicate possible success must also consider the specific context and history of Maryland's journey to this point.

Maryland has made progress implementing the new model, but continues to work through many details involved with delivery reform of this scale. Chiefly, as the model currently only caps hospital-based payments, it will need to be expanded or modified to address value in other settings of care. As Maryland moves reforms forward, its experience will continue to offer lessons for other initiatives. This report captures some lessons learned to date by outlining the history and evolution of Maryland's system, providers' reactions to the newest iteration, and the broader implications of the model.

## II. Maryland's All-Payer Rate-Setting Model Prior to 2014

### *Evolution of Maryland's model*

Since developing its all-payer rate-setting system in the 1970s, Maryland has relied upon its core infrastructure while making frequent adjustments to fine-tune the effectiveness of the model. This "evolutionary" approach to ensuring flexibility and making updates on an on-going basis likely is one of the strengths of Maryland's effort that has allowed the state to preserve its rate-setting system longer than peers.<sup>3</sup> A detailed discussion of the state's rate setting history is beyond the scope of this paper, but the notable elements outlined below offer useful context for the current model developed in a 2014 waiver agreement with CMS.

Maryland launched its rate-setting system in 1971 in an effort to address persistent poor financial performance and inefficient care delivery.<sup>4</sup> An independent state agency, the Health Services Cost Review Commission (HSCRC), was tasked with using rate setting to slow the growth of hospital costs, achieve price equity, and ensure access to care.<sup>5</sup> The agency's jurisdiction was (and continues to be) limited only to payment for inpatient and outpatient hospital services—other service lines and settings were not included in the effort.<sup>6</sup> At first, the state's model only applied to payments made by private insurers, but in 1977 the state negotiated a waiver of traditional Medicare and Medicaid payment rates with the federal government that required public payers to pay the same rates as commercial payers in the state.<sup>7</sup>

### *Requirements for maintaining Federal waiver*

Under the framework of Maryland's rate-setting system, Medicare and Medicaid reimbursement rates for hospital services are higher in Maryland than elsewhere in the country. In fact, some experts estimate that this results in nearly \$1 billion in additional Medicare payments to Maryland providers each year.<sup>8</sup> Conversely, private insurers reimburse Maryland hospitals at lower rates than they do in other states.<sup>9</sup> As a condition of maintaining its waiver with CMS and the associated higher level of federal payments, Maryland agreed to keep its cumulative payment growth beginning in 1981 below the national average growth of Medicare per case payments.<sup>10</sup> Thus, under the previous waiver, the HSCRC closely monitored Medicare spending and rates to ensure the state maintained a reasonable "cushion" and continued to qualify for the waiver.<sup>11</sup>

### *Maryland's rate-setting mechanisms*

Maryland's rate setting model aimed to keep health care spending sustainable for both hospitals and payers by tying payments to reasonable costs and maintaining equity in rates across payers. The HSCRC relied on significant amounts of cost data submitted by

3) Atkinson 2009.

4) Schmith 2015.

5) Ibid.

6) Ibid.

7) Ibid.

8) Sun and Kliff 2013.

9) Rajkumar et al. 2014.

10) Colmers 2014.

11) Murray 2014.

hospitals to set rates.<sup>12</sup> Each hospital's payment rates were based on this cost data, the health status of the hospital's patient population and the level of uncompensated care provided to that population.<sup>13</sup> Thus, each hospital had slightly unique payment rates within the system, but those rates were used by all of the state's payers for a given hospital's services.<sup>14</sup>

The HSCRC initially set rates at the beginning of each year, collected cost, charge, and payment data from hospitals during the year, and then retrospectively reconciled the hospital's total charges against the rates set at the beginning of the year.<sup>15</sup> Most recently, the state employed two rate review methodologies, one that compared hospitals' costs to those of peer hospitals and another that compared hospitals' charges to other hospitals' charges.<sup>16</sup> After conducting this review, if the HSCRC found a particular hospital's charges or costs to be higher than their peer group, the agency could pursue further discussions and a more detailed rate review to help reset the hospital's rates as appropriate.

Over time, the HSCRC broadened the basic unit of service for which it set rates. Early on, the agency set permissible charge rates at a line item-level for individual cost centers (e.g., operating rooms and intensive care units) within a hospital. Later on, it set rates at the discharge level and, eventually, the episode level. The broadening of the basic unit of payment was intended to increase the incentives for hospitals to reduce costs. The most recent approach—the charge-per-episode model—was implemented as a voluntary program in 2011.<sup>17</sup> While the HSCRC set charge rates for the hospital, this in effect set payment rates as well since hospitals were not allowed to give payers a discount off the charge rate (as typically occurs in non-regulated payer systems).

#### *Volume Adjustment System*

In an effort to manage growth in the volume of services provided, the HSCRC implemented the Volume Adjustment System (VAS) in 1977. The VAS limited the amount of revenue growth that hospitals could realize by increasing volume.<sup>18</sup> The system set lower payment rates for new volumes under the assumption that reimbursement for new volumes need only cover variable costs since the rate-setting model already accounted for fixed costs. The HSCRC made several adjustments to the VAS over the years, softening or eliminating the VAS adjustments across the 1990s and 2000s. Following these changes, Maryland saw dramatic increases in the number of inpatient and outpatient cases, leading to much higher growth of total payments to hospitals.<sup>19</sup> The lack of success controlling volumes was a key factor in the 2014 updates to Maryland's model.

#### *Quality programs prior to 2014*

The HSCRC's original work was focused almost exclusively on spending and utilization oversight rather than care quality.<sup>20</sup> However, beginning in 2008, the HSCRC launched new all-payer initiatives to reward hospitals based on quality of care that aligned with Medicare's national adoption of pay-for-performance standards. The Maryland version of these quality programs included the Quality-Based Reimbursement (QBR) Initiative, which adjusts payments based on performance on process of care and patient experience measures (similar to Medicare's Value-Based Purchasing program) and the Maryland Hospital-Acquired Conditions (MHAC) Initiative, which adjusts payments based on the rate of 65 potentially preventable complications (similar to CMS' Hospital-Acquired Condition Reduction program).<sup>21</sup> In addition, the state adopted incentives to reduce readmissions in its 2011 introduction of the charge-per-episode rate model.

12) Health Services Cost Review Commission, HSCRC Overview.

13) Health Services Cost Review Commission, Hospital Rates, Charge Targets, and Compliance.

14) Zito 2012.

15) Eastaugh 1992.

16) Maryland Hospital Association 2007.

17) Foreman and Hulvey 2014.

18) Murray 2014.

19) Ibid.

20) Ibid.

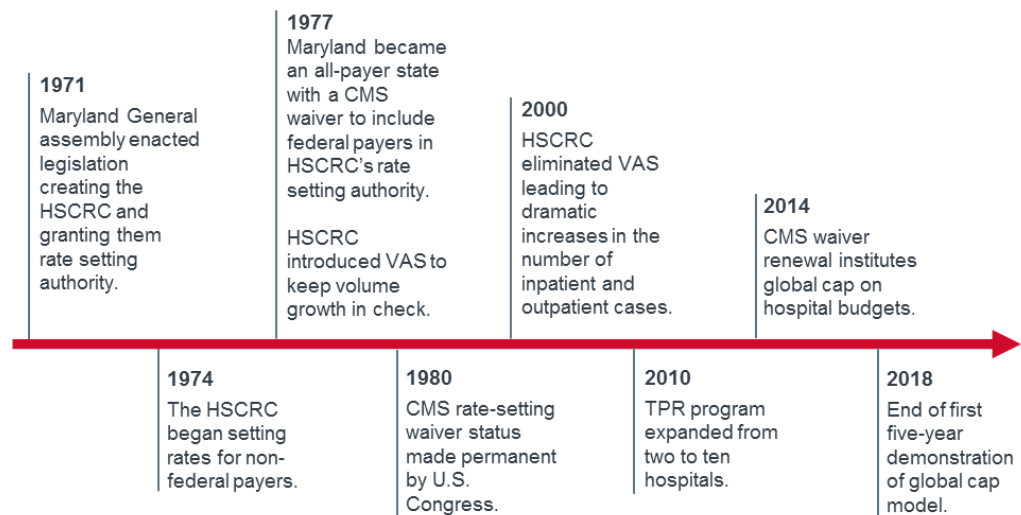
21) Health Services Cost Review Commission, Quality Improvement.

## Total Patient Revenue System

In 1980, the HSCRC established a unique payment model—known as the Total Patient Revenue (TPR) system—for rural hospitals. The state has used the model in less-populated regions of the state where an individual hospital has an easily defined market area, often the county where each hospital is located.<sup>22</sup> Under the system, participating hospitals agree to a fixed global budget, with targets adjusted annually to account for inflation and population fluctuations.<sup>23</sup> The system—Maryland’s first attempt at population-based payment—is intended to create incentives for the hospitals to better manage health care costs across their service areas, with a particular focus on slowing the growth of hospital service volumes.<sup>24</sup>

In 2010, the TPR program expanded from two hospitals to ten hospitals.<sup>25</sup> Over the next three years, TPR hospitals reduced inpatient admissions by 17.7%, compared to a 9% reduction across non-participating hospitals. TPR hospitals also reduced avoidable admissions by 17% over the same period, compared to a 12.8% reduction across non-participating hospitals.<sup>26</sup> The success of the expanded TPR model led the participating hospitals to renew for another three-year term in July 2013 and served as a model for the global budget cap system adopted for non-TPR hospitals in 2014.<sup>27</sup> The TPR program continues in tandem with the new system.

## Major Milestones of Maryland’s All-Payer Model



## Results of the model up to 2014

While the six other states that established rate-setting systems in the 1970s and 1980s eventually ended those programs, Maryland has sustained its all-payer rate-setting model and achieved some success in reducing spending per hospital admission.<sup>28</sup> Between 1976 and 2007, Maryland’s average cost-per-admission decreased from 26% above the national average to 2% below the national average.<sup>29</sup> This cost containment generated an estimated \$40 billion in savings over that same time period.<sup>30</sup> The system also brought increased access and equity to Maryland’s uninsured population and resulted in general financial stability for the state’s hospital sector.<sup>31</sup>

Although Maryland’s rate-setting system has been a model for the nation, throughout the early 2000s it faced significant challenges in sustaining overall cost savings. Given the

22) Health Services Cost Review Commission, TPR Rate Setting Methodology.

23) Zito 2012.

24) Sharfstein 2014.

25) Health Services Cost Review Commission, TPR Rate Setting Methodology.

26) Sharfstein 2014.

27) Health Services Cost Review Commission, "New All-Payer Model for Maryland Global Budget Development for FY 2014."

28) States that dropped rate-setting were Connecticut, Massachusetts, New Jersey, New York, Washington, and West Virginia. See Atkinson 2009.

29) Murray 2009.

30) Ibid.

31) Ibid.

initial waiver's emphasis on per-case payment rates rather than utilization rates, the model was not as successful in slowing volume growth. When the HSCRC removed the VAS limits in the early 2000s, the agency anticipated that the rise of health maintenance organizations would control utilization. Yet from 2001 to 2007, hospital inpatient admissions increased by 2.7%, almost triple the average national growth rate of 1%.<sup>32</sup> In 2009 Maryland's per-admission cost growth also began to exceed the national rate, eroding the cushion on Maryland's waiver agreement and threatening its status.

### III. Introduction of Global Budget Caps Under 2014 Update to Waiver

In 2012, Maryland began negotiating several updates to its waiver with CMS. The waiver agreement was ripe for modernization as care increasingly shifted to outpatient settings and the state faced the possibility of failing to meet its Medicare cost-per-case spending targets, a key condition of its arrangement with CMS. In addition, CMS expressed interest in helping the state pursue a path more focused on holding providers accountable for per-capita spending trends.<sup>33</sup> Ultimately, CMS and Maryland agreed to a new five-year waiver, beginning January 1, 2014, that utilizes a modified payment model developed in partnership with the Center for Medicare and Medicaid Innovation (CMMI). By employing the broad authority granted to CMMI, the current all-payer model benefits from greater program flexibility and may serve as a validated approach for developing all-payer models in other states.

#### *Description of the waiver*

The new waiver agreement sought to shift Maryland's focus from controlling per-episode hospital spending to controlling total per-capita expenditures for hospital services.<sup>34</sup> Whereas the previous waiver required Maryland to limit growth of Medicare's per-episode payments, the new agreement requires the state to limit total annual hospital spending growth to 3.58%—the ten-year per capita growth rate of the state's economy—and generate at least \$330 million in total Medicare hospital savings relative to the per capita national trend over the five-year waiver period.<sup>35</sup> To achieve those goals, the agreement requires shifting at least 80% of hospital revenue to population-based payment structures by 2018. Population-based payments are defined in the waiver as either (1) hospital reimbursement linked to the total projected hospital costs for a specific population, or (2) a global cap on a hospital's budget based on historic volume, costs, and service patterns.<sup>36</sup>

The 2014 agreement also emphasizes quality of care and population health outcomes, elements not included in Maryland's earlier waivers. The waiver requires an equal or greater proportion of state hospital revenue be tied to quality performance as would be under national Medicare programs.<sup>37</sup> The state agreed to reduce its aggregate Medicare 30-day unadjusted all-cause all-site readmissions rate to the national level and achieve a 30% cumulative reduction in the rate of 65 preventable hospital-acquired conditions (HACs). Additionally, Maryland must continually measure and demonstrate performance on population health metrics, many of which come from the state's population health and health equity initiative (State Health Improvement Process) and include metrics such as life expectancy, emergency department usage, and obesity prevention.<sup>38</sup>

Finally, the agreement requires Maryland to submit to CMS a proposed plan for shifting the model to include accountability for the total cost of care (not just hospital care). The plan must be submitted to and approved by CMS prior to the renewal of the current

32) Murray 2014.

33) Rajkumar et al. 2014.

34) Centers for Medicare & Medicaid Services 2014.

35) *Ibid.*

36) *Ibid.*

37) *Ibid.*

38) Health Services Cost Review Commission 2015.



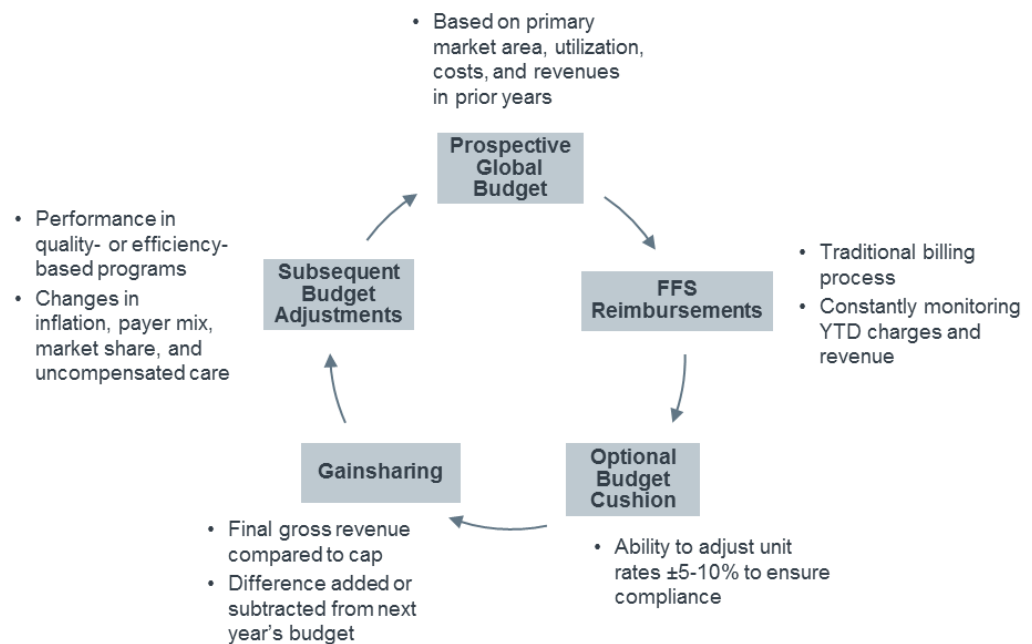
waiver, which ends December 31, 2018.<sup>39</sup> Meeting this provision will require the state to create a system that incorporates services across the full spectrum of care including physician, post-acute, long-term, and ambulatory services.

### *Maryland's efforts to implement new waiver requirements*

To meet the waiver requirements, the HSCRC relied on two global hospital budget models: the existing TPR system continued with ten participating rural hospitals, and a new model—known as the Global Budget Revenue (GBR) system—was created for hospitals with overlapping markets. GBR transitioned non-TPR hospitals from the predominant per-admission system structure to global hospital budgets. This new model establishes an annual budget cap so each hospital's annual revenues from providing hospital services to Maryland residents are known at the beginning of the fiscal year. The annual budget is calculated based on historical utilization, costs, and revenues and then adjusted for inflation and performance in quality- or efficiency-based programs as well as changes in payer mix, volume, market share, and uncompensated care.<sup>40</sup>

Maryland hospitals continue to bill through the traditional fee-for-service system with rates set by the HSCRC, but are expected to monitor cumulative year-to-date charges and revenue to ensure compliance with the annual global budget. During the year, if a hospital projects that it will fail to meet its annual budget cap, the hospital can adjust unit rates up or down by 5%, and by as much as 10% with the HSCRC's approval, to reach the target.<sup>41</sup> For hospitals that exceed the cap or bill less than the cap for a year, the HSCRC will subtract or add the difference to the hospital's budget cap for the subsequent year.<sup>42</sup>

## Maryland's Prospective Global Budget Process



The HSCRC has been scrutinizing and adjusting the TPR and GBR models as needed, including adding options for transfer cases from community hospitals to academic medical centers (AMCs) and improving the methodology for adjusting budgets based on

39) Centers for Medicare & Medicaid Services 2014.

40) Health Services Cost Review Commission, Completed Agreements under the All-Payer Model.

41) Health Services Cost Review Commission, Agreement: Global Budget Revenue and Non-Global Budget Revenue.

42) Health Services Cost Review Commission 2015.



shifts in where patients receive care.<sup>43</sup> This market shift adjustment is meant to ensure that the budgets reflect changes in patient preferences, with a particular emphasis on distinguishing total market volume growth from volume shifts between hospitals.<sup>44</sup> The HSCRC continues to fine-tune the market shift adjustment to improve its accuracy. While the HSCRC has created robust market shift calculations and scenarios, hospitals still have reservations about how market share is being measured and how shifts are being accounted for. In particular, questions persist about whether the adjustments adequately reflect all scenarios, including circumstances where utilization rates drop due to improved care delivery.

### *Results to date*

By the end of 2014, Maryland surpassed the waiver requirement of moving 80% of hospital revenue to population-based models, with 95% of hospital revenue under either the TPR or GBR models.<sup>45</sup> The remaining 5% of hospital revenue is attributable to care provided to patients from outside the state treated at five Maryland AMCs. These AMCs participate in GBR for Maryland residents, but are allowed to exclude revenue from out-of-state patients from their cap.

Although a more extensive analysis comparing hospitals and markets is necessary, data from 2014—the first year of the GBR model—show promising financial and quality results.<sup>46</sup> Specifically, CMS and the state estimate that the new model saved Medicare \$116 million, a significant portion of the \$330 million that the state agreed to save over five years. In addition, Maryland made progress on other five-year goals. The state saw per capita hospital costs for all payers grow at just 1.47%, well below the 3.58% waiver target. In addition, potentially preventable conditions dropped by 26.3% and the gap between the rate of all-cause readmissions among the state's Medicare patients and the national rate shrank to 1%. Reporting of population health and care management improvements by each hospital began in July 2015 and will not be available until mid-2016 or later.

Even with these promising initial results, CMS and the state recognize there is more to be done.<sup>47</sup> Although improving, hospital utilization rates, per capita spending, and all-cause readmission rates for Medicare beneficiaries continue to be higher in Maryland than national averages. In addition, rates of particular preventable conditions in Maryland, including infections due to central venous catheters and catheter-related urinary tract infections, actually rose in 2014. Moreover, Maryland's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores still are among the lowest in the country.

### *Future plans under the waiver*

With all of the hospitals in the state participating in global budget-type payment models, the HSCRC is now focusing on supporting implementation of population-based and patient-centered approaches to care delivery, including efforts to reduce what the state calls "potentially avoidable utilization" (PAU).<sup>48</sup> Readmissions, preventable admissions, emergency department visits, avoidable admissions from skilled nursing facilities, and HACs all contribute to PAU. Maryland's model rewards and penalizes providers based on how hospitals perform on many of these PAU-related factors. If hospitals can utilize better care coordination, prevention, and chronic care, and improve the quality of care to ultimately reduce PAU, they will be rewarded for their efforts by avoiding a reduction in their global budget for the subsequent year.<sup>49</sup> QBR continues to be the state's efficiency program equivalent to CMS' Hospital Value-Based Purchasing program. The HSCRC has also indicated it will study care coordination methods, including integrated care

43) Health Services Cost Review Commission, Review of Market Shift Calculations.

44) Health Services Cost Review Commission 2015.

45) *Ibid.*

46) Patel et al. 2015.

47) *Ibid.*

48) Health Services Cost Review Commission 2015.

49) Health Services Cost Review Commission, Global Budget Revenue (GBR) Potentially Avoidable Utilization (PAU) Efficiency Adjustment.

networks, gainsharing models, and other pay-for-performance models as it seeks to help align provider incentives across the continuum and control the total cost of care.<sup>50</sup>

### Five-Year Goals and Preliminary First-Year Results

Five-Year Goal	Metric	2014 Performance	Progress On Five-Year Goal
80%	Hospital revenue in population-based payment structures	95%	
<3.58%	Total growth of per capita hospital costs	1.47%	
\$330M	Savings to Medicare	\$116M	
30%	Reduction in avoidable complications	26.3%	
1.2%	Reduction in all-cause Medicare readmissions	.2%	

### IV. Market Implications of Updated Waiver

Maryland’s most recent all-payer model appears to be impacting providers’ approach to care efficiency and quality in its early stages, but its impact may be limited in some respects because the current model only focuses on hospital services. Hospitals appear to be accelerating development of their population health strategies and expanding collaborations in response to the model’s incentives. However, some hospitals’ initial focus also may be on growing market share and shifting care to non-hospital settings. Until the model expands to include payments across the broader continuum, the benefits of broader population health may not be realized fully. Based on the experiences of stakeholders involved in the model, there are five key takeaways from the effort thus far:

1. *Global budget model is accelerating—as opposed to redirecting—provider efforts to improve care delivery*

Providers in Maryland indicated that they already were pursuing initiatives to transform care and improve population health prior to the 2014 launch of the updated model. One of the most prominent initiatives to transform care in the state before 2014 was the state’s development of a patient-centered medical home (PCMH) infrastructure. While providers view their efforts under the new model as consistent with their previous strategy, they do acknowledge that the new incentives add fuel to the fire. The multi-payer nature of Maryland’s approach is a key reason that the incentives have been such a powerful accelerant. Further, providers expect that the pace of care transformation will

50) Health Services Cost Review Commission 2015.

only continue to accelerate as the state proposes and implements an expanded model in 2019.

### *2. Providers are adjusting operations and re-prioritizing care delivery changes in response to the model*

While at a high level providers are largely continuing their previous strategy, the structure of the global budget model has driven some adjustments to operations and renewed emphasis on care delivery improvements. For example, some hospitals report that they increased their monitoring of utilization and revenue to ensure that they do not surpass their annual budget limit. Some hospitals also report prioritizing efforts to shift care for service lines like behavioral health, obstetrics, and radiation therapy to non-hospital settings as appropriate, since revenue from non-hospital settings does not accrue against the cap and care in those settings may be just as effective.

“

#### **Global Budget Impact on Hospital Strategy**

“This new model completely transforms the way that we think about the levers to profitability as a system. Under a global budget the main goals are to reduce utilization and lower costs.”

*Maryland Hospital Executive*

### *3. Providers see increasing market share as taking on new importance as path to growth*

Another result of the global budget cap is the heightened importance of market share growth as a strategy for sustaining profits. Hospitals have long sought to improve their market share, and Maryland's model may be reinforcing the focus on this strategy. The HSCRC does not grant budget cap increases for GBR hospitals if the new volume represents an increase in total market volume. But hospitals can apply for and receive increases in their budget cap if they can show that increased volume at their facility shifted from another hospital and is not growth in volume to the overall market. One provider executive observed that many hospitals in the more established TPR model have seen their overall cap decrease over time and views growing market share as the best option to avoid a similar “death spiral”. Finally, many providers expect that the introduction of a total cost of care framework in 2019 will only add to the emphasis on market share.

### *4. Providers are expanding efforts to collaborate as they seek true population health*

Despite the competition for market share, hospitals have also been pursuing collaborations as a way to address broader population health issues. Many of these partnerships likely would have come together over time absent the model, but the transition has accelerated their formation. In some cases, state funding is propelling the partnership. In May 2015, the HSCRC awarded eight Regional Partnerships for Health System Transformation grants totaling \$2.5 million.<sup>51</sup> The grants require hospitals to create partnerships that develop care coordination and population health services for a specific population.<sup>52</sup> For example, the Southern Maryland Regional Coalition for Health System Transformation links the hospitals in Prince George's and Calvert counties to focus on high-risk Medicare beneficiaries.<sup>53</sup> Another initiative, The Advanced Health

51) Department of Health and Mental Hygiene 2015.

52) Ibid.

53) Doctors Community Hospital 2015.

Collaborative, is a voluntary alliance between five hospitals—notably none of which compete with each other—that focuses on sharing best practices for primary care and behavioral health integration.<sup>54</sup>

The payment model also seems to be encouraging collaboration with non-acute care providers, such as local health departments, treatment providers, and community groups, in order to focus more on public health and social determinants. In Baltimore, for example, hospitals are working with the city health commissioner on projects including a stabilization center and a program that would identify and treat “high utilizers” of emergency services.<sup>55</sup>

#### *5. Providers’ interest in access to data has grown as incentives shift focus toward population health*

Adoption of health information technology (HIT) and greater access to data are key elements of hospitals’ efforts to succeed under the global budget cap. The Maryland Accountability and Reporting System (MARS) database is one of the most complete and accurate compilations of hospital costs and discharges in the country and is used for decision support for hospitals and the HSCRC.<sup>56</sup> Additionally, the HSCRC spent \$10 million to create the Chesapeake Regional Information System for our Patients (CRISP), a state-wide health information exchange. As of August 2015, 56 hospitals; 41 long-term and post-acute facilities; and 15 labs and radiology centers were participating in CRISP.<sup>57</sup>

## **V. Conclusion**

### *Critical factors for success of model*

As Maryland’s experience with the global budget cap model evolves, the state’s ability to meet the waiver’s performance requirements and drive improvements in population health depends on several critical elements. Early results, as well as conversations with provider executives, suggest that the model is progressing in the right direction. But it is essential to monitor whether the state is able to maintain the positive pace of progress seen at the outset, and the factors outlined below will be key to success:

- ▶ *Developing a care delivery model that successfully improves population health:* Although the model aligns incentives to some extent around improving overall health for populations, the state and providers face the challenge of designing health promotion and care delivery models that yield improvements in population health. This is a challenge common to other care transformation efforts around the country.
- ▶ *Engaging providers beyond the hospital setting, especially physicians:* As mentioned, Maryland’s model presently only caps payments to hospitals for hospital-based services. While many physicians and other non-hospital providers are enthusiastic about efforts to transform care, hospitals face a challenge in aligning their enthusiasm despite unaligned (or even conflicting) financial incentives. As the state expands the scope of its global budget caps in 2019, incentives for providers across the care continuum will be better aligned, which may spur more rapid achievement of improved health.
- ▶ *Sustaining access to hospital services despite slowing payments to hospitals:* One little-discussed aspect of the Maryland model is the likelihood that success of the model will result in lower overall hospital utilization and associated payments to hospitals. This will require hospitals in the state to adapt their strategy and services, possibly to the point of reducing beds or even closing facilities while focusing on alternative care

54) Advanced Health Collaborative.

55) Cornish and Hsu 2015.

56) Maryland Hospital Association 2007.

57) CRISP.

settings. State leaders will have to balance efforts to slow health care spending with the need to maintain sufficient access for residents.

#### Future Areas of Focus



Expand model to include accountability for total cost of care



Reduce “potentially avoidable utilization”



Transition 80% of primary care providers to a PCMH program

#### Critical Factors for Future Success



Develop a care delivery model that successfully improves population health



Engage providers beyond the hospital setting, especially physicians



Sustain access to hospital services despite slowing payments to hospitals

#### *Lessons for stakeholders beyond Maryland*

While Maryland’s all-payer model is unique, it offers lessons for officials and providers in other states even if specific reforms differ from those implemented in Maryland. Although the model has faced some setbacks and needs for adjustment over the years, the fact that it is still in place after forty years and has largely achieved its goals is no small feat. Certainly, some factors of success in Maryland may be difficult to replicate outside of Maryland, but many principles, outlined below, have broad applicability across efforts to transform payment and care delivery:

- ▶ *Multipayer payment reforms catalyze delivery system change better than single payer efforts:* One of the defining elements of Maryland’s payment model is its all-payer nature. While hospitals in other states have started to transform their models of care delivery, the mix of fee-for-service and value-based incentives they face across payers results in less-than-full investment in transformation. Because value-based incentives are synchronized across Maryland hospitals’ entire business, the hospitals can fully invest in dramatically transforming their strategy and care delivery.
- ▶ *Hospitals are willing to restructure business model in exchange for financial stability and predictability:* Maryland hospitals benefited enough from the stability they enjoyed under the rate-setting system that they were very invested in efforts to maintain the state’s waiver status. Maintaining—and even improving—budget predictability was sufficient motivation for the hospitals to agree to cap their revenue.
- ▶ *Consistent evolution of the model has helped it endure over time:* Although Maryland has used basically the same framework for its model over the last 40 years, the HSCRC has made adjustments on a regular, ongoing basis. This measured evolution of the model has allowed it to withstand changes in the state’s health care environment and outlast other states’ attempts at rate-setting. Other payment reform efforts might similarly benefit from concerted efforts to improve models as stakeholders gain experience with the model.
- ▶ *Hardwiring specific state and provider goals into model increases confidence in expectations and improves engagement:* Because the state’s commitment to CMS outlines specific, challenging goals that it must meet over five years to maintain the waiver, providers have improved visibility into the trade-offs that lie ahead. With agreed upon targets in hand, the state and providers can focus discussions on how to achieve those targets as opposed to negotiating the targets themselves.





## Recommended Reading

- Patel et al. "Maryland's Global Hospital Budgets — Preliminary Results from an All-Payer Model." *New England Journal of Medicine* 373, no. 20 (November 2015): 1899-901. <http://www.nejm.org/doi/pdf/10.1056/NEJMp1508037>.
- Rajkumar et al. "Maryland's All-Payer Approach to Delivery-System Reform." *New England Journal of Medicine* 370, no. 6 (January 2014): 493-95. <http://www.nejm.org/doi/citedby/10.1056/NEJMp1314868#t=article>.
- Murray, Robert. "The Maryland All-Payer Hospital Rate Setting System: A Look Back – How Did We Get Here?" December 2014. <http://www.hilltopinstitute.org/news/Murray-presentation-141205.pdf>.
- Maryland Hospital Association. *Achievement, Access, and Accountability: Maryland's All-Payer Hospital Payment System*. Issue brief. July 2007. [http://www.hscrc.maryland.gov/documents/HSCRC\\_PolicyDocumentsReports/GeneralInformation/AshbyReport2007.pdf](http://www.hscrc.maryland.gov/documents/HSCRC_PolicyDocumentsReports/GeneralInformation/AshbyReport2007.pdf).
- Health Services Cost Review Commission. *Monitoring of Maryland's New Maryland All-Payer Model Biannual Report*. Report. April 2015. <http://www.hscrc.state.md.us/documents/Legal-Legislative/Reports/HSCRC-Biannual-Report-on-All-Payer-Model-April-2015.pdf>.

## Works Cited

Advanced Health Collaborative. <http://www.ahcmaryland.org/about-us/>.

Atkinson, Graham. "Issue Brief: State Hospital Rate-Setting Revisited." *The Commonwealth Fund*, October 2009. [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2009/oct/1332\\_atkinson\\_state\\_hospital\\_ratesetting\\_revisited\\_1015.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2009/oct/1332_atkinson_state_hospital_ratesetting_revisited_1015.pdf).

Centers for Medicare & Medicaid Services. *Maryland All-Payer Model Agreement*. 2014. [http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs\\_hospital/documents/chcf\\_all\\_payer\\_model\\_agreement.pdf](http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/chcf_all_payer_model_agreement.pdf).

Colmers, John. "Taking Payment Reform 'Global': How Maryland's Hospital Rate Waiver Will Change Hospital Financial Incentives and Rewards Through Global Budgeting." October 2014. [http://www.academyhealth.org/files/HCFO/Colmers\\_RWJF - Academy Health - 102414 - FINAL.pdf](http://www.academyhealth.org/files/HCFO/Colmers_RWJF_-_Academy_Health_-_102414_-_FINAL.pdf).

Cornish, Audie, and Andrea Hsu. "In Maryland, A Change In How Hospitals Are Paid Boosts Public Health." *NPR*. October 2015. <http://www.npr.org/sections/health-shots/2015/10/23/451212483/in-maryland-a-change-in-how-hospitals-are-paid-boosts-public-health>.

CRISP. <https://crisphealth.org/FAQs>.

Department of Health and Mental Hygiene. "DHMH, HSCRC Award \$2.5 Million to 8 Regional Partnerships." May 2015. <http://dhmh.maryland.gov/newsroom/Pages/Health-Transformation-Grants.aspx>.

Doctors Community Hospital. "Southern Maryland Regional Coalition for Health System Transformation Awarded \$200,000 Planning Grant." News release, May 2015. <http://www.dchweb.org/about-us/media-center/news-releases/southern-maryland-regional-coalition-health-system>.

Eastaugh, Steven R. *Health Care Finance: Economic Incentives and Productivity Enhancement*. Greenwood Publishing Group, 1992.

Foreman, Arin, and Jennifer Hulvey. "HSCRC Rate System." January 2014. <http://slideplayer.com/slide/4464594/>.

Health Services Cost Review Commission. Agreement: Global Budget Revenue and Non-Global Budget Revenue. March 2014. <http://www.hscrc.state.md.us/documents/global-budgets/Global-Budget-Revenue-Agreement-AAMC.pdf>.

Health Services Cost Review Commission. "Completed Agreements under the All-Payer Model." <http://www.hscrc.maryland.gov/gbr-tpr.cfm>.

Health Services Cost Review Commission. "Global Budget Revenue (GBR) Potentially Avoidable Utilization (PAU) Efficiency Adjustment." <http://www.hscrc.state.md.us/init-gbr-pau.cfm>.

Health Services Cost Review Commission. "Hospital Rates, Charge Targets, and Compliance." [http://www.hscrc.state.md.us/hsp\\_Rates.cfm](http://www.hscrc.state.md.us/hsp_Rates.cfm).

Health Services Cost Review Commission. "HSCRC Overview." <http://www.hscrc.state.md.us/aboutHSCRC.cfm>.

Health Services Cost Review Commission. Monitoring of Maryland's New Maryland All-Payer Model Biannual Report. Report. April 2015. <http://www.hscrc.state.md.us/documents/Legal-Legislative/Reports/HSCRC-Biannual-Report-on-All-Payer-Model-April-2015.pdf>.

Health Services Cost Review Commission. "New All-Payer Model for Maryland Global Budget Development for FY 2014." March 2014. <http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/pay/2014-03-13/global-budget-update-3-11-14.pdf>.

Health Services Cost Review Commission. "Quality Improvement." HSCRC Initiatives. [http://www.hscrc.state.md.us/init\\_qi.cfm](http://www.hscrc.state.md.us/init_qi.cfm).

Health Services Cost Review Commission. "Review of Market Shift Calculations." May 2015. <http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/pay/2015-05-04/6-Draft-Market-Shift-Calculations-20150501.pdf>.

Health Services Cost Review Commission. "TPR Rate Setting Methodology." [http://www.hscrc.state.md.us/init\\_tpr.cfm](http://www.hscrc.state.md.us/init_tpr.cfm).

Maryland Hospital Association. Achievement, Access, and Accountability: Maryland's All-Payer Hospital Payment System. Issue brief. July 2007. [http://www.hscrc.maryland.gov/documents/HSCRC\\_PolicyDocumentsReports/GeneralInformation/AshbyReport2007.pdf](http://www.hscrc.maryland.gov/documents/HSCRC_PolicyDocumentsReports/GeneralInformation/AshbyReport2007.pdf).

McDonough, J. E. "Tracking the Demise of State Hospital Rate Setting." Health Affairs 16, no. 1 (1997): 142-49. <http://content.healthaffairs.org/content/16/1/142.full.pdf>.

Murray, Robert. "Setting Hospital Rates To Control Costs And Boost Quality: The Maryland Experience." Health Affairs 28, no. 5 (2009): 1395-405. <http://content.healthaffairs.org/content/28/5/1395.full>.

Murray, Robert. "The Maryland All-Payer Hospital Rate Setting System: A Look Back – How Did We Get Here?" December 2014. <http://www.hilltopinstitute.org/news/Murray-presentation-141205.pdf>.

Patel et al. "Maryland's Global Hospital Budgets — Preliminary Results from an All-Payer Model." New England Journal of Medicine 373, no. 20 (November 2015): 1899-901. <http://www.nejm.org/doi/pdf/10.1056/NEJMp1508037>.

Rajkumar et al. "Maryland's All-Payer Approach to Delivery-System Reform." New England Journal of Medicine 370, no. 6 (January 2014): 493-95. <http://www.nejm.org/doi/citedby/10.1056/NEJMp1314868#t=article>.



Schmith, Jerry. "History and Overview of the HSCRC." January 2015.  
[http://hfmamd.org/downloads/HSCRC\\_Workshop\\_2015/schmith\\_hscrc\\_history\\_overview.pdf](http://hfmamd.org/downloads/HSCRC_Workshop_2015/schmith_hscrc_history_overview.pdf).

Sharfstein, Joshua M., MD. "Maryland All-Payer Hospital Model." May 2014.  
[http://www.nhpf.org/uploads/Handouts/Sharfstein-slides\\_05-30-14.pdf](http://www.nhpf.org/uploads/Handouts/Sharfstein-slides_05-30-14.pdf).

Sun, Lena H., and Sarah Kliff. "Maryland Already Sets Hospitals' Prices. Now It Wants to Cap Their Spending." The Washington Post, May 25, 2013.  
<https://www.washingtonpost.com/news/wonk/wp/2013/05/25/maryland-already-sets-hospitals-prices-now-it-wants-to-cap-their-spending/>.

Zito, Michael A., Jr. "Maryland Rate Regulation Overview and Potential Impact of Healthcare Reform." March 2012.  
[http://hfmamd.org/images/meeting/033012/rate\\_regulation\\_overview\\_033012\\_5.pptx](http://hfmamd.org/images/meeting/033012/rate_regulation_overview_033012_5.pptx).