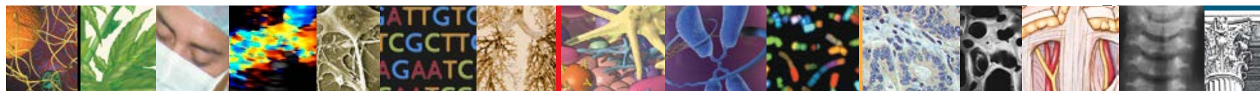

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Perspective

Maryland's All-Payer Approach to Delivery-System Reform

Rahul Rajkumar, M.D., J.D., Ankit Patel, J.D., Karen Murphy, Ph.D., John M. Colmers, M.P.H.,
Jonathan D. Blum, M.P.P., Patrick H. Conway, M.D., and Joshua M. Sharfstein, M.D.

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) and the State of Maryland jointly announced the launch of a statewide model that will transform Maryland's health care delivery system. Although some aspects of the new approach may be unique to Maryland and not applicable elsewhere, both the principles of this model and the process that led to its development may serve as a guide for future federal–state partnership efforts aiming to improve health care and to lower costs through an all-payer approach.

Since the late 1970s, Maryland has operated what is now the country's only all-payer rate-setting system for hospital services. An independent commission sets a rate structure for each hospital. All payers, public and private, pay for services according to these rates. Medicare's participation is authorized by the Social Security Act and is tied to a growth limit in Medicare payment per hospital admission.

This system has eliminated cost shifting among payers, more equitably spread the costs of uncompensated care and medical education, and limited the growth of per-admission costs. The system's historical performance in containing payments per admission for all payers has been notable.[1] However, in recent years, both the incentives created by Maryland's current Medicare waiver and changes in the delivery system have created unnecessary pressure to increase the volume of hospital services provided. This pressure, combined with the fact that Medicare pays higher rates for hospital services in Maryland than it does under the national prospective payment systems for inpatient and outpatient care, has resulted in per capita Medicare hospital costs in Maryland that are among the country's highest.

The new model, which is made possible by the authority granted to the Center for Medicare and Medicaid Innovation under the Affordable Care Act, will change the basis for Medicare's participation in Maryland's system. In place of the limit on per-admission payment, the new model focuses on overall per capita expenditures for hospital services, as well as on improvements in the quality of care and population health outcomes.

For 5 years beginning in 2014, Maryland will limit the growth of per capita hospital costs for all payers, including the growth of costs of both inpatient and outpatient care, to 3.58%, the 10-year compound annual growth rate of the per capita gross state product. Maryland will also limit the

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annual growth of Medicare's per capita hospital costs to 0.5% less than the actual national growth rate per year for 2015 through 2018, thereby saving Medicare at least $330 million over the next 5 years. The new approach does not change the fundamental entitlement nature of Medicare or Medicaid and does not affect the guarantee of care for beneficiaries.

In addition, Maryland has set the goal of reducing its unadjusted all-cause, all-site hospital readmission rate for Medicare beneficiaries to the national mean over 5 years by surpassing the improvements that are occurring in other states. The state has established a readmission-reduction program based on payment levels per 30-day episode that have shown some impressive initial results. Similarly, Maryland will measure its performance on prevention of 65 potentially preventable conditions associated with hospital care and seek a cumulative aggregate reduction of 30% on these measures over 5 years. In this area, the state has tied increasing amounts of revenue to performance on measures of both absolute and relative quality of care. CMS will conduct a rigorous evaluation of the model that examines its effects on the total cost of care, quality, access, and patient experience.

To succeed under the new model, Maryland's rate-setting commission, known as the Health Services Cost Review Commission, will change its approach to regulation. Over the past several decades, the commission has adjusted rates for hospital services on an annual basis. The commission's update is based on multiple factors, including the Medicare "market basket" forecast, current economic conditions, productivity improvements, changes in case mix, and the previous year's performance. In addition to the annual rate update, the commission has also developed a variable-cost-factor tool that is designed to influence hospitals' behavior by reducing the incentive for increased volume. Using this tool, the commission allows hospitals to keep only a fraction of revenue for incremental increases in volume above a budgeted amount, which can be modified on the basis of demographic trends, hospital performance, and other factors. Conversely, as volume declines, the commission permits hospitals to retain a portion of the lost revenue.

Over the next 5 years, the commission will seek to shift hospital revenue away from fee-for-service models into population-based payment models that reward providers for improving health outcomes, enhancing quality, and controlling costs. Maryland already operates a "Total Patient Revenue" model that establishes fixed global budgets for certain rural hospitals on the basis of historical trends in the cost of providing care for the specific populations they serve. Future models may include providing a fixed amount of revenue for organizations caring for geographically defined populations, establishing rules that apply to all payers covering care provided by accountable care organizations, or bundling payments. The state's all-payer system offers a powerful platform that will allow CMS and Maryland to work together to test innovations and payment reforms.

The resulting changes should be visible at hospitals throughout Maryland in the form of more coordinated care, a greater emphasis on care transitions, and a renewed focus on prevention. Maryland hospitals are already actively engaged in community health planning. Early experience with global budgets in the state suggests that with the right incentives, hospitals will collaborate with public health agencies, community health organizations, long-term care providers, and others in a range of creative ways.[2] The new payment structure will align the incentives for hospitals and the state's growing number of patient-centered medical homes to manage the health of populations. In the second stage of the plan, starting in 2019, Maryland will seek to build on this progress to control the total cost of health care.

The process of developing Maryland's all-payer model was transparent, productive, and sometimes intense. Within Maryland, hospitals, payers, physician organizations, consumer groups, and others contributed ideas — and eventually their support — in dozens of meetings and through public commenting. Maryland health officials met with CMS representatives for more than a year, sharing ideas on how the all-payer system could be aligned with the goals that CMS has set for the country in terms of lower cost and improved outcomes in health care. Although CMS has a long history of working with states through the Medicaid program and already collaborates with states on multiple innovative reforms, this model is unique in its all-payer approach. The two parties were able to reach agreement because they concentrated on areas of mutual benefit and shared goals.

CMS and Maryland have a strong shared interest in the success of this model. If it proves successful, Marylanders, including

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both Medicare and Medicaid beneficiaries, will benefit from improved health at lower cost, and the experience will offer an important proof of concept for other states. If it's unsuccessful, Maryland will transition to the national Medicare hospital-payment system over the course of 2 years — abandoning an approach to hospital financing that has served the state well for more than three decades.

The new model addresses two challenges in health care in ways that should provoke thoughtful examination. First, a critical challenge for national delivery-system reform is to align payment incentives across multiple payers. Maryland's all-payer system can be a laboratory for rapid innovation in delivery-system reform, because the state can bring all payers to the table in order to create consistent and aligned incentives for providers. Second, implementing this model throughout a state with more than 5.8 million people living in urban, suburban, and rural settings will test these reforms in many different environments.

With this new foundation, we believe that Maryland has taken an important step forward. Its model heralds a new opportunity to emphasize partnerships between federal and state governments and between the public and private sectors to support delivery-system reform. CMS will continue to seek other state partners that want to transform care delivery by focusing on care improvement, better health, and a more efficient health system.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Centers for Medicare and Medicaid Services (R.R., A.P., K.M., J.D.B., P.H.C.), the Maryland Health Services Cost Review Commission (J.M.C.), Johns Hopkins Medicine (J.M.C.), and the Maryland Department of Health and Mental Hygiene (J.M.S.) — all in Baltimore; Brigham and Women's Hospital, Boston (R.R.); and Cincinnati Children's Hospital Medical Center, Cincinnati (P.H.C.).

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