Maryland Tests Whether All-Payer Model Based on Total Cost of Hospital Care Can Save Money and Improve Quality

Maryland is the only state with an all-payer model for hospital services, which eliminates the cost-shifting between payers that takes place in other states.

Under an updated version designed to reduce avoidable emergency room, inpatient and outpatient spending at hospital-owned facilities, hospitals have agreed to a 3.58 percent annual ceiling on per capita hospital revenue growth. Furthermore, Maryland has assured the Centers for Medicare and Medicaid Services (CMS) $330 million in Medicare savings over five years.

For an update on the new initiative, we spoke with John M. Colmers, Vice President of Health Care Transformation and Strategic Planning at Johns Hopkins Medicine, and Chairman of Maryland's Health Services Cost Review Commission; and Carmela Coyle, President and Chief Executive of the Maryland Hospital Association.

***John M. Colmers** is Vice President of Health Care Transformation and Strategic Planning for Johns Hopkins Medicine.*

***Carmela Coyle** is President and CEO of the Maryland Hospital Association.*

What was the thinking behind the shift to an all-payer system based on global budgets, and what are you hoping to achieve that wasn't possible under the prior system?

Carmela Coyle: For 40 years, Maryland has had an all-payer system. Hospitals don't determine how much they charge for their services; instead, an independent state commission does. All Marylanders pay the same price for the same service in the same hospital, no matter who is paying the bill – Medicare, Medicaid, Blue Cross Blue Shield, United Healthcare, Kaiser, or an uninsured individual. While this system has reduced the rate of growth in hospital spending, there were clearly opportunities to reduce the rate of growth in both hospital and non-hospital costs overall.

John Colmers: The old model was not sustainable. Many things hospitals have been trying to achieve nationally – like reducing readmissions and complications – have the effect of increasing payments per admission under an all-payer model. That's because you are removing less expensive cases from the equation. In other words, our desire to do the right thing was threatening our ability to keep the system all-payer.

This initiative isn't an attribution model, but literally a global budget model based on a hospital's total prior year revenues. Can you explain how this works?

Coyle: In an attribution model, you identify patients or individuals and assign them to a particular insurance company, or in this case, to a hospital. In a global budget model, each hospital receives an amount of money for the entire year and is asked to take care of anyone who comes through their doors. The global budget is based on what the hospital's total patient revenues were in the prior year with some adjustments. The independent rate-setting commission adds these global budgets across the state to ensure we don't exceed the spending growth limits outlined in the experiment.

Colmers: A hospital won't receive any more revenues beyond what has been approved under its global budget agreement. If a hospital goes over its approved budget, its

rates are reduced in the subsequent year. But if a hospital is under budget because it did a good job of reducing readmissions or unnecessary care, it will be allowed to raise unit prices. In other words, hospitals aren't penalized if doing the right thing results in lower volume.

How will you navigate through the various laws and regulations – Stark, for example – that make it difficult to align incentives across providers in order to manage the total cost of care?

Coyle: This is one of our most difficult challenges. We've got a 40-year-old mechanism in place for controlling hospital rates. We do not have mechanisms for controlling spending in the physician sector, in the post-acute care sector, or in the pharmaceutical sector. We will examine Stark waivers that align the economic interests of physicians and hospitals. We want providers to pull on the same rope, for example, by meeting specific quality measures, utilizing the same cost reduction techniques, or working together to reduce inpatient hospital services and treat people more cost-effectively.

Colmers: We need the authority to address things such as gain-sharing and other forms of collaboration between hospitals, physicians, and nursing homes. Those tools are not immediately available. As these new models develop, we will go back and ask for specific authorities to meet the exemptions that are permissible under Stark and other federal laws.

How did you convince hospitals to make the types of infrastructure investments necessary to coordinate and integrate care delivery?

Colmers: It doesn't take convincing when you change the financial incentives. Hospitals want to do it. A broader question was whether the Commission was going to provide some upfront funding and allow investments within the constraints of the global growth rate. As it turned out, the Commission did allow those investments. And if hospitals are able to generate savings based on reduced spending, they will be able to use those savings to invest in both infrastructure and the community.

Coyle: We described it as an almost immediate 180-degree turn. Under the old way of paying for hospital care, you were paid per admission. So the focus was really just on acute inpatient care. As soon as you change the incentives using global budgets for the total cost of care, it immediately makes economic sense for hospitals to be sure patients are treated in the most appropriate settings possible.

What are the first steps others should take when considering whether to adopt an all-payer approach coupled with a global budget for hospitals in their states?

Colmers: Let me be very clear. I don't know whether the other states would consider doing this. We have had an all-payer system in Maryland since 1977, so it's something that's very familiar for us and works well for us. Our goal here is not to proselytize and get everybody else to do what it is that we are doing.

We do think that there are valuable lessons that CMS and others can learn. Aligning incentives to improve the delivery system requires a degree of cooperation, trust and work with the payer and political leadership, so that's an important lesson.

Coyle: Right now we're working to improve the system we have in Maryland, but it may not be workable for other states. The greatest challenge is that hospitals are required to redefine themselves to be about more than just hospital care. This is about hospitals refocusing on health care in their communities. The challenges associated with working together to keep people healthy and truly engaging patients and families as a critical part of the care delivery team will ultimately be a key to success.

This is a five-year initiative. What comes next?

Colmers: The model itself at this point is primarily a hospital model. We do have what we call a "guard rail" regarding total spending. CMS' concern was that by holding down hospital costs, that somehow we would see this vast explosion of non-hospital spending, so we are going to monitor that. Our goal long-term, and our commitment in this demonstration, is that by the end of the third year to have a proposal to go back to CMS and look at the total cost of care.

Coyle: One of the things we will be pursing is hospital/physician gain-sharing. It's another way for us to create economic alignment between physicians and hospitals and to share in some of the savings that are generated. There may also be opportunities for us to focus on specific bundles of payment – acute/post-acute – and ways to change how we are paid to encourage and incent providers in Maryland to work together. So those are just some of the examples of the kind of things we will be exploring and likely testing as this experiment continues over the next five years.