MARYLAND ALL PAYER SYSTEM:

HISTORY AND PERFORMANCE

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OUTLINE

- History
- Structure
- Performance
- Tools
- S.W.O.T. Analysis
- Discussion

Background/Disclaimer

HISTORY OF PAYMENT REFORM IN MARYLAND

The Maryland Experiment

IN MARYLAND…THINGS ARE DIFFERENT

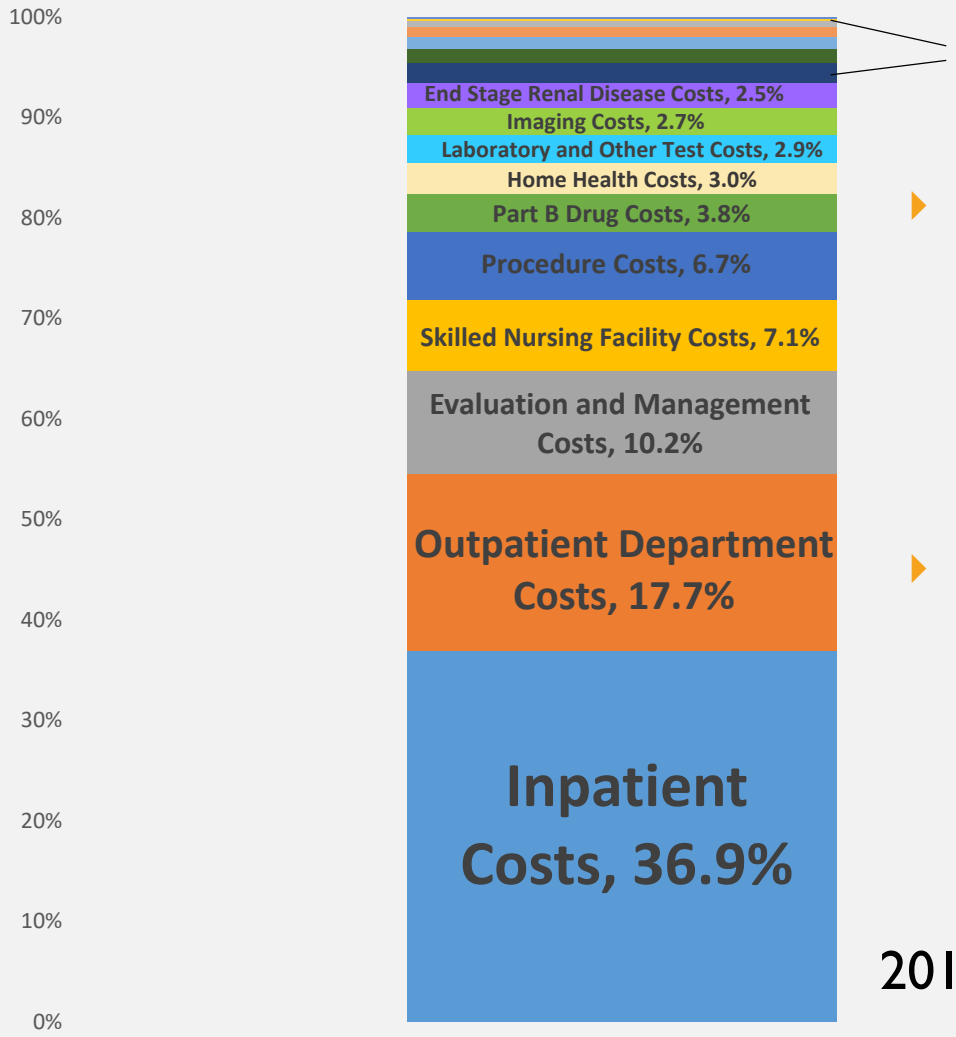
All-Payer hospital rate setting system since 1977

- Maryland has set hospital rates since the mid-1970s
  - **H**ealth **S**ervices **C**ost **R**eview **C**ommission
    - Independent 7- member Commission
    - Public utility model
    - Serves as watchdog and regulator
- Maryland hospitals are *waived* from Federal Medicare payment methods
  - Hence – The Medicare waiver)
- All payers participate
- Unique in the country

VALUE OF THE ALL-PAYER SYSTEM

- Cost containment for the public
- Equitable funding of uncompensated care
- Stable and predictable payment system for hospitals
- All payers fund GME
- Transparency
- Leader in linking quality and payment
- Local access to regulators
- Avoids cost shifting across payers

WHY START WITH HOSPITALS?



- ~75%+ of Medicare expenditures are tied to a hospitalization
  - Hospitals ~56%
  - Post-acute ~12%
  - Facility related physician fees ~10%
- Importance of Medicare waiver

2015 Maryland Medicare Dollar %

TIMELINE

1971

- Enabling Statute
- Broad authority

1977

- Medicare Waiver

1980-2013

- Per case payment
- Early geographic payment

2014

- Global budget model

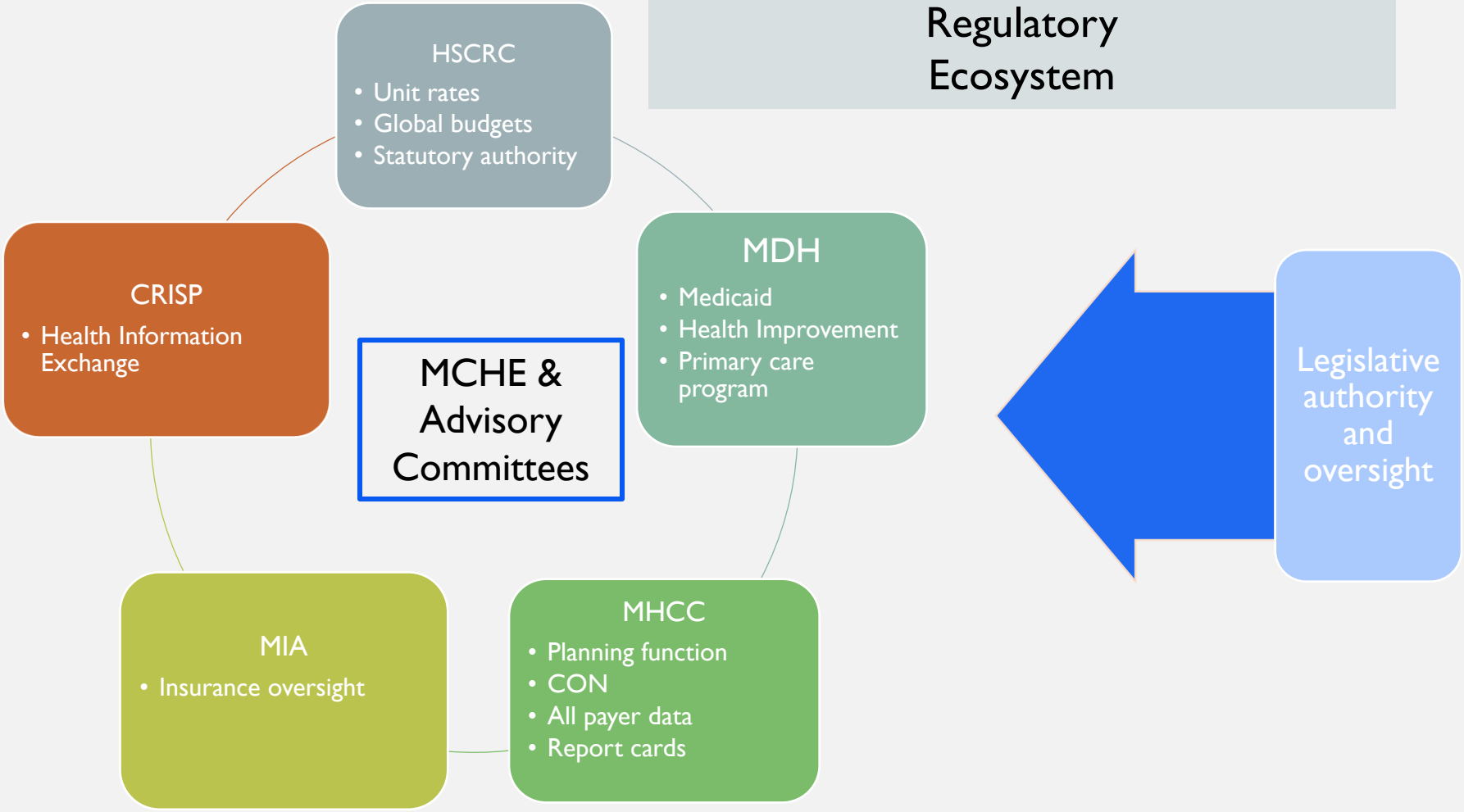
2018

- Total Cost of Care (TCOC) Model
- MDPCP
- Episode payments

2024

- Ahead Contract signed

Regulatory Ecosystem



Legend

- HSCRC – Health Services Cost Review Commission
- MDH – Maryland Department of Health
- MHCC – Maryland Health Care Commission
- MIA – Maryland Insurance Administration
- CRISP – Chesapeake Regional Information System for our Patients
- MCHE – Maryland Commission on Health Equity

HSCRC TOOLS

- Rate setting
- Annual Update
  - Inflation
  - Quality Performance
  - Compliance to Global Budget/MPA
  - Volume
    - Demographic
    - Market shift
    - Other
  - Integrated Efficiency
    - Revenue for Reform

PERFORMANCE

[Mathematica, Inc., *Evaluation of the Maryland Total Cost of Care Model: Progress Report. April 2024*]

Exhibit ES.3. The model reduced Medicare spending and service use during the MD TCOC period (2019 to 2022), with effects that were generally larger than those at the end of the MDAPM period

Outcome	Favorable direction of effect[b]	Average annual percentage impact of the Maryland Model[a]: During the last two years of the MDAPM period (2017 to 2018)	During the MD TCOC period (2019 to 2022)	Difference[c]
Medicare FFS spending				
Total Medicare FFS spending (Part A and B)	↓	-1.1%*	-2.1%**	-1.0pp**
Total Medicare FFS spending + non-claims payments[c]	↓	-1.3%**	-2.2%**	-0.9pp**
Hospital spending (inpatient and outpatient)	↓	-4.7%**	-6.1%**	-1.4pp**
Non-hospital spending	↓ or ↑[e]	3.6%**	3.1%**	-0.5pp
Service use and quality of care				
All-cause acute care hospital admissions	↓	-10.6%**	-16.2%**	-5.6pp**
Outpatient ED visits and observation stays	↓	-2.8%**	-5.9%**	-3.1pp**
Intensity of hospital care (measured by standardized hospital spending)[d]	↓	-4.6%**	-8.0%**	-3.4pp**
Potentially preventable admissions	↓	-9.9%**	-16.8%**	-6.9pp**
30-day post-discharge unplanned readmission	↓	-7.9%**	-8.9%**	-1.0pp*
Timely follow-up after acute exacerbation of chronic conditions	↑	2.2%**	2.6%**	0.4pp
Patient experience				
Patients' rating of their personal doctor	↑	0.10%	0.30%	0.2pp
Patients' rating of their hospital[e]	↑	1.50%	0.70%	-0.8pp
Medicare Diabetes Prevention Program				
Use of Diabetes Prevention Program services[f]	↑	Not shown[g]	Not shown[g]	Not shown[g]

PERFORMANCE

Mathematica, Inc., *Evaluation of the Maryland Total Cost of Care Model: Progress Report. April 2024*

Exhibit ES.1. All-payer hospital global budgets, the Maryland Primary Care Program, and quality adjustments to hospital budgets were the largest potential drivers of change in the MD TCOC Model in 2022, as measured by the statewide size of the incentive or investment

MD TCOC Model component	Measure of incentive size or investment	Size of incentive or investment in 2022 ($ millions)
1. All-payer hospital budgets	Retained revenue: The difference between a hospital's revenues based on its global budget and the lower revenues it would have earned due to volume reductions under an FFS schedule[a]	−$79M / $1.1B
2. Maryland Primary Care Program	Payments to participating practices and their supporting Care Transformation Organizations	$195M
3. Quality adjustments to hospital global budgets	Adjustments to hospital budgets based on each hospital's performance on quality measures	−$102M / $86M
4. Medicare Performance Adjustment	Adjustments to hospital budgets based on each hospital's performance on total cost of care for Medicare FFS beneficiaries	−$42M / $25M
5. Regional Partnership Catalyst Grants	Competitive grant funding for hospitals for diabetes prevention and management services and for behavioral health crisis services	$27M
6. Episode Care Improvement Program	Amount hospitals received for reducing Medicare episode costs while meeting quality targets	$2M

Loss Gain

[a] Hospitals that exceeded volumes built into their global budgets had negative retained revenue.

B = billion; FFS = fee-for-service; M = million.

FUNDAMENTAL CHALLENGE

Create results of a well-organized pre-payment model

without capitated payment

S.W.O.T ANALYSIS

	+	-
Internal	**Strengths**	**Weaknesses**
External	**Opportunities**	**Threats**

STRENGTHS

- Longevity
- Infrastructure
- All Payer
- CRISP
- Results in TCOC/Readmissions
- Political support
- Covid-19

WEAKNESSES

- Complex system/Difficult to replicate
- Volume policies
- Retained revenue
- Slow to respond
- Lack of Planning – Capacity imbalance
- Physician alignment
- ED wait times

OPPORTUNITIES

- Improved alignment across payers/providers
- Medicaid MDPCP
- More delivery system reform
- Improved Incentives
- Use savings to innovate

THREATS

- Uncertainty in Washington
- Political changes

DISCUSSION