Maryland All-Payer & Total Cost of Care Models

Facility Based Global Budgets

The Maryland All-Payer Model is centered around a facility-based global budget, which sets a prospective budget around the expected spending of a facility (such as a hospital) to provide services and care for their patient population. This approach provides facilities with greater certainty about their annual revenue and budget.

The elements of the Maryland All-Payer Model include:

1. **Budget Process:** A prospective facility-based global budget for each hospital in the state based on gross hospital revenue from the previous year with adjustments for inflation, infrastructure requirements, demographic changes, payer mix, and performance on quality measures. The budget includes all hospital inpatient and outpatient services unless specifically excluded by the HSCRC.
2. **Payment Approach:** Hospitals continue to bill under the existing fee-for-service system at rates set by the HSCRC, however, they are required to monitor their total year-to-date charges and revenue, compare them to their annual global budget, and adjust unit charges for services on an ongoing basis to remain within the approved budget.
3. **Quality:** Budget are adjusted by performance on hospital acquired conditions, hospital readmission rates, and performance on measures of 1) person and community engagement, 2) clinical care, and 3) patient safety.

Maryland operates the first statewide all-payer global budget model in the United States. Launched in 2014, the Maryland All-Payer model allowed Maryland to set facility-based global budgets for Medicare, Medicaid, and commercial payments for all hospitals in the state. The Maryland All-Payer model was built off a rate setting system established by the Maryland legislature in 1971. The legislation created the Health Services Cost Review Commission (HSCRC), an independent State agency with hospital rate setting authority. The HSCRC was given responsibility for rate setting determinations for private payers in 1974 and expanded to include Medicare and Medicaid under a 1977 federal waiver.

The Maryland All-Payer model was established under the Center for Medicare and Medicaid Innovation (CMMI) waiver authority allowing Maryland to retain its historic rate setting authority for Medicare in exchange for reducing per-capita hospital expenditures and improving patient outcomes. As a condition of the model, Maryland must agree to shift 80 percent of hospital revenue into a facility-based global budget payment model, limit annual per-capita cost growth to 3.58 percent[1], generate at least $330 million in overall Medicare savings, and achieve a 30 percent reduction in hospital-acquired conditions over a five-year model period.

In 2019, Maryland and CMS entered into a new ten-year model agreement called the Total Cost of Care (TCOC) model. The TCOC model built off the Maryland All-Payer model to incorporate financial incentives for hospital and provider alignment on care delivery and state-level accountability for meeting financial targets for all Medicare beneficiary expenditures in the state. The TCOC model added two additional programs to the existing facility-based global budget model, the Care Redesign Program (CRP) and the Maryland Primary Care Program (MDPCP).

[1] This was the 10-year average per capita state gross product calculated at the time of the model design.

The CRP is a voluntary program that allows hospitals to enter into a participation agreement with CMS, the state of Maryland, and providers. Under the agreement hospitals that have reached a Medicare savings threshold may make incentive payments to non-hospital health care providers who partner with the hospital and perform care redesign activities aimed at improving quality of care. The MDPCP is a voluntary program modeled after CMMI's Comprehensive Primary Care Plus model and offers primary care providers a per beneficiary per month payment (PBPM) from CMS to furnish advanced primary care services to their patients. Participating practices are also eligible to participate in one of two tracks, a Standard Track and an Advanced Track, that offer differing levels of performance-based incentive payments and risk for providers who reduce the hospitalization rate and improve the quality of care for their attributed Medicare beneficiaries.

Impacts of the Maryland All-Payer Model

- **Bending the cost curve, reducing admissions, and improving quality:** According to an HSCRC report covering 2014-2017, the Maryland Model has:
    - Controlled health care cost growth, limiting annual per-capita cost growth to 2.03 percent (well below the 3.58 percent model target). This has translated into $916 million in cumulative Medicare savings almost three times the model target of $330 million in savings).
    - Reduced hospital readmissions from 1.22 percent above the national average prior to the model start, to 0.19 percentage points below the national average in 2017.
    - Improved quality by generating a 53 percent reduction in the rate of hospital acquired conditions (HACs) across all payers (exceeding the model target of a 30 percent reduction in HACs).
- **Reduced All-Cause and Avoidable Hospital Admissions:** The final evaluation report issued by CMMI found that from 2014-2018 the Maryland model reduced all-cause and potentially avoidable hospital admissions by almost seven percent.
- **Impacts on Commercial Payer Expenditures:** The same CMMI evaluation found that commercial insurers in Maryland had six percent slower growth in hospital expenditures during the course of the model.

CMMI was essential to the reimagining of the 1970's era Maryland rate setting system. CMMI's ability to test the unique payment reform approach central to the All-Payer Model generated valuable data to inform the development of the more mature Total Cost of Care Model, which addresses the challenge of aligning hospitals and primary care.