Health Reform in Maryland:

Lessons for Other States and the Nation

Prepared by Jack Meyer, Ph.D.

for the Roundtable on Maryland Health Reforms

School of Public Policy, University of Maryland

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Introduction and Statement of Purpose

The purpose of this report is to summarize the highlights of the Roundtable Discussion on Maryland health reform conducted by the School of Public Policy at the University of Maryland. This meeting, facilitated by Jack Meyer, Visiting Professor at the School of Public Policy, was held on September 19, 2019. Participants included outside experts and members of the faculty, along with some graduate students. The purpose of this meeting was to explore elements of key Maryland health reforms that might provide useful lessons for other states as well as be building blocks of future national reforms. An ancillary goal was to identify ways to explain the Maryland reforms in an easily understandable fashion in order to help people who are not deeply involved in these policies understand how they affect patients receiving care, the impact on a wide range of hospitals, physicians, and others who deliver care, and the major payers.

The Development of the Maryland Model

From 2014 through 2018, the Maryland Health Services Cost Review Commission (HSCRC) implemented the first phase of a fundamental reform to its four-decade long All-Payer Model. Prior to this reform period, the All-Payer Model had three successful accomplishments. First, it greatly reduced and nearly completely eliminated the public-to-private health care cost shift, under which Medicare payments were significantly below commercial payer payments to hospitals while Medicaid payments were much lower still. Maryland government officials, as far back as the 1970s, understood that cost shifting is not cost control and greatly reduced the public/private payment differential. This required a waiver from the federal government enabling the public programs to pay hospitals virtually the same rates as they were paid by private insurers and self-insured employers, rather than the way they paid hospitals in all other states, which starting in 1984 became inpatient and outpatient prospective payment systems under Medicare featuring Diagnosis Related Groups, or DRGs.

Second, this original system included substantial payments to hospitals for uncompensated care. Third, the cost per case payments created incentives for hospitals to deliver care more efficiently.

This system worked well both in Maryland and for the federal government for nearly four decades. But in the years just before the start of this five-year reform period, the Centers for Medicare & Medicaid Services (CMS) expressed concern that they might be paying too much in Maryland and needed stronger cost controls in place in order to renew their commitment to the All-Payer Model.

The Transformation of the Maryland Model

The main feature of the new All-Payer Model was the conversion from setting a hospital revenue cap based on *hospital costs per case in the inpatient setting* to a system setting a revenue cap based on *total hospital cost per capita.* The new system held hospitals accountable not only for the cost of an inpatient hospital stay, as before, but also *admission rates, readmission rates, and hospital outpatient costs.* No longer would hospitals be rewarded for ever-higher volume. Rather, there would be strong incentives to reduce avoidable ER use, inpatient admissions and readmissions, and hospital outpatient care. This created new incentives to rely strongly on both clinical preventive services and community-based services that address the social determinants of health.

Maryland met all the targets established in the 2014-2018 All-Payer Model agreement with CMS:

- Cumulative five-year Medicare savings in hospital expenditures at the end of 2018 were $1.4 billion, compared to the $330 million promised over five years. The cumulative savings result in Medicare spending that is 8.74 percent below the national average since 2013.
- All-Payer hospital annual revenue growth per capita, promised to be less than 3.58 percent per year,[1] was held to 1.47 percent in 2014, 2.31 percent in 2015, 0.8 percent in 2016, 3.54 percent in 2017, and 1.50 percent in 2018.
- The All-Payer Quality Improvement reduction in potentially preventable conditions (PPCs), promised to be at least 30 percent over five years, was 51 percent after five years (end of 2018).
- Maryland moved from exceeding the national average in readmissions for Medicare in 2013 (16.6 percent in Maryland compared to 15.38 percent nationally) to a readmission rate for Medicare that was slightly below the national average at the end of 2018 (15.40 percent in Maryland compared to 15.45 percent for the nation).[2]

The Total Cost of Care Model

In January 2019 Maryland began the second phase of its major reforms under the Total Cost of Care (TCOC) Model, or as it is sometimes now referred to, the Maryland Model. Under the new agreement with CMS, which can last up to ten years, Maryland has committed to achieve an annual Medicare savings target of $300 million by year five (2023), and a cumulative amount of Medicare savings of about $1 billion over the first five years of the agreement (2019-2023).[3]

Outcomes Based Credits

An important element of the Maryland Model that other states may want to consider involves Outcomes-Based Credits for achieving population health improvement targets. Under their agreement with CMS, Maryland must address a minimum of three population health priorities and establish an acceptable methodology for assessing the State's performance in achieving specific targets against a national comparison group. Maryland has until December 31 of each Model Year to ask CMS for Outcomes Based Credits to be applied to the Annual Medicare Savings for the Model Year, and must

[1] The rate of 3.58 percent was the average annual rate of growth in Maryland's Gross Domestic Product (GDP) over the ten-year period preceding the new Model. Thus, Maryland committed to ensuring that hospital revenues would not grow faster than the Maryland economy had grown over the previous decade. This commitment can be seen against the backdrop of several decades in which the growth in US health care spending has outpaced the growth of the US economy by a significant margin.

[2] Maryland Health Services Cost Review Commission. All-Payer Model Results, CY 2014-2018. Updated by HSCRC to include 2018 results.

[3] If annual Medicare savings in 2019 or 2020 exceed annual savings targets, CMS will add one-half of the difference between actual Medicare savings for that year and the annual target for that year to the Annual Medicare Savings for the subsequent year, so that the State gets partial credit for exceeding the targeted savings. The TCOC model features "guardrails" that limit "over-runs." During the performance period, Medicare TCOC per beneficiary must not exceed the growth of national Medicare TCOC by more than 1 percent in any given year and must not exceed the growth rate in national Medicare TCOC by any amount for two or more consecutive years. Maryland Total Cost of Care Model State Agreement. July 9, 2018. http://hscrc.state.md.us/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf

submit data, programs, and documentation showing both the performance achieved compared to the targets and the savings to Medicare.[4]

One participant stated that this arrangement between Maryland and CMS is a welcome and unusual case of "monetizing" savings from population health initiatives. For example, if Maryland is successful in lowering the incidence of diabetes, the State would get a "credit" toward the next year's TCOC. This type of arrangement, according to this participant, is unprecedented and very welcome as a specific reward for meeting a population health goal.

Other Key Features of the Model Agreement

The TCOC agreement between Maryland and CMS stipulates that over the performance period of the model, by May 1 of each year, Maryland must report to CMS the percentage of payments that are literally population-based. The objective seems to be to move gradually but steadily toward a system in which hospitals' revenue caps are determined by the expected total costs of serving the full population in a region surrounding them.[5]

Other adjustments to the global budgets stipulated in the Model agreement between Maryland and CMS include the Public Payer Differential, under which public payers such as Medicare and Medicaid pay slightly lower rates than private payers,[6] and the Medicare Performance Adjustment (MPA). The MPA is an algorithm for attributing Medicare fee-for-service beneficiaries to Maryland hospitals for purposes of calculating the total cost of care attributed to that hospital. Thus, the MPA is important to moving toward the accountability of hospitals for population-based health. The Quality Adjustment Score measures hospitals' progress in reducing hospital-acquired conditions, such as infections, and the hospital readmission trends are tracked by using the all-payer, case-mix adjusted readmission rate. Under the Care Redesign Program, hospitals have formed partnerships with physicians and other providers, as well as with private payers, to improve care management for patients with complex medical conditions. The focus is on "warm hand-offs" from hospitals to skilled nursing facilities, home health agencies, other providers, and to the patient's home, to avert situations in which patients "fall over a cliff" after leaving the inpatient hospital setting. Under the Care Redesign program, the federal government provides waivers from various federal laws that allow providers to cooperate in care management for high-need patients without legal penalties.[7]

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[4] Maryland Total Cost of Care Model State Agreement. Signed July 9, 2018. p. 15. https://hscrc.state.md.us/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf

[5] Maryland must use its All-Payer rate-setting authority to ensure that 95 percent of all Regulated Revenue for Maryland residents is paid according to Population-Based Payments that will be subject to adjustments based on hospital quality results and Value-Based Payment programs developed and administered by the State. But recognizing that in the initial years at least, most hospitals will not be ready to take full accountability for the total cost of care for all fee-for-service Medicare patients in a geographic area, including physician services, diagnostic testing, post-acute and long-term care, the agreement says that Maryland can meet this obligation in one of two ways—first, through directly population-based payments, such as prospectively tying hospitals' reimbursement to the projected utilization of services by a specific population or sub-population; or second, by establishing a fixed budget for Regulated Maryland hospitals for services expected to be furnished. Maryland Total Cost of Care Model State Agreement. Supra. pp. 16-17.

[6] Such differentials are very small, and the gap is substantially smaller than found in other states. Thus, the public-to-private cost shift, while not completely eliminated, is very slim in comparison to usual practices in the US.

[7] Maryland Total Cost of Care Model Agreement. Supra.

Supporting Primary Care Practices

An important feature of the Total Cost of Care Model is primary care practice transformation. Under the traditional model, primary care physicians spend a small amount of time with a large number of patients, with all work done in the office during normal business hours. Neither doctors nor patients are pleased with such arrangements; there is scant time for the physician to get the full picture of a patient's needs, which frequently go beyond physical conditions to involve behavioral health problems and social needs that adversely affect health.[8]

The new Maryland Primary Care Program (MDPCP) began in January 2019 and will enable Maryland to transition away from encouraging more services and higher costs to rewarding efficiency, value, and better health outcomes.[9] Practices in the program are expanding their capabilities to offer comprehensive health care including expanded access to care, robust care management services, coordinated services with other health care entities, improved beneficiary supports and care planning, and a data-focused approach to managing the health of the practices' patient population. With enhanced payments to allow for hiring a broader set of care team members and visual data analytics in an integrated view on the Chesapeake Regional Information System for our Patients (CRISP), practices are spending more time with patients who need extra support while providing non-traditional services to the broader patient panel.

A new Learning System is assisting practices entering the program to meet the specific requirements of the program and offering technical and educational resources to support the transition.[10] The Program Management Office at the Maryland Department of Health (MDH) is supplementing federal program support by providing hands-on tools and resources. These include on-site practice coaches, training on CRISP tools, development of predictive tools to focus on unnecessary utilization, and contractor assistance to optimize electronic health records (EHRs) and integrate behavioral health services. The Maryland Department of Health is also working with CRISP and partner community-based organizations to facilitate primary care practices' ability to make electronic referrals to community-based organizations that can help patients obtain such services as Meals on Wheels, housing safety checks, transportation, and diabetes prevention programs.

Under practice transformation, regional entities called Care Transformation Organizations (CTOs) are providing support via care management personnel, infrastructure, and technical assistance. The CTOs generate economies of scale to provide services that many practices would otherwise find challenging financially and operationally to provide on their own. This includes helping primary care practices obtain the help of on-site care managers, pharmacists, behavioral health counseling, social services, community health workers, and health education. CTOs will help primary care practices work with CRISP to offer practices on-site assistance in how to provide, receive and use data from CRISP, Maryland's Health Information Exchange. This could include real-time alerts to primary care doctors when a patient in the practice is in the ER or is admitted to a hospital.

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[8] Jack Meyer. Health Policy Reforms to Fit the Modern US Labor Force and Address the Underlying Cost Drivers. Prepared for the School of Public Policy, University of Maryland Roundtable Series in Health Reform. January 2019.
[9] Maryland Health Services Cost Review Commission. Summary of the Maryland Primary Care Program. June 2018. https://health.maryland.gov/mdpcp/Pages/home.aspx

[10] HSCRC. Summary of the Maryland Primary Care Program. Supra.

As of September 2019, the Maryland Department of Health had recruited 380 primary care practices into the new program. These practices include a total of nearly 1,600 primary care physicians. Twenty-one CTOs are operational. Strong recruitment efforts continue.

Physician payment reform will reinforce the new practice model. CMS will provide funding directly to Practices and CTOs. The funding can include Care Management Fees, Performance Based Incentives Payments, and enhanced, pre-paid fee-for-service payments.

Elements of the Maryland Model that could be "exportable"

The Roundtable discussion focused primarily on the elements of the Maryland Model that may be "exportable" to other states, or perhaps even provide some valuable lessons for national health reform. Participants stressed that the Maryland Model, in its entirety, would not simply be "airlifted" into other states. Yet, certain features of that model, with appropriate adaptation to the circumstances of other states, could be adopted elsewhere.

Global Budgets

As Maryland shifted from a charge per case system to one based on global budgets (Global Budget Revenue, or GBR), it created better rewards for efficiency, supported population health, and helped to achieve better care.[11] Global revenue caps create a powerful incentive for hospitals to work with physicians and other clinicians, as well as community-based organizations, to reduce avoidable ER use, inpatient admissions, and readmissions. There is a corresponding incentive to use outpatient hospital care efficiently. Hospitals now do better financially be keeping people well, helping them manage their chronic conditions and adopt healthier lifestyles, and referring them to social services they need related to safe housing, transportation, and good nutrition, among other factors.

Global budgets marked a major change in the health care system away from ever-increasing volume of every part of the hospital—ER, inpatient stays, outpatient care, and the medical practices that hospitals have purchased. Those increases, like everything else in our health care system, were growing on "auto-pilot." This is not limited to hospitals. Physicians were driven to see ever-more patients each day, and long-term care chains of facilities were seeking entrance into the state. In fact, as volume continued to grow, people began to realize that the health care delivery system does not have a "right-sized" health care work force to meet patient needs.

Thus, the broader significance of global budgets is that they introduce a strong measure of discipline that forces hospitals to think very differently. It forces them to recognize tradeoffs and choices. With a fixed budget, more of this may mean less of that—choices that can be mitigated, to some extent, by realizing actual efficiencies in the delivery of care. This is very different from the norm of the US health system, which features continued incentives to increase volume whether the added care improves health outcomes or not. Frequently, these efforts reduce spending in one corner of the system, only to see it increase in another corner. Global budgets are a closed-end system.

Of course, as one meeting participant noted, with such a system, the concern shifts from excessive spending to the possibility of under-spending. Maryland regulators have tried to guard against such outcomes through the type of adjustments to the revenue caps noted above. While additions to hospital

[11] https://hscrc.state.md.us/Pages/rates.aspx

capacity are subject to rigorous regulatory review, if the case is made that the need for such capacity is real, approval can be granted.

Global Budgets are not "all-or-nothing"

A key theme of the discussion was that applying global budgets to all acute care hospitals in a state, which is central to the Maryland Model, is not the only way to make important changes in incentives and achieve both cost control and improvements in the delivery system. Adopting this type of statewide hospital global budget approach is one way, and a very promising option, particularly in view of the remarkable results that Maryland has achieved. But it is also possible for a state to use global budgets for some sub-set of hospitals instead of all hospitals, or at least start that way. In fact, Maryland began its global budget initiative with a kind of "pilot" at ten rural hospitals. This paved the way for the statewide initiative that followed.

Other State Initiatives that Resemble Maryland's System

Other states are testing models that resemble the Maryland Model in certain respects. Some of these initiatives are not as comprehensive or "closed-end" global budget systems as Maryland has, but meeting participants explained that states do not have to copy Maryland as-is in order to pilot or implement new cost control and quality improvement models that bear careful evaluation and may be promising. It is not "all-or-nothing."

For example, the discussion uncovered the fact that Arkansas has used an episode of care bundled payment (EBP) approach to pay for perinatal care. This multi-payer approach covered the majority of births in the State and holds physicians responsible for all care within a discrete episode, rewarding them for the efficient use of their own services and for the efficient management of other health care inputs. Perinatal spending in Arkansas decreased by 3.8 percent overall under EBP, compared to surrounding states, and there was a limited improvement in quality of care. Both prenatal and post-partum spending were reduced compared to the control group, with the difference in facility spending being particularly noteworthy.[12]

One meeting participant noted that Pennsylvania has entered into an agreement with CMS to use global budgets for hospital inpatient and outpatient care at rural hospitals. Medicare, Medicaid, and certain commercial payers are participating so that it approaches an all-payer model. The Pennsylvania Rural Health Model will test whether the predictable nature of global budgets will enable participating hospitals to invest in quality and preventive care, and to tailor their services to better meet the needs of their local communities. Following a pre-implementation period in 2017-2018, the Model was launched in 2019 and will run through 2024. Pennsylvania will prospectively set the all-payer global budget for each participating rural hospital, based primarily on hospitals' historic net revenue for inpatient and outpatient hospital-based services and on the payer's respective portion of this global budget.[13]

Oregon is now exploring various alternative measures of a "benchmark" rate of growth to serve as a limit or cap on the annual growth in statewide health spending. Senate Bill 889 established a Health

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[12] Caitlin Carroll, Michael Chernew, Mark Fendrick, Joe Thompson, and Sherri Rose. Effects of Episode-Based Payment on Health Care Spending and Utilization: Evidence from Perinatal Care in Arkansas. May 20, 2018. https://scholar.harvard.edu/files/ccarroll/files/carroll_etal_ebp_2018.pdf

[13] Centers for Medicare & Medicaid Services. Pennsylvania Rural Health Model. https://innovation.cms.gov/initiatives/pa-rural-health-model/

Care Cost Growth Benchmark Program. This law set up an Implementation Committee to support designing and launching the Benchmark Program. This program is intended to promote a predictable and sustainable rate of growth for total health expenditures in the State, ensuring that such outlays do not exceed established economic indicators and personal income growth (all on a per capita basis). In a measure that goes well beyond the Maryland Model, the same spending cap would be placed on all providers, payers, and health care entities in the State, and the state would publish lists of such entities that exceed the cap on growth.

Meeting participants suggested that some states could do something in the spirit of an all-payer approach but without fully equalizing payment rates. One participant noted that some mix of public and private payers might each commit to a version of a global budget, but not necessarily in an "all-payer" structure. In this case, there would not be a regulatory agency such as HSCRC that would oversee global hospital budgets for all payers, but individual payers could commit to a total cost of care approach and work with hospitals, physicians, and other providers to try to enforce it. A substantial cost-shift is likely to remain in this approach.

One participant explained that states have considerable leverage in achieving more cost control than is normally found in the US health care system through a combination of their purchasing arrangements under Medicaid and CHIP and their purchasing power as one of if not the largest employer in the state. Some states also operate their own ACA Marketplace as well. Through setting up common quality and patient safety reporting requirements and innovative payment arrangements, states could help drive change in the delivery and payment systems.

Another participant suggested that states could consider regulating commercial payers' hospital payment rates so that they could not be more than a certain percentage above Medicare payment rates (e.g. not more than 10 percent above Medicare rates). This could be accompanied by a commitment to raise Medicaid payment rates so that they were closer to, even if somewhat lower than Medicare rates. This approach would not end the public-to-private cost shift, but it would compress hospital payment rates and substantially reduce the cost-shift. According to this participant, since Medicare prospective hospital payment rates, inpatient and outpatient, are based on the underlying average cost of treating a whole range of illnesses (e.g. diagnosis-related groups (DRGs), this approach would bring a measure of cost control to the system.

A meeting participant noted that CMS continues to be favorably impressed with the results achieved in Maryland through global budgets. States that have not taken steps nearly as bold as Maryland may want to be on alert: "get yourself ready for this model," the participant noted. "It may be coming to your area in the future."

The Importance of Strong Leadership

Meeting participants stressed the importance of strong leadership at the top to make the type of comprehensive health reform in Maryland successful. One participant stressed that this must start with a strong cabinet-level Secretary, who has a commitment to implementing effective cost control and is willing to make the difficult decisions to make it happen. Maryland has had very knowledgeable and well-respected Health Secretaries, from both political parties.

This leadership must include the key health agencies in a state. Maryland has had top leadership at HSCRC, the Department of Health, Medicaid, CRISP, and the Maryland Health Care Commission. Another

key to the success of the Maryland Model has been the continued leadership of the seven Commissioners of the HSCRC. There is a strong commitment among the Commissioners to set the course for health care system transformation and establish key and achievable goals. This has been done while avoiding micro-management and relying heavily on the excellent HSCRC staff to implement the initiatives and periodically report to the Commissioners at the open, monthly Commission meetings and more informally in executive sessions. There is remarkable collegiality and mutual respect among the Commissioners, and a spirit of "let's get this done, and get it done right." The Commissioners are also a totally nonpartisan group. Both MHCC and CRISP also have active Commissioners who guide the work of these agencies and provide effective oversight.

Further, CRISP interacts with each of these agencies and with hospitals, physicians, clinics and other providers and payers both to collect information from them and disseminate vital data to them and help them use this data. This involves data on patients' conditions and real-time alerts when patients go to the ER and/or are admitted to the hospital, facilitating important follow-up care. All these Maryland state health agencies have benefitted from strong leadership for many years.

The agencies have had very knowledgeable and effective staff members. This includes a mix of people with many years of experience and deep knowledge of the Maryland Model and other health care initiatives, accompanied by younger support staff with fresh skills and dedication. In Maryland, as in other states, the challenge is to retain such excellent talent and build a staff of adequate size to get the job done.

All these ingredients—leadership at the top, effective Commissioners, high-quality staff—are key to the success of the Maryland Model. States considering similar initiatives should focus on these important "human inputs" and leadership qualities along with the design issues. The best blueprint can flounder if it is not overseen and implemented by a dedicated, experienced, and collegial team.

A Bipartisan Spirit

A related element of Maryland's success is an unusual degree of bipartisanship. Elections come and go, and the Governorship passes back and forth among Republicans and Democrats. In the author's experience of working with and advising Maryland on health reform issues over many years, at no time has a new Governor taken office and tried to undo the work of the predecessors on the All-Payer Model. Further, each Governor has appointed qualified senior staff at the Cabinet and sub-Cabinet levels, at times even selecting a person from the other political party to serve as Secretary or in other positions. Similarly, leaders and members of both parties in the Maryland legislature have been mainly very supportive of the All-Payer Model. Generally, there has been a minimum of ideological warfare and partisan bickering. This is not to say that there is no dissent or no controversy. But the parties seem to agree on the goals and support what has been built, rather than a "tear down and start over" approach. The differences are mainly in how best to achieve the goals. This is another key ingredient to Maryland's success.

Stakeholder Involvement

Maryland has relied heavily on stakeholder involvement in the evolution and development of the Model. Over the period from 2013 through 2016 HSCRC regularly convened an Advisory Panel of stakeholders. The author facilitated all these meetings and drafted the Panel's reports to HSCRC, reflecting the Panel's recommendations on how best to implement the All-Payer Model. Further, HSCRC

empaneled numerous Work Groups on various key aspects of the Model, and this initiative continues. Completed Work Groups include Care Coordination, Physician Alignment and Engagement, and Data and Infrastructure. Ongoing Work Groups include Total Cost of Care, Consumer Standing Advisory Committee, Performance Measurement, Payment Models, and DHMH-HSCRC Duals Care Delivery.[14]

Stakeholders include hospitals, physicians, community health centers, post-acute and long-term care facilities, insurance companies, and consumer groups. Researchers and policy experts have advised these groups and provided technical assistance. Some leaders of consumer groups, who have provided considerable time and expertise to the ongoing stakeholder engagement, and want the Maryland Model to be successful, believe that the implementation of the Model needs more than being invited to meetings and Work Groups. They have expressed that the Model does not show sufficiently how the public will learn about and come to embrace policy changes. In their view, further work is needed to inform the public about the potential benefits to them of this Model, and how they will be able to make informed decisions and benefit from the changes and contribute to the Model's success. Among the questions asked are, since we are told that the Model saved Medicare $1.4 billion over five years, how does that savings translate into a better patient experience and improved health outcomes?

The University of Maryland Horowitz Center for Health Literacy recommends that the Maryland Model should (1) Include meaningful health literacy and equity components in the person-centered care goals and implementation; create plain language summaries of all policy materials, post them on easy-to navigate websites, and distribute through social media channels; implement the HSCRC Consumer Engagement Task Force recommendations to educate, engage, include, and activate Maryland residents; incentivize hospitals to implement health literacy-informed hospital admission, discharge, and care transition processes, as well as information on grievance and appeals processes; provide health literacy technical assistance to primary care practices through the Care Transformation Organizations (CTOs); and evaluate how health literacy and consumer engagement activities affect program outcomes and improve health equity.[15]

Timely and Reliable Data is Also Important

Maryland has done an excellent job of collecting and analyzing data on cost, quality, and patient safety. One important accomplishment was to obtain from CMS data on patients' medical conditions that was "identifiable" to patients, with careful and meticulous privacy protections. HSCRC was able to convince CMS that they would be using this data to help patients. It would lead to the development of customized and comprehensive care plans that address the complex and overlapping medical and social needs of Medicare patients. Accomplishing this goal of data acquisition illustrates another ingredient of success—patience combined with persistence. Maryland's negotiations with the federal government on this matter dragged on for a considerable period. But HSCRC persisted and convinced CMS that its purpose in getting this identifiable data was a valid one, with benefits to patients, and that there would be rigorous protections in place.

[14] HSCRC. https://hscrc.maryland.gov/Pages/Completed-Workgroups.aspx

[15] University of Maryland School of Public Health, Horowitz Center for Health Literacy and Consumer Health First. Maryland Model: Success Depends on Health Literacy and Equity. April 2019.

Summary and Conclusions

The longstanding Maryland All-Payer Model has undergone a fundamental transformation over the past several years, and further reforms are underway. The State has worked in partnership with the federal government on the full set of reforms.

From 2014-2018 Maryland agreed to ambitious targets related to cost control, quality improvement, and patient safety. All the targets were met and exceeded. Maryland committed to save Medicare $330 million over this period, and the actual savings were $1.4 billion. The new Total Cost of Care Model, running for at least eight and as many as ten years, has broadened the scope of Maryland health reforms beyond hospitals to include physicians and other providers. About $1 billion in savings has been promised to Medicare over the five years beginning in 2019.

Global hospital budgets have been the lynchpin of the Maryland model, and these budgets have fundamentally changed the incentives in the system, away from more and more volume as a business model, to discovering effective programs and policies to reduce avoidable ER use, inpatient admissions and readmissions, and hospital outpatient care. This has led hospitals to develop partnerships with each other and with community-based organizations.

Meeting participants believe that these global budgets can work in other states. Yet, they stressed that there are other approaches to cost control and quality improvement that resemble global budgets in some ways but take a different approach. This might involve piloting global budgets in selected hospitals, as Maryland did; episode-of-care bundled payments and other forms of Advanced Alternative Payment Models (AAPMs); and setting limits on per-capita total spending growth for the whole statewide health system and each entity participating in it.

The meeting participants also stressed the importance of strong leadership and a nonpartisan approach to health care policymaking. They believed that strong leadership at the Cabinet and agency levels was critical to the success of bold reforms in Maryland. This has been supported by talented staff. The best designed reforms may not succeed if they fall victim to partisan bickering or fear of being criticized for taking bold and decisive, albeit occasionally controversial steps. All these human factors have been very important to Maryland's success.

Attendees

Roger Lipitz; Ocean Assets Managing Member

Robert Orr; University of Maryland School of Public Policy Dean

Phil Joyce; University of Maryland School of Public Policy Assistant Dean

Betty Duke; University of Maryland School of Public Policy Professor

Robert Sprinkle; University of Maryland School of Public Policy Professor

Tony McCann; University of Maryland School of Public Policy Lecturer

Jack Meyer; Independent Health Policy Consultant

Susan Parker; University of Maryland School of Public Policy Professor

Cathleen Worsnop; University of Maryland School of Public Policy Professor

Stan Dorn; Families USA Director, National Center for Coverage Innovation and Senior Fellow

Leni Preston; Founder Consumer Health First

Kathleen Nolan; Regional Vice President Health Management Associates

Chris Peterson; Maryland Health Services Cost Review Commission Principal Deputy Director

Alice Burton; Burton Policy Consulting President

Christopher King; Georgetown Department of Health Systems Administration Chair

Chad Perman; Maryland Health Systems Transformation Director

John Colmers; Johns Hopkins Health Care Transformation and Strategic Planning Senior Vice President

Nathan Jessen; University of Maryland Post Doctorate Student

Kate Thomas; University of Maryland Lipitz Fellow

Aliana Pitt; University of Maryland Master of Public Policy Graduate Student