# Has Maryland found a solution to the U.S. healthcare cost crisis?

August 29, 2014 | Print | Email



Leaders at Mercy Medical Center in Baltimore don't need to worry about payer mix. "Rates are uniform, no matter what your payer source is," says Thomas Mullen, president and CEO of Mercy Health Services. "A Blue Cross patient will pay the same as Medicare."

That's because Maryland currently runs the country's only all-payer hospital rate setting system, under which facilities in the state are paid the same amount by all government and private health insurers. Since the state legislature established the all-payer model in 1971, the cost of a hospital admission has plummeted, the financial stability of the state's hospitals has improved, and Maryland has seen the lowest markup of charges compared to costs in the U.S., according to a 2009 *Health Affairs* article by Robert Murray, executive director of the Maryland Health Services Cost Review Commission, the state agency tasked with setting hospital rates.

In January, Maryland and CMS announced a new initiative meant to modernize the system by promoting value instead of volume. If the all-payer model proves successful under its new terms, it could potentially provide a blueprint for efforts to contain costs and improve quality of care in other states.

"I think the hospitals will tell you that they're actually very nervous about what's going to happen, and I don't blame them," says Maryland Health Secretary Joshua Sharfstein, MD. "But the general sense is we have a chance to be masters of our own destiny."

**The why and how of Maryland's all-payer system**

State lawmakers revamped the Maryland rate setting system decades ago in response to skyrocketing hospital costs and growing levels of uncompensated care, according to Mr. Murray's article. The Maryland Hospital Association originally suggested rate regulation to bolster providers that were struggling financially as a result of treating the uninsured, and hospital trustees crafted the bill that established the Health Services Cost Review Commission, which consists of seven governor-appointed members serving staggered four-year terms. Six years after its creation, the commission obtained a waiver from CMS to align Medicare reimbursement with the rates set for other payers. "This Medicare waiver is the linchpin for the system and a galvanizing force for all stakeholders," Mr. Murray writes.

Originally, the rate-setting commission used service-specific unit rates as the basis for hospital reimbursement. The state sought to contain hospital revenues through case-mix-adjusted per-case limitations, with annual updates to account for inflation. Under this system, average hospital cost per case in the state went from 26 percent greater than the national average in 1976 to 2 percent lower in 2007, according to Mr. Murray. Furthermore, while American Hospital Association data places the average hospital markup of charges over costs exceeded 180 percent in 2007, Maryland's average markup was just 21.5 percent.

Additionally, according to a *New England Journal of Medicine* perspective piece Dr. Sharfstein co-authored earlier this year, the system has "eliminated cost shifting among payers, more equitably spread the costs of uncompensated care and medical education," in addition to successfully holding down per-admission spending. In terms of how it affects hospitals, Mr. Mullen of Mercy Health says the system was well-received because of the financial predictability and stability it offers: "We knew what our revenues would be going forward, as long as we received the volume levels."

However, despite its many positive points, the original all-payer model had some considerable flaws. Mr. Murray's article notes that hospital admissions ballooned at a rate of 2.7 percent in Maryland from 2001 to 2007, compared with the national growth rate of 1 percent.

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Dr. Sharfstein says the old system created "some perverse incentives" that became apparent over the years and drove the state's decision to redesign its payment model: "It was creating some incentives for high volume. It was recognized that was not optimally aligned with the triple aim of lowering overall costs, enhancing the patient experience and improving outcomes." Additionally, Maryland wasn't able to keep costs

per admission contained as effectively as desired. The combination of those two factors meant the state was in danger of losing its CMS waiver unless it changed the rate-setting methodology, according to Dr. Sharfstein.

Therefore, Maryland and CMS agreed on a new initiative to update the 36-year-old Medicare waiver. Under the new system, the all-payer system is based on containing per capita total hospital cost growth rather than payment per admission. The state has agreed to limit its annual all-payer per capita total hospital cost growth to the 10-year average growth rate of the state's economy, 3.58 percent, according to CMS. Additionally, Maryland will transition essentially all of its hospital revenue into global payment models during the five-year initiative.

The state is also aiming to improve quality of care by reducing its aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate to the national rate, achieving an annual aggregate 6.89 percent reduction in 65 preventable hospital-acquired conditions, and submitting an annual report on its performance relative to numerous population health measures. Overall, the initiative requires Maryland to produce $330 million in Medicare savings over the course of five years.

Although it's still not a perfect system, "in terms of being a fundamental turning upside down of the payment incentives…it's a very positive thing," says John Deane, president of Advisory Board Consulting at The Advisory Board Company. "We're noticing institutions in Maryland are having an awakening of having the imperatives to deliver value both in terms of cost and quality. They're excited that the new payment methodology will reward that."

Karoline Mortensen, PhD, an assistant professor in the University of Maryland's Department of Health Services Administration in College Park, echoes the impression that people across the state are enthused by the updated all-payer project. "We like this idea that we are finally the state focusing on population health," she says.

The new model and the switch to global hospital budgets makes sense in promoting population health efforts, according to Mr. Mullen. "We're all working on ways to take out unnecessary volume in the system, because that volume drives costs, and, on a global budget, if we save that cost we keep it," he says. "It's actually worth the investment to provide care coordinators and connect with these patients to make sure these patients are stable and don't need to use our resources. That's actually the right way to do healthcare."

For instance, Mercy Medical Center has identified opportunities to improve care for and decrease spending on diabetic patients, particularly those on renal dialysis. If these patients miss their dialysis visit for a day or two, they can go into a toxic state and require admission to the hospital. Mr. Mullen says the hospital has worked with dialysis providers to create space in off-hours, so they can, for instance, administer treatment at 10 p.m. Under the global budget, that frees up dollars that would have been spent on preventable hospital admissions to go toward more population health management efforts.

"A hospital admission for a renal patient can be $25,000 to $30,000," Mr. Mullen says. "There might be, at our hospital, three of those a week. Three times $25,000…$75,000 dollars a week we could save."

Still, he anticipates succeeding under the new reimbursement model won't necessarily be easy. Physicians aren't included in the all-payer system, and Mercy Medical Center is looking at how to effectively coordinate with them through gainsharing. "Primary care doctors are aligned with this type of system because of patient-centered medical home initiatives, but the specialists aren't," he says. "Specialists are still paid on a per-procedure basis."

Dr. Mortensen confirms that physicians "feel sort of left out," since gainsharing hasn't been established for them at a lot of hospitals: "Physicians don't really feel that they have all the support that's necessary. The state's going to have to keep in very close contact with physicians and pay attention to their concerns."

**Could Maryland's method work elsewhere?**

If the revamped all-payer model fails to meet its goals after five years, Maryland's hospitals will spend two years transitioning back to national Medicare payment systems. If it succeeds, it could potentially inspire similar payment innovation plans throughout the U.S. However, industry experts say what works in

Maryland won't necessarily prove effective in other states.

Although it's the only one with an all-payer system right now, other states have implemented and failed to sustain similar models. For instance, New Jersey created an all-payer system in the '80s, according to a 1993 *Health Affairs* article. But various stumbling blocks — including Medicare's withdrawal from the system in 1988 and a 1992 court decision finding the all-payer model was largely pre-empted by the Employee Retirement Income Security Act — led to the system's collapse in the early '90s.

As for why the all-payer system in Maryland hasn't met with a similar fate, Dr. Sharfstein offers a couple of reasons: "There has been a degree of collaboration between the hospitals and the state and the payers that has really been remarkable over the last several decades. There's a real feeling that everybody's in this together. And then I think the other major factor is there's a provision in the Social Security Act that assures Medicare participation under certain conditions. It's a combination of some provisions in law that are really helpful and the spirit in the state."

Maryland's Democratic-leaning political atmosphere and small size — with only a couple of dominant hospital systems and, historically, one major insurer — have also contributed to the sustainability of the all-payer system, according to Dr. Mortensen of the University of Maryland.

Mr. Deane of The Advisory Board also cited politics as a possible hurdle for implementation in other states or nationwide, noting that "the notion that state government or federal government would be so involved in the American healthcare system as to prescribe the rates by all payers…would be a challenging position to take." Still, Maryland's new initiative could shift that attitude.

"If Maryland proves measurable success in terms of reducing the cost of care I think it may push policymakers to take a closer look," he says. "But they are going to need to see that success first, and there may still be questions about how other markets will respond to the same approach."

It will be years before it's clear whether Maryland's new payment model is the answer to the healthcare cost containment question or not. For now, though, hospitals and state regulators seem to feel it holds promise.

"I've been in this business since 1978, and this is probably the most meaningful thing I've ever seen in controlling costs without it affecting quality," Mr. Mullen says. "We don't have it solved, but I think we're moving in the right direction."

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