VALUE OF THE MARYLAND MODEL

**EQUITY**
Marylanders get great health care – no matter where you live, who you are, or your income. In our hospital payment system, everyone pays the same, sparing Marylanders from cost-shifting and the two-tiered care that burdens patients and worsens outcomes elsewhere. The Maryland Model promotes equitable access and equitable outcomes.

**COMMUNITY**
Maryland, under the Total Cost of Care Model, is the only state where hospitals are accountable for the health of their communities. Hospitals invest outside their walls, so people do not have to come in to benefit. Focusing on the health of the community, hospitals collaborate more and use their resources to help their neighbors.

**VALUE**
Hospitals in Maryland don’t dictate prices, and they aren’t paid more to do more. In the Maryland Model, hospitals get a set budget to help keep their communities healthy. Your hospitals focus on quality and the value of care.
ALL-PAYER PRICES: NO COST-SHIFTING

OTHER STATES

MARYLAND

Equitably share burden of uncompensated care

Protect access in rural and vulnerable communities
MARYLAND HOSPITALS ARE DEEPLY COMMITTED

Global revenue budgets set by HSCRC

Risk for costs of care beyond the hospital

Powerful quality of care incentives

Dedicated to whole population health

HSCRC = Health Services Cost Review Commission
REAL RESULTS

- **$2.5 billion + Medicare hospital savings (2014-20)**
- **$1.6 billion + Medicare total cost of care savings (2014-20)**
- **Lowest outpatient private payer costs in the nation**
- **Second Lowest inpatient private payer costs in the nation**
- **54% slower Medicare hospital spending growth than the nation (2014-21)**

Quality Results Since 2014

- 51% reduction in hospital preventable complications
- Better than national Medicare hospital readmission rate

The answer to America’s health care cost problem might be in Maryland

Maryland has a health care system unique in the United States: A global hospital budget.

In 49 of the 50 states, more sick patients in hospital beds means more revenue. Maryland is the exception. Hospitals’ budgets are fixed, as are the rates they can charge. Once they hit their revenue caps, they don’t make more money on having patients in the hospital — and there is a carrot-and-stick system to ensure hospitals don’t exceed those caps.

By limiting how much revenue hospitals can bring in, it pushes hospitals to look at sickness as something to be treated not just within their walls, but within their community: making sure a heart disease patient has access to healthy food, for example.

“Maryland is doing more and providing better incentives than any other individual state,” said Gerald Kominski, health policy scholar at UCLA.

The president one Maryland hospital has an unofficial motto as patients leave his hospital: “We hope to never see you again.”
For the past 18 months, while I was undergoing intensive physical therapy and many neurological tests after a complicated head injury, my friends would point to a silver lining: “Now you’ll be able to write about your own bills.”

But my bills were, in fact, mostly totally reasonable.

That’s largely because I live in Washington, D.C., and received the majority of my care in next-door Maryland, the one state in the nation that controls what hospitals can charge for services and has a cap on spending growth.
CMMI director hints at shift away from payment models for every episode of care, specialties

CMMI Director Liz Fowler was more in favor of promoting models that address the total cost of care, like Maryland’s state model that sets a per capita limit on total Medicare costs in the state.

“We are looking at incorporating more safety net providers in that system and encouraging more closer collaboration with Medicaid,” she said, referring to Maryland’s model.
Overall, and especially since 2014, the Maryland model has been a financial success by almost any metric. Over the period 2015-2019, Maryland’s standardized per-capita Medicare spend declined from 1 percent above the national average to 1 percent below, with improvement in many quality metrics. Global budgets create powerful incentives for hospitals not to overcharge or overtreat.

Due to Maryland’s uniform rate-setting mechanisms, the state’s employer-based health plans pay among the country’s lowest rates. By one estimate, from 2011 to 2017, commercial insurance payments to Maryland hospitals ranged from $392 to $544 million per year lower than they would have been without all-payer rate setting.

Importantly, it shifts incumbent health care payers and providers into value-based care delivery gradually but inexorably. How can Maryland’s model be extended to other states?
5 CMMI Objectives to Achieve Equitable Outcomes

- Drive accountable care
- Advance health equity
- Support care innovations
- Improve access by addressing affordability
- Partner to achieve health system transformation

Of 50 CMMI models that have been evaluated, only six have shown statistically significant savings – one being Maryland.
The Maryland Model gets right what other states are getting wrong.

The people of Maryland can’t afford to lose it.