Achieving Accountable Care

In the Era of Health Care Reform

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Dartmouth Medical School

Director, Center for Population Health
Director for Population Health and Policy
The Dartmouth Institute for Health Policy and Clinical Practice
Houston: We’ve got a problem
Toward a sustainable health system
Current reforms: Is the glass half full or half empty?

1. What we know: market failure in health care
2. A path toward value-based payment
3. Achieving sustainability in health care
4. Half full, half empty?
Toward a sustainable health system

Current reforms: Is the glass half full or half empty?

1. What we know: market failure in health care
What have we learned?
Variations in Spending: Is More Always Better?

Early work

(2) Baicker et al. Health Affairs web exclusives, October 7, 2004
(3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005
(4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006
(6) Fowler et al. JAMA: 299: 2406-2412
What have we learned?
Variations in Spending: Is More Always Better?

Early work
Variation in price and illness-adjusted spending largely due to avoidable use of the hospital as site of care; specialist visits; imaging and tests

Effective Care: benefit clear for all
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65-69
- Pap Smear, Women 65+
- Pneumococcal Immunization (ever)

Preference Sensitive: values matter
- Total Hip Replacement
- Total Knee Replacement
- Back Surgery
- CABG following heart attack

Supply sensitive: often avoidable care
- Total Inpatient Days
- Inpatient Days in ICU or CCU
- Evaluation and Management (visits)
- Imaging
- Diagnostic Tests

If bar on this side higher spending regions get more

Ratio of rate in high spending to low spending regions
What have we learned?
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Early work

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Higher use of these services is not – on average -- better.
Thus: there’s lots of waste.
Cutting prices in high cost regions will make things worse.

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Variations in Spending: Is More Always Better?

Early work

Why the variation?
Not preferences, malpractice, or payment system (only)
Capacity important, but explains less than half of the spending differences
Judgment – in “gray area” decisions -- is critical
Why clustered regionally? Local components: capacity and culture

“...a culture that focuses on the wellbeing of the community, not just the financial health of our system.”

Jeff Thompson, MD
CEO Gunderson-Lutheran
La Crosse WI

“Here ... a medical community came to treat patients the way subprime mortgage lenders treated home buyers: as profit centers.”

Atul Gawande
What have we learned?
Variations in Spending: Is More Always Better?

Early work

Why the variation?

Recent insights

Chernew: Under and over 65 utilization correlated, but not spending
Prices are important determinants of spending in under 65

MedPAC: Hospitals under pressure to keep costs down do so
There are many low cost, high quality hospitals
It is possible to reduce unit costs and thus prices
## What have we learned?
Causes of market failure – and potential approaches

<table>
<thead>
<tr>
<th>Underlying problem</th>
<th>Key principles</th>
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<td><strong>Confusion</strong> about aims</td>
<td><strong>Clarify aims:</strong> Better health, better care, lower costs – for patients and communities</td>
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<td><strong>Absent or poor data</strong> leaves practice unexamined, value unknown</td>
<td><strong>Better information</strong> that engages physicians, supports improvement; informs consumers and patients</td>
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<td><strong>Flawed conceptual model.</strong> Health is produced only by individual actions of expert (specialist) physicians.</td>
<td><strong>New model: It’s the system.</strong> Establish organizations accountable for aims and capable of <em>redesigning practice</em> and <em>improving value of care</em></td>
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<td><strong>Wrong incentives</strong> reinforce model, reward fragmentation, induce more care and entrepreneurial behavior.</td>
<td><strong>Rethink our incentives:</strong> Realign incentives – both financial and professional – with aims.</td>
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Toward a sustainable health system

Current reforms: Is the glass half full or half empty?

1. What we know: market failure in health care
2. A path toward value-based payment
The science of improvement has advanced
Microsystems and continuous improvement

**Microsystem**: front-line unit where patient and family interact with clinician to produce value for a specific condition: e.g. office practice, inpatient unit.

**Key elements:**
Flow is clear and well defined
Microsystems are linked
Measurement is integrated
Professional work is redefined:
Involves care and improvement

**Figure 7-2.** Percentage of Intermountain Healthcare System Diabetic Patients with Glycolated Hemoglobin (HA1C) > 9%, June 1999–March 2006

*Figure 7-2. This figure represents data for more than 20,000 patients. National guidelines recommend that all patients with diabetes be managed to HA1C levels < 9%, and ideally, to levels < 7.*
The Policy Window
Perhaps a vanishing opportunity

Environment in health care has changed
Growing consensus on aims: better health, better care, lower costs
Science of improvement well established – and can help

What will happen if we do nothing?
Fee increases below medical price inflation: -1%; -2.5% or more.

Federal support for change is strong – at least for now
Public and population health
Comparative effectiveness research
Health Information Technology
Coverage expansion – new paying patients (for most part)
Center for Medicare and Medicaid Innovation: $10b appropriated

Commitment to value-based payment (in principle)
The New Policy Environment
Major approaches to value based payment

**Episode (Bundled) Payments**
- **Theory:** single payment for episode (e.g. total knee replacement), encourages collaboration and integration to improve care
- **Limitation:** incentive to provide more episodes remains

**Medical Home**
- **Theory:** Augmented payment to support currently unfunded activity and support redesign of practice
- **Limitation:** Leaves full responsibility on shoulders of PCP

**Accountable Care Organizations**
New Models of Care and Payment
Accountable Care Organizations

Origins

Recognized need to establish organizational accountability for overall care
Research found that most care is provided by informal (but real) physician networks around one or more hospitals
Physician Group Practice demonstration looked promising (but was limited)

Approach

Provider organizations establish legal entity willing to be accountable for full continuum of care as a real or virtually integrated local delivery system

Robust performance measurement – to ensure focus on demonstrably improving care and reassure public

“Gated” shared savings: establish target spending levels; shared savings – under fee-for-service or partial capitation;
No beneficiary “lock-in”
ACO’s and the ACA
Section 3022 of the Affordable Care Act

Medicare Shared Saving Program- Jan. 1, 2012
Part of Medicare → Not a Demonstration or Pilot Program

Requirements to Participate:

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<th>Accountable for quality, cost and care of Medicare patients, minimum 3 years</th>
<th>Formal legal structure to receive and distribute shared savings</th>
<th>Minimum 5,000 attributed Medicare patients</th>
<th>Ability to report quality, cost, and care coordination measures – and others</th>
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Legislation supports a diverse range of Medicare ACO payment models

Evaluation of cost savings based on benchmarks created from historical spending and utilization data.
Coverage of ACOs in the News

Frequency of Publications referencing “Accountable Care Organizations” by month, Jan’ 09-Jan’ 11

- # Unique instances ("Accountable Care" OR "Accountable Care Organization" in ” All News Sources – English" in LexisNexis Academic Search, Conducted 2/17/2011)

Passage of the ACA, March 2010
Success is far from certain

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How might it not?
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ACOs Across the Country
ACO and relevant payment reform pilots are being demonstrated across the country
Brookings-Dartmouth Pilot Sites

Monarch HealthCare  
**Irvine, California** (serves Orange County)  
- Org Type: Medical Group and IPA  
- Payer Partner: Anthem Blue Cross  
- ACO Status: Letter of Agreement signed 01/11, patients attributed, payer partners are sharing data, preparing to report on tarter-set measures  
- Size: > 497 PCPs  
  >2,500 contracted, independent physicians

HealthCare Partners  
**Torrance, California** (serves LA County)  
- Org Type: Medical Group and IPA  
- Payer Partner: Anthem Blue Cross  
- ACO Status: Patients attributed, Finalizing Letter of Agreement, preparing to report on starter-set measures  
- Size: >1,200 employed and affiliated PCPs  
  >3,000 employed and contracted specialists

Tucson Medical Center  
**Tucson, Arizona**  
- Org Type: Hospital System and affiliated practices  
- Payer Partner: United Health Care  
- ACO Status: Finalizing Letter of Agreements for Medicare Advantage and PPO populations retroactive to 01/11, Patients attributed, will report on starter set data pending finalized Agreement.  
- Size: ~80 providers  
  10,000 Medicare patients assigned

Norton Healthcare  
**Louisville, KY**  
- Org Type: Integrated Delivery System  
- Payer Partner: Humana  
- ACO Status: Letters of agreement signed, Patients attributed, starter set data collected and will be reported pending finalizations of all agreements.  
- Size: ~400 Providers  
  30,000 Medicare Patients Assigned
# How might it not?
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Brookings-Dartmouth Pilot Site Performance Measures

Administrative-Only
- Utilization
- Readmission
- Starter Set:
  - Over-use
  - Population Health
  - Safety

Clinically Enriched
- Coronary Artery Disease
- Diabetes
- Hypertension
- Pediatrics
- Preventive Care

Patient Reported Experiences of Care
- Core (Primary Care)
- Chronic Care
- Specialty Care
- Hospital Discharge

Patient-reported outcomes
- Measures are currently under development
Performance Measurement:
Administrative Measures

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<tr>
<th>Priority</th>
<th>Starter Set Measures</th>
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<td>Overuse</td>
<td>Low back pain: use of imaging studies</td>
</tr>
<tr>
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<td>Appropriate Testing for Children With Pharyngitis</td>
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<td></td>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
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<td>Appropriate treatment for children with upper respiratory infection (URI)</td>
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<td>Population Health</td>
<td>Breast Cancer Screening</td>
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<td>Cervical Cancer Screening</td>
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<td>Diabetes: HbA1c Management (Testing)</td>
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<td>Diabetes: Cholesterol Management (Testing)</td>
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<td>Cholesterol Management for Patients with Cardiovascular Conditions (Testing)</td>
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<td>Use of appropriate medications for people with asthma</td>
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<tr>
<td>Safety</td>
<td>Persistence of Beta-Blocker Treatment After a Heart Attack</td>
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<td>Annual monitoring for patients on persistent medications</td>
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## Performance Measurement:
### Clinically-Enriched Measures

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<td>Cholesterol management for patients with cardiovascular conditions</td>
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<td>ACE inhibitor or ARB therapy</td>
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<td>Diabetes</td>
<td>Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus</td>
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<td>Hemoglobin A1c Poor Control in Diabetes Mellitus</td>
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<td></td>
<td>HbA1c Control (&lt;8.0%)</td>
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<td></td>
<td>High Blood Pressure Control in Diabetes Mellitus</td>
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<td>Kidney Disease Screen</td>
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<td>Hypertension</td>
<td>Blood Pressure Control</td>
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<td>Pediatrics</td>
<td>Childhood Immunization Status</td>
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<td>Immunization for adolescents</td>
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<td>Preventive Care</td>
<td>Colorectal Cancer Screening</td>
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Payment Models For Introducing Risk

All models must have strong incentives to improve quality

“One-sided” shared savings model
ACO not at risk for losses if spending exceeds target

“Two sided” or symmetric risk model
ACO receives a share of savings when spending is below the total cost of care target, but has to pay back all or a portion of spending above the total cost of care target

Total cost of care target under FFS
ACO retain all or most of the savings below the established target and is at risk for most or all of the costs above the target

Total cost of care target under partial capitation
ACO receives a PMPM payment for specific services
ACO will be expected to return some or all of these PMPM payments to the extent that the total cost of care target is exceeded
ACO’s and the ACA
ACOs in the Medicare Shared Saving Program can serve as the venue to house and collaborate with other reforms.
Alternative Quality Contract (AQC) 
Launched in 2009 For HMO and POS Members

Patient Population
   Enrollees choose Primary Care
   Patient Population serves as basis for budget setting and quality measurement

AQC Provisions
   Integration across the continuum of care
   Accountability for performance measures (ambulatory and inpatient)
   Global budget for all medical services (health status adjusted)
   Sustained partnerships (5 Year contract)

Global Payment
   Fixed budget based on historical spending. During contract groups are paid fee-for-service, BCBS pays surplus or collects deficit relative to budget at end of year.
   Groups can select 50% or 100% risk
   Bonus payments, up to 10 percent of global payment, based on providers’ performance toward nationally accepted quality measures
Financial Structure of the AQC

Financial Structure based on four components:
- **Global payment**
  - Based on total medical expenses
  - Health status adjusted
- **Margin Retention**
  - Initial Global Payment includes inefficiencies
- **Performance Incentive**
  - Up to 10% of Total Medical Expense
- **Inflation**
  - Set at general inflation

Source: BCBSMA
How might it work?
An optimistic scenario

ACO’s (rewarded for quality and reduced cost growth) should seek:
- To strengthen primary care
- To reduce costs through redesigning care, reduced hospital use
- To align care with patients and caregivers’ values
  
  *And to make careful “buy vs build” decisions*

Referral centers should seek:
- To manage their own primary care populations as ACOs
- To demonstrate value (and deliver high quality / low cost episodes)
  
  *Capture market share for wanted, needed episodes*

A virtuous cycle?

ACOs continually re-engineer their care, referring wisely to others

Referral centers specialize appropriately, (fewer centers, higher volumes)

Poor quality, high cost providers forced to improve or find new work….

*Community costs fall, while quality improves*
## How might it not?
**Success is far from certain**

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**Multi-payer**; **align other reforms**
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| Just one more way to structure the local medical arms race | Government engagement; Consider health care a commons |
How might it not?  
Success is far from certain.
“These marketing ploys are wildly successful across the entire country. Patients are viewed as the ball in a pinball machine, popped back and forth, ringing up profits, until finally they escape past the paddles and can no longer render income. I believe that the fingers controlling those paddles, Dr. Fisher, often use those "gray areas of judgment" as an excuse to shoot the patient back to the triple-score bumpers.”

Geoffrey G. Smith, MD, Casper Medical Imaging
May 24, 2007 (email)
Toward a sustainable health system

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The Tragedy of the Commons

The population problem has no technical solution; it requires a fundamental extension in morality.

Garrett Hardin

At the end of a thoughtful article on the future of nuclear war, Wiesner and York (/) concluded that: "Both sides in the arms race are . . . confronted by the sional judgment . . ." Whether they were right or not is not the concern of the present article. Rather, the concern here is with the important concept of a h human im available population (2). A A finite

“Each man is locked into a system that compels him to increase his herd without limit — in a world that is limited. Ruin is the destination toward which all men rush...”

Avoiding the tragedy of the commons
Elinor Ostrom

Traditional view
Common pool resources create social dilemmas
Only two possible solutions:
Treat as private goods: create private property rights
Treat as public goods: government regulation

Might there be a third way?
Are there examples of how local communities have managed to sustain a common pool resource

Indeed

Beyond Markets and States: Polycentric governance of Complex Economic Systems
Avoiding the tragedy of the commons
Managing common pool resources

**Design Principles**
- Defined boundaries, known “appropriators”
- Those affected help establish rules
- Monitoring, graduated sanctions, conflict resolution mechanisms
- “Nested” structures (practices, integrated systems, regions)

**Processes that contribute**
- Communication
- Relationships, trust
- Recognition of shared interests
- Focus on problem solving

**Stewardship as a core value**
Stewardship
In clinical microsystems: Care redesign and Conversation

Figure 7-2. Percentage of Intermountain Healthcare System Diabetic Patients with Glycolated Hemoglobin (HA1C) > 9%, June 1999–March 2006

Figure 7-2. This figure represents data for more than 20,000 patients. National guidelines recommend that all patients with diabetes be managed to HA1C levels < 9%, and, ideally, to levels < 7%.


Practice Variation Report

May 29, 2008 Presentation at Federal Trade Commission
Tom Lee, MD (Partners Healthcare System)
(used with permission)
Stewardship
In clinical microsystems: Care redesign and Conversation

MEDICAL HOMES: A SOLUTION?

By Robert J. Reid, Katie Coleman, Eric A. Johnson, Paul A. Fishman, Clarissa Hsu, Michael P. Soman, Claire E. Trescott, Michael Erikson, and Eric B. Larson

The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers
Stewardship
In Regions: Care redesign – And Conversation

“How Will We Do That?”
May 26-27, 2010

Key elements:
Regional platform for stakeholders
Shared aims, accountable to community
External constraint – (Everett, WA)
Use of data to drive change
Physicians as partners in leadership
Reduced use of hospital (Asheville)

Grand Junction, CO
Tallahassee, FL
Cedar Rapids, IA
Portland, ME
Grand Rapids, MI
Cedar Rapids, IA
Manchester, NH

Newark, NJ
Buffalo, NY
Rochester, NY
Asheville, NC
Bend, OR
Everett, WA

Map: Medicare Spending per capita 2006
- $10,250 to 17,184 (55)
- 9,500 to < 10,250 (69)
- 8,750 to < 9,500 (64)
- 8,000 to < 8,750 (53)
- 6,039 to < 8,000 (65)
- Not Populated
Stewardship
In Regions: Care redesign

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It's up to us.

“There, there it is again—the invisible hand of the marketplace giving us the finger.”
Stewardship
In Regions: Care redesign – And Conversation

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High self-efficacy; Joy in work
If not us, who?
Thoughts on strategy
A two-track approach toward value-based payment

**Per-capita Costs** = **Volume** \( \times \) **Price**

- **Avoidable Care** (visits, tests, hospital stays)
- **Excess Cost** (waste)
- **Unreasonable margin**

**Nearer Term (regulatory approaches)**
- Transparency on volume, prices, costs, margins
- Stop capacity growth (voluntary non-proliferation pact?)
- Budget review: if lower costs then greater margin
- OK

**Longer Term (a more effective market)**
- All payer ACOs; open discussion of costs, margins
- Engage and inform consumers (shared decision-making)
- Measure, monitor and reward health improvement
- Continued re-design: Regional Stewardship Councils

**Reduce Capacity**
**Improve Population Health**
**Improve Care**
**Redesign**
**Refer wisely**
**Pressure providers**
Toward a sustainable health system

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Health Care Reform
Half full? Half empty?

It’s up to us

Health care reform (& ACOs) could fail
Public fearful – and could reject the model
Providers could see as just a new label for business as usual

We have a choice

What might we do?
Consider our role as stewards
Step forward to help ACOs succeed
Authenticity
Better care, better health and lower costs – for patients and communities
$9 Billion NJ Medicaid Program.

NJ Senate unanimously approves bill creating 5 Urban ACOs, each serving 5,000 Medicaid Patients. Jan. 2011

Six groups formed ACO’s in anticipation of legislation:

AtlantiCare, Atlantic Health, Hackensack University Medical Center, Robert Wood Johnson Medical System, Summit Medical Group, Optimus Healthcare Partners

“We’re the most expensive state, in the most expensive delivery system in the world”

- Dr. Jeffery Brenner
Medicare and ACO’s
Medicare Health Care Quality Demonstration- “646” Demo in Indiana

Origins
IHIE was founded in 2004 by 13 organizations including hospitals, providers, researchers, and public health organizations.

Data Infrastructure- QHF
Compiles claims data with real time clinical data from hospital and labs to provide monthly patient specific reports, focus on chronic disease management
Notifies physicians how closely care provided matches with evidence based practice guidelines.

Quality Care Measures- 14 by Year 1 → 30 Measures by Year 5

Shared Saving with Medicare
Part of Bonuses linked to virtual provider-hospital network specific performance

<table>
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<tr>
<th>Multi- Payer Demo</th>
<th>Pay for Performance</th>
<th>Quality Health First Patient Reports (QHF)</th>
<th>800 Physicians 100,000 Medicare Patients per Year</th>
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<td>July 2009- May 2014 Metro Indianapolis</td>
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Indiana Health Information Exchange
The Maryland Model
Maryland’s All Payer Hospital Payment System

Since 1971 the Health Services Cost Review Commission (HSCRC) sets hospital rates which all payers, including Medicare, pay.

HSCRC collects data on costs, patient volume, inpatient/outpatient data, and financial condition of the hospital, and gives payment incentives based on performance and quality.

Rates are set prospectively allowing “efficient and effective” hospital to remain financially solvent.

In 1976 hospital admission rates in Maryland were 26% above the national average, by 2007 they were 2% below. If national costs had grown at the same rate as Maryland, savings would exceed...

$1.8 trillion

The Maryland Model

Maryland’s low and consistent mark-up charges means that costs between insurers, and between the fully insured and uninsured are the same, eliminating cost shifting. Payment rates also include costs of uncompensated care, allowing all payers to share this burden.

**Average Hospital Markup (Charges Over Costs), Maryland And United States, 1980–2007**

- **Percent markup**
  - 160
  - 120
  - 80
  - 40
  - 0


**NOTE:** Maryland's Markup includes the provision for the financing of uncompensated care (which accounts for about 8 percent of hospital revenue or approximately 40 percent of Maryland's 21.5 percent markup of charges over costs).
