



DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

April 20, 2022

The Honorable Guy Guzzone
Chair, Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Ben Barnes
Chair, House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2021 Joint Chairmen's Report (p. 113) – Home and Community-based Waiver Services Expansion

Dear Chair Guzzone and Chair Barnes:

Pursuant to the 2021 Joint Chairmen's Report (p. 113) the Maryland Department of Health (MDH) respectfully submits a report on shared Medicare savings from Medicaid-funded home- and community-based services (HCBS). Specifically, MDH was requested to address the following:

A draft report completed by the Hilltop Institute for the Maryland Department of Health (MDH) concluded that, on balance, there are costs to Medicaid associated with the expansion of home- and community-based waiver services, although these costs were lower than cited in the past. However the report noted opportunities that may exist for programming that allows the State to share in the savings that accrues to Medicare from Medicaid-funded waiver services to the dual eligible and using those savings to defray the costs of waiver expansion. The committees are interested in pursuing such opportunities and request that [the Department] submit a report with specific programmatic recommendations on ways to claim Medicare savings to apply to costs for waiver expansion.

If you have any questions about this report, please contact Heather Shek, Director, Office of Governmental Affairs, at heather.shek@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

cc: Steven R. Schuh, Deputy Secretary, Health Care Financing and Medicaid
Heather Shek, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

Report on Medicaid-funded Home- and Community-Based Services Expansion

*Submitted by the Maryland Department of Health, pursuant to the 2021 Joint Chairmen's
Report, pg. 113*

Introduction

Pursuant to the requirements of the 2021 Joint Chairmen's Report (pg. 113), the Maryland Department of Health (the Department) submits the attached report on shared Medicare savings from Medicaid-funded home- and community-based services (HCBS). Specifically, the report stated:

A draft report completed by the Hilltop Institute for the Maryland Department of Health (MDH) concluded that, on balance, there are costs to Medicaid associated with the expansion of home- and community-based waiver services, although these costs were lower than cited in the past. However the report noted opportunities that may exist for programming that allows the State to share in the savings that accrues to Medicare from Medicaid-funded waiver services to the dual eligible and using those savings to defray the costs of waiver expansion. The committees are interested in pursuing such opportunities and request that [the Department] submit a report with specific programmatic recommendations on ways to claim Medicare savings to apply to costs for waiver expansion.

This report provides background information on HCBS and a review of Washington State's shared savings implementation. Following this background, the report provides a discussion of how Maryland's Total Cost of Care (TCOC) Model could support a shared savings program, the budget impact of such a program and recommendations going forward.

Background

2020 Home- and Community-Based Services Report

The 2020 Joint Chairmen's Report requested a 'Report on Longitudinal Cost-Benefit Analysis of Expanding Home- and Community-Based Waivers.' As directed, the Hilltop Institute (Hilltop), in consultation with the Department, published a report on Maryland's Home- and Community-Based Options Waiver (CO waiver), which included a review of HCBS implementation in other states, an examination of the Department's historic HCBS expenditures and an analysis of the costs of expanding the CO waiver.

The 2020 report noted that the literature is mixed as to whether states have realized cost savings from Medicaid HCBS programs, and there is little evidence showing that Medicaid HCBS programs actually delay or avert nursing facility admission. However, participants in waiver programs consistently report a higher quality of life and satisfaction than those in institutional care.

Historically, the Department's long-term services and supports (LTSS) spending reflects a shift away from institutional care towards community-based programs. From 2013 to 2019, the number of individuals in HCBS programs grew by 39 percent, while there was a 3 percent decline in Medicaid participants residing in nursing facilities. Expenditures in HCBS grew by 74 percent, and nursing facility services grew by only nine percent. At the same time, the number of licensed nursing facility beds in the state decreased by 13 percent.

Hilltop found that the potential cost of every additional waiver participant is \$10,000-\$12,500 in state funds per year (\$20,000 - \$25,000 total funds). Thus, the total cost of expanding the CO Waiver would

be \$31-\$39 million annually for the estimated 3,088 individuals on the current waiver registry who would likely meet the eligibility requirements.

The report concluded that, because savings from Medicaid HCBS programs for individuals who are eligible for both Medicare and Medicaid (dual-eligibles) are most likely to accrue to Medicare, states should consider alternative payment models that require Medicare savings to be shared with Medicaid. In its submission, the Department included a shared savings concept note that had been developed in conjunction with the Maryland Health Services Cost Review Commission (HSCRC) in late 2019.

Washington State Managed Fee-for-Service Model

Washington State operates a well-established alternative payment model, on which the Department based its concept. In 2013, CMS and the State of Washington launched a Managed Fee-for-Service Financial Alignment Initiative Demonstration (FAI). The original demonstration period was set to end in 2016 but has been repeatedly extended and is now set to end in December 2022.

As a part of the FAI, Washington State is held accountable for improving the coordination of care across existing providers and Medicare and Medicaid service delivery systems. In return, the State will be eligible to receive a retrospective performance payment based on its performance on quality and savings criteria.

Under the FAI, eligible Medicare-Medicaid participants must elect to receive health home services, which includes comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family supports and referral to community and social support services. The FAI did not create any new or expanded benefits beyond those provided as part of the health home program. As of May 2019, the State had 11 health home entities serving approximately 13,000 participants across all of its 39 counties.

The retrospective performance payment is calculated based on the total amount of federal savings.¹ As such, it is possible that Medicare savings would be offset by increased federal Medicaid spending. If there are net federal savings, then the State is eligible for up to 50 percent of those savings, if quality measures and minimum savings rate have been met. The performance payment can be no greater than six percent of total Medicare expenditures for the FAI population.

There have been four evaluation reports during the demonstration period. The most-recent, published in summer 2021, found that there have been decreases in skilled nursing facility admissions, long-stay nursing facility use and physician visits for the overall demonstration eligible population.² Eighty-seven percent of CAHPS survey respondents reported that they were satisfied with the help they received to coordinate their care. Additionally, from 2013 to 2018, the FAI achieved a total of \$232.2 million in gross Medicare Parts A and B savings.

Overview of Maryland Shared Savings Concept

¹<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAMFFSMOU.pdf>

² <https://innovation.cms.gov/data-and-reports/2021/fai-wa-fourth-eval-report>

The TCOC Model encourages the development of innovative programs to support care coordination and improve health outcomes for high-needs populations. Contingent on federal approval, the TCOC Model provides a vehicle for Medicare to share any savings with Medicaid that have resulted from Medicaid upfront investment, addressing the so-called ‘wrong pocket’ problem. Medicaid proposes to work with the HSCRC to develop an initiative for Maryland’s dual eligibles, using Washington State’s FAI for fee-for-service Medicare-Medicaid enrollees as a basis for developing the financial mechanism for shared savings.

Shared Savings Framework for New Investments

With state and federal approval, Maryland could employ a shared savings approach to offset various Medicaid investments in services and delivery models benefitting dual eligibles. In its original shared savings concept note, the Department identified potential candidates for a Medicare-Medicaid shared savings approach, including LTSS. While this report focuses on LTSS, because many dual eligibles also have behavioral health diagnoses, the Department is interested in pursuing a parallel framework to balance investments into crisis stabilization services as well. Such services would be accessible to all Medicaid enrollees that need the need including, but not limited to, the duals population; the Medicare-Medicaid shared savings approach would apply to just the duals.

Long-Term Services and Supports

The dual-eligibles constitute a major proportion of the Medicaid enrollees who utilize care across the post-acute and LTSS continuum. In Maryland, the CO waiver, authorized under §1915(c) of the Social Security Act, enables Medicaid participants who would otherwise require care in a nursing facility or other institution to receive care in their home or community. Individuals interested in participating in the waiver are added to the CO waiver registry maintained by the state. Advocates have encouraged the Department to add additional slots to the CO waiver to decrease the number of individuals on the registry. As noted earlier, the state cost for each additional CO waiver enrollee is estimated to be about \$10,000-\$12,500 per year (\$20,000 - \$25,000 total funds).³

Key Financial Variables

In the envisioned model, Medicaid would make an upfront financial investment, with the potential for shared savings to generate a return on investment (ROI). The proportion of any Medicare savings accrued that could be shared with Medicaid would depend on the following financial variables, which would be subject to negotiation with CMMI:

- The percentage of Medicare savings (federal) that are shared with Medicaid (state); and
- The percentage of the dually-eligible population accessing the service.

In addition, at the time this concept was originally discussed between the HSCRC and Medicaid in 2019, the HSCRC’s approach to shared savings programs applied a ‘Global Budget Revenue offset.’ In essence, Medicare savings generated would interact with a hospital’s Global Budget Revenue (GBR). Decreased hospitalization rates for a participating hospital would lead to higher Medicare rates for this hospital, for all payers to offset. The GBR effect would allow hospitals to retain a portion of the savings in the GBR. The increased Medicare rates received by the hospital for the model population would be deducted

³ <https://health.maryland.gov/mmcp/Documents/JCRs/2020/HCBSexpansionJCRfinal1-21.pdf>

from any potential savings shared with Medicaid. All savings generated by non-hospital providers would be available to Medicare and Medicaid.

Since the Department and the HSCRC first developed the shared savings concept as presented in the 2020 HCBS JCR, other innovative payment models have rolled out in Maryland. Principal among them is the Episode Quality Improvement Program (EQIP), a voluntary, episodic payment program that allows specialist physicians to participate in a Medicare value-based payment program and does not employ a GBR offset. (Maryland physicians have remained largely in fee-for-service arrangements, as the TCOC model precludes their participation in national value-based models.) In developing a shared savings program for Medicaid HCBS, the Department would seek to align with the EQIP payment components and not factor in the previously-presented GBR offset.

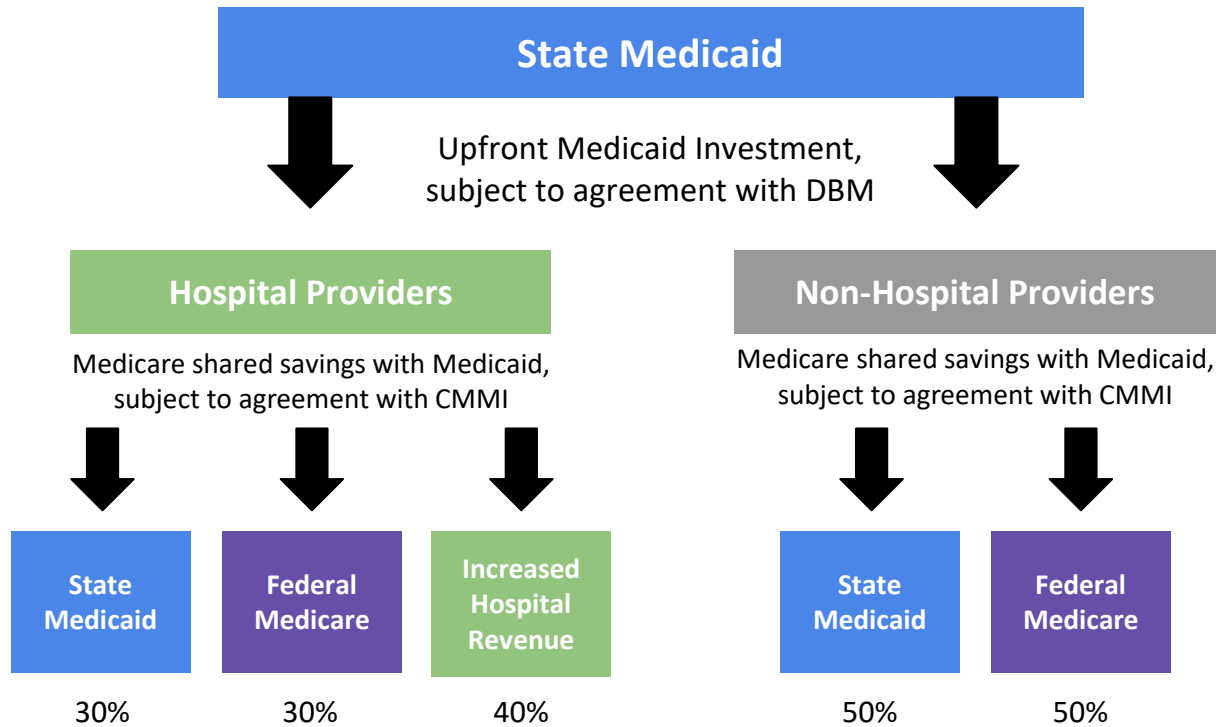
Table 1 and Figure 1 depict potential savings flows for both hospital—assuming a GBR offset—and non-hospital savings.

Table 1: Example of Potential Medicaid Savings Using Proxy Variables

Setting	With GBR Offset		Without GBR Offset
	Hospital	Non-Hospital	All Settings
Medicare Savings	\$20 million	\$20 million	\$40 million
Percentage of Medicare Savings Shared with Medicaid	30% ⁴	50%	50%
Medicaid Savings	\$6 million	\$10 million	\$20 million
Total Medicare Savings Pool	\$40 million		\$40 million
Savings Paid out to Medicaid	\$16 million		\$20 million

⁴ Based on hospitals retaining 40 percent of Medicare savings in Global Budgets.

Figure 1: Financial Flows (displaying GBR offset)



Model Savings Negotiation and Next Steps

Moving forward with implementing the shared savings framework would require signoff by relevant state and federal agencies. Within the State of Maryland, the Department of Budget and Management (DBM) would need to approve the upfront Medicaid investment, based on the expected savings to be shared with Medicaid in future years.

On the federal side, whereas the Washington managed FFS model was negotiated with the CMS Medicare-Medicaid Coordination Office (MMCO), due to the TCOC Model, the development, approval and implementation of a similar program in Maryland would be conducted between the Department, the HSCRC and the Center for Medicare and Medicaid Innovation (CMMI). It is anticipated that the proposed model would necessitate an amendment to Maryland's TCOC contract.

As the implementing state agency of the TCOC Model, the HSCRC has indicated the following elements to be developed in detail before submitting a shared savings concept note to CMMI:

- 1) Description of the concept;
- 2) Description of the population impacted; and
- 3) Identification of the budget, investment necessary and estimated shared savings.

The Department will develop a concept note for the CO waiver expansion according to these guidelines and will also continue to participate in Regional Partnership Catalyst activities to monitor potential asks of Medicaid to fund crisis services.