



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

January 27, 2021

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

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

Re: 2020 Joint Chairmen's Report (p. 117) – Report on Impact of Health Services Cost Review Commission-Led Programs on Medicaid Dual-Eligibles

Dear Chairs Guzzone and McIntosh:

Pursuant to the requirements of the 2020 Joint Chairmen's Report (p. 117), the Maryland Department of Health submits the attached report on Medicaid dual-eligible enrollees. Specifically, the committees requested information on:

Medicaid spending on dual-eligible enrollees (enrollees eligible for Medicaid and Medicare) is disproportionate to enrollment. The Maryland Department of Health (MDH) has investigated various efforts to substantially reform service delivery for these individuals but has not implemented them. Rather, MDH has adopted an approach of monitoring how programs utilized by the Health Services Cost Review Commission (HSCRC) under the Total Cost of Care model can benefit Medicaid spending on the duals. The committees are interested in a report on what programs are being utilized by the duals and the benefits accruing to Medicaid.

Thank you for your consideration of this information. If you have any questions about this report, or would like additional information, please contact Assistant Secretary, Webster Ye at (410) 767-6481 or webster.ye@maryland.gov.

Sincerely,

Dennis R. Schrader
Acting Secretary

Attachment



maryland
health services
cost review commission

Analysis of HSCRC Programs on Dual Medicare / Medicaid Beneficiaries

Joint Chairman's Report

November 2020

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Executive Summary

The *Report on the Fiscal 2021 State Operating Budget (SB 190) And the State Capital Budget (SB 191) and Related Recommendations* (2020 Joint Chairmen’s Report) directed the Health Services Cost Review Commission (HSCRC) and the Maryland Department of Health (the Department) to submit a report on utilization of HSCRC-led programs by individuals dually-eligible for Medicare and Medicaid (dually-eligible beneficiaries) and the benefits accruing to Medicaid. The Report includes the following language:

“Impact of Health Services Cost Review Commission-led Programs on Medicaid Dual Eligibles: Medicaid spending on dual-eligible enrollees (enrollees eligible for Medicaid and Medicare) is disproportionate to enrollment. The Maryland Department of Health (MDH) has investigated various efforts to substantially reform service delivery for these individuals but has not implemented them. Rather, MDH has adopted an approach of monitoring how programs utilized by the Health Services Cost Review Commission (HSCRC) under the Total Cost of Care model can benefit Medicaid spending on the duals. The committees are interested in a report on what programs are being utilized by the duals and the benefits accruing to Medicaid.”

The HSCRC implements its programs on either an all-payer basis or a Medicare-specific basis. While there are no HSCRC programs that specifically target the dual-eligible beneficiaries, the Department has implemented and is in the process of developing a series of duals-focused initiatives. Since 86 percent of the total Medicaid spend for dually-eligible individuals occurs outside of the rate-setting jurisdiction of the HSCRC (primarily nursing facility expenses and home- and community-based services), the opportunity for cost savings to the Medicaid program directly resulting from hospital services is limited. While the Total Cost of Care Agreement requires Maryland to control total cost of care growth for Medicare and provides a tool (comprehensive data, payment waivers, and the Medicare Performance Adjustment) to support that effort, there is no current equivalent for Medicaid. Rather, initiatives led by MDH—e.g., as outlined in previous reports—have the potential to contain Medicaid total cost of care and transform care delivery.¹ Even so, the update factor and potentially avoidable utilization policies have generated saving for all Marylanders, including dual-eligible beneficiaries.

This analysis shows that two of HSCRC’s principal quality programs have resulted in a substantially lower rate of preventable hospitalizations and readmissions for dual-eligible beneficiaries. The benefits of these programs primarily accrue to Medicare, since Medicare is the primary payer for hospital services, while for

¹ See ‘Implementation of a Duals ACO.’ Available: <https://mmcp.health.maryland.gov/Pages/Reports-and-Publications.aspx>.

the dual-eligibles, Medicaid primarily pays for services that are outside of HSCRC's regulatory authority. However, this analysis shows that both the Medicaid and Medicare cost growth rates for dual-eligible beneficiaries has been relatively limited. The per capita costs for dual-eligible beneficiaries grew at about half of the rate of the overall economy. The Medicaid portion is likely indirectly related to HSCRC policies because a majority of Medicaid spend happens outside of the hospital, but may be due to a reduction in the number of hospitalizations that led to lower post-acute care costs paid by Medicaid.

Background on the Dual-Eligible Beneficiaries

Dual-eligible individuals are eligible to receive benefits from both Medicare and Medicaid. Generally, individuals become eligible for Medicare when they turn 65 years old, although there are younger beneficiaries who qualify for other reasons. Most significantly for the dual-eligible population are individuals who are eligible for Medicare because they received Social Security Disability Insurance for two consecutive years.

In fiscal year (FY) 2020, dual-eligible beneficiaries in Maryland represented around 15 percent of the Medicare population and less than 11 percent of the Medicaid population. In relation to their size of the population, these duals represent a disproportionate share of both the Maryland Medicaid budget and Medicare expenditures in the State. In CY 2016, total Medicaid expenditures for full-benefit duals was approximately \$2.18 billion, which is roughly 26 percent of the program's total expenditures on only 11 percent of the population. Medicare spending on duals represents a similar percent of the overall Medicare budget. Medicaid and Medicare pay roughly equal costs for the dual-eligible beneficiaries but they cover different sets of services. In general, Medicare is the 'first payer,' meaning that Medicare will pay for services that are covered by both Medicare and Medicaid. This means that Medicare covers hospital and physician services for the dually-eligible beneficiaries. Medicaid is the 'payer of last resort,' meaning that it pays for costs and services that are not covered by Medicare. This means that Medicaid pays the Medicare Parts A and B premiums and cost-sharing and also a wide variety of services that are not covered by Medicare.

Additionally, Medicare does not cover Long-Term Services and Supports (LTSS) beyond a limited post-acute care benefit and does not cover any specialized home and community-based services that are covered by Maryland Medicaid, especially more comprehensive behavioral health services and LTSS such as nursing facility services, home health and personal care. Consequently, the vast majority of Maryland Medicaid's expenditures for dual-eligible beneficiaries is for LTSS. Nursing facility expenses accounted for 46 percent of Maryland Medicare expenditures on dually-eligible beneficiaries and home- and community-based services accounted for 40 percent of Maryland Medicaid's expenditures on dually-eligible beneficiaries. Together, these two modalities accounted for about 86 percent of the \$2.18 billion that

Maryland Medicaid spent on care for dually eligible beneficiaries. As noted in the Executive Summary, both areas are outside of the regulatory jurisdiction of the HSCRC to set hospital rates.

Background on the Maryland TCOC Model

Maryland has employed a unique approach to hospital payments for over 40 years. Payment for hospital services are set according to regulation by the HSCRC. This system requires that all payers—including Medicare, Medicaid, and commercial insurance companies—pay the same rate for the same hospital service at the same hospital. This allows the payment rates for hospital services to be based on the actual cost of providing care, rather than each payer’s market power.

This system relies on a federal “waiver” of Medicare rules. The waiver not only allows the HSCRC to set the payment rates for Medicare, but it also allows the State to create unique solutions to state-level policy problems. For example, the waiver has allowed the State to finance care provided to individuals who are unable to pay. Additionally, the waiver creates a stable finance system for Maryland hospitals that helps to preserve access to care, especially in rural communities.

In return for the Medicare waiver, Maryland was required by the federal government to meet an annual test evaluating the growth of inpatient hospital costs for each hospital stay. As national patterns and standards of care changed over the years, the waiver test became outdated and was replaced with a succession of federal demonstration models starting with the All-Payer Model (2014-2018) and then the Total Cost of Care Model (2019-2028). These demonstration models maintain the State’s ability to set hospital payments for Medicare but also require the State move the delivery system away from fee-for-service and towards a more value-based delivery system while simultaneously reducing the Medicare total cost of care for Maryland Medicare beneficiaries.

Impact of HSCRC Programs on Dual-Eligible Beneficiaries

The HSCRC implements most of its payment policies on an all-payer basis, so that Marylanders benefit equitably regardless of their source of health insurance. The HSCRC’s primary tools to limit the growth of healthcare costs are 1) an update factor which determines the growth of hospital payments; and 2) a Potentially Avoidable Utilization (PAU) Efficiency Adjustment which reduces hospital payments for hospital services that are related to an unplanned readmission or a hospitalization that could have been prevented through improved care, care coordination or effective community-based care. Combined, these policies have significantly bent the cost curve for hospital services and reduced the avoidable hospitalization rate in the State.

Dual-eligible beneficiaries have benefitted significantly from these policies. As Medicare beneficiaries, they are included under the Maryland TCOC Model where the State has saved more than \$2 billion since the

beginning of the Model. However, the savings primarily have accrued to Medicare and not Medicaid because HSCRC regulates hospital payments – which are covered under Medicare Parts A and B and are therefore paid by Medicare for dual-eligible beneficiaries – and the Medicaid portion of the dual-eligible beneficiary costs is for services that are primarily outside of HSCRC’s regulatory authority. However, Medicare covers only limited post-acute care stays at nursing homes and so the majority of post-acute care costs are paid by Medicaid. The number of post-acute care events declines along with the number of hospitalizations and therefore reducing the hospitalization rate will generate some Medicaid savings because of fewer post-acute care episodes.

The sections below analyze the cost and utilization trend for dual-eligible beneficiaries in Maryland between 2016 and 2019. While the All-Payer Model began in 2014, data limitations have restricted the duration of the analysis to this time period only.

Medicare & Medicaid Total Cost of Care

HSCRC analyzed the total cost of care for dual-eligible beneficiaries in the State using claims data provided by the Centers for Medicare and Medicaid Services (CMS) and Maryland Medicaid. Beneficiaries were limited to those flagged as dual-eligible in each data set (Medicare and Medicaid) and then combined to create a complete picture of the dually eligible beneficiaries. Table 1 below shows the results of the analysis.

Table 1: Annualized Medicaid and Medicare Costs for Dual-Eligible Beneficiaries

Year	Number of Duals	Total Annual Per Capita Costs	Annual Medicaid Per Capita Costs	Annual Medicare Per Capita Costs
2016	142,056	\$34,367	\$16,653	\$17,713
2017	146,359	\$34,944	\$16,673	\$18,271
2018	147,711	\$35,633	\$16,974	\$18,658
2019	149,499	\$36,403	\$17,513	\$18,889

Between 2016 and 2019, both Medicare and Medicaid costs for the dual-eligible beneficiaries grew at a relatively restrained rate – albeit on a very expensive cost base. Medicaid per capita expenditures for the dual-eligible beneficiaries grew at a compounded average rate of 1.8 percent per year. Medicare per capital expenditures grew at 2.2 percent per year.

Typically, the HSCRC judges the success of its payment policies by two standards: 1) whether the growth rate of Maryland Medicare costs is less than the growth rate of national Medicare costs; and 2) whether the growth rate of hospital costs are growing more slowly than the overall economy. Comparing the cost growth for dual-eligible beneficiaries in Maryland to those nationally is not feasible because of data limitations. Under the second standard, the growth rate of costs for the dually-eligible beneficiaries – both their

Medicaid and Medicare shares – appears relatively limited. The Maryland gross domestic product (state GDP) grew at an average rate of 3.4 percent between 2016 and 2019, in comparison with the compound annual growth rates of 1.8 percent and 2.2 percent for Medicaid and Medicare, respectively.

The limited growth of the duals Medicare costs can be attributed to a relatively low update factor for hospital costs. Since Medicare pays the hospital costs for the dual-eligible beneficiaries, the update factor does not fully explain the limited growth in the duals Medicaid costs, which largely pay for services that are not regulated by the HSCRC. However, it is possible that other HSCRC policies have reduced the utilization rate for hospital services and thereby reduced the need for post-acute care services, which is partially covered by Medicaid.

Readmissions

The first component of the PAU Efficiency Adjustment is the number of unplanned readmissions at the hospital. This measure is intended to hold hospitals accountable for reducing a hospital's readmissions related to complications from previous hospitalization and/or providing inadequate care coordination. HSCRC analyzed the readmissions rate for the dual-eligible beneficiaries, as shown in Table 2 below. This measure is an important indicator of the quality of care provided by hospitals but reductions in readmissions could also result in Medicaid savings by reducing downstream post-acute care utilization that is partially paid by Medicaid.

Table 2: Readmissions Rate for Dual-Eligible Beneficiaries

Year	Duals Admissions (Rate per 1000)	Readmissions Rate
2016	329	19.9
2017	315	19.6
2018	301	19.6
2019	283	18.8

Under the Model, the readmissions rate for dual-eligible beneficiaries has fallen by more than 1 percentage point. In the context of national trends, this is a substantial reduction in the readmissions rate. Over the same time, the national readmissions rate for dual-eligible beneficiaries rose from 19.8 to 20.3 percent. Furthermore, given the clinical complexity of dual-eligible beneficiaries, a 1 percentage point reduction in the readmissions rate is a substantial accomplishment.

Additionally, the readmissions rate is impacted by the number of admissions. As shown in Table 2 the total number of hospitalizations for the dual-eligible beneficiaries has fallen by almost 14 percent. As the number

of hospitalizations declines, the readmissions rate is expected to rise because avoidable hospitalizations tend to have a lower clinical acuity. The remaining hospitalizations are likely to be more complex and therefore have a higher risk of a readmissions. Simultaneously reducing both the overall hospitalization rate and the readmissions rate represents a substantial improvement in care for dual-eligible beneficiaries.

Potentially Preventable Hospitalizations

The second component of the PAU Efficiency Adjustment is the number of ambulatory care sensitive conditions for which good outpatient care could potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. For example, hypertension or bacterial pneumonia are both treatable in ambulatory settings unless the condition persists, at which point hospitalization may become necessary. Thus, the number of conditions that progress to the hospitalization stage is a measure of the quality of ambulatory and preventative care provided by the hospital and the delivery system more generally. These admissions are measured using Prevention Quality Indicators (PQIs) developed by the Agency for Health Care Research and Quality (AHRQ). Table 3 below shows an analysis of potentially preventable admissions for the dual-eligible population.

Table 3: Potentially Preventable Hospitalizations for Dual-Eligible Beneficiaries

Year	Duals PQI 90 (Rate per 1000)
2016	68.9
2017	67.0
2018	61.5
2019	60.1

As shown above, the number of potentially preventable admissions has fallen by almost 13 percent since 2016. This represents a substantial improvement in the quality of care provided by the delivery system in Maryland. Again, however, the link to Medicaid savings is indirect since the cost of the avoided hospitalizations would have been paid by Medicare. It is also possible that these avoided admissions were a result of post-acute services and other services that have been partially paid for by Medicaid and reduced the need for services because of the upstream improvements in beneficiary health.

Conclusion

Dual-eligible beneficiaries are very expensive for both Medicaid and Medicare. However, since 2016 the growth rate of their per capita costs has been relatively limited, as compared to the per capita gross state product. The Medicare portion of their costs has been constrained by HSCRC's payments policies, which have substantially limited the growth rate of hospital costs and led to a substantial reduction in the rate of

unnecessary hospital services. The savings from these programs primarily accrue to Medicare, which covers hospital services for dual-eligible beneficiaries. Because the Medicaid portion of the dual-eligible beneficiary costs is largely attributable to services that HSCRC does not have authority to regulate (such as LTSS), the HSCRC payment policies do not achieve the same degree of savings. Thus, the relatively limited growth in the Medicaid portion of the dual-eligible beneficiary costs is likely only indirectly related to HSCRC payment policies. It is possible that the reduction in avoidable hospitalizations has resulted in savings from downstream post-acute care services, which is partially paid by Medicaid. At the same time, the limited growth in dual-eligible costs may be due to factors beyond HSCRC's payment policies.