Medicaid Total Cost of Care Savings

Submitted by the Maryland Department of Health, in collaboration with the Health Services Cost Review Commission, pursuant to Section 20 of the Budget Reconciliation and Financing Act of 2018 (Chapter 10 of the Acts of 2018)

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Acronyms

ACO	Accountable care organization
AHRQ	Agency for Healthcare Research and Quality
ASO	Administrative services organization
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CRP	Care Redesign Program
DPP	Diabetes Prevention Program
FFS	Fee-for-service
HSCRC	Health Service Cost Review Commission
InCK	Integrated Care for Kids
LTSS	Long-term services and supports
MCO	Managed care organization
MDPCP	Maryland Primary Care Program
MHAC	Maryland Hospital-Acquired Conditions Program
MPA	Medicare Performance Adjustment
MSSP	Medicare Shared Savings Program
MTS	Mobile Treatment Services
OTP	Opioid Treatment Program
PAU	Potentially-avoidable utilization
PDI	Pediatric Prevention Quality Indicator
PQI	Prevention Quality Indicator
PRP	Psychiatric Rehabilitation Program
QBR	Quality-Based Reimbursement Program
RRIP	Readmissions Reduction Incentive Program
SNF	Skilled nursing facility
SUD	Substance Use Disorder

Executive Summary

Section 20 of the Budget Reconciliation and Financing Act of 2018 (Chapter 10 of the Acts of 2018) required:

(a)(1) The Maryland Department of Health and the Health Services Cost Review Commission shall develop 5–year and 10–year Medicaid–specific cost savings targets, which shall include a reduction in total hospital costs, total cost–of–care, and quality measures.

(a)(2) The Medicaid–specific cost savings targets developed under paragraph (1) of this subsection shall be established in addition to, and apart from, any Medicaid–related or Medicaid–specific goals included in the successor all–payer model contract.

(b) On or before December 15, 2018, the Department and the Commission shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on the Medicaid–specific targets developed and an implementation plan to achieve the targets.

(c) On or before December 15, 2019, the Department and the Commission shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on its progress in meeting the Medicaid–specific targets that have been developed.

The Total Cost of Care Model provides for many innovations in the delivery of health care services; to date, many of the targets—and therefore programs—under the model focus on Medicare. Maryland finds itself at a critical juncture to incorporate Medicaid-specific elements into the model.

Approximately 85 percent of the Maryland Medicaid population is enrolled in the HealthChoice managed care program, which puts managed care organizations at risk for their enrollee's health care through a capitated per member, per month payment. Under this risk arrangement, it is difficult to develop total cost of care savings akin to the Total Cost of Care Model. However, there are opportunities to increase efficiencies under the HealthChoice program, both within the program's structure itself, as well as the incorporation of quality metrics and targets for the HealthChoice population under the Total Cost of Care Model.

The greatest opportunity for developing total cost of care savings targets lies within the population of individuals dually-eligible for Medicare and Medicaid. This population currently receives care on a fee-for-service basis, with little coordination between payers and providers. The implementation of the new Total Cost of Care Model presents the prospect of developing care coordination programs for the dually-eligible and aligning incentives to prevent the shifting of costs between Medicare and Medicaid.

In addition to the financial targets and quality programs set forth in the Total Cost of Care Agreement, the Agreement also stipulates that the State select a minimum of three broad population health goals. For the selected goals, the Centers for Medicare and Medicaid Services will credit savings generated under the population health goals toward the federal investments into the new Maryland Primary Care Program. While the savings calculations and corresponding credits will be specific to the Medicare population, it is the intent of the Medicaid program to similarly focus quality programs and other initiatives in support of improvement toward those same goals.

Background and Purpose

The replacement of the 2014-2018 All-Payer Model Agreement with the Total Cost of Care Model, which extends the model through the end of 2028, requires the State to meet certain metrics throughout the ten-year demonstration period. While some of those metrics apply across payers, such as limiting per capita all-payer hospital revenue growth, other metrics are Medicare-specific, including targets for cumulative Medicare savings in total cost of care expenditures. The Maryland Medicaid program has been instrumental in supporting the achievement of the required Medicare savings under the All-Payer Model. The implementation of the Medicaid expansion under the Patient Protection and Affordable Care Act allowed Maryland hospitals to generate approximately $600 million in Medicare savings from reductions in hospital assessments and uncompensated care from fiscal year (FY) 2015 through FY 2018.

Although the new Total Cost of Care Model Agreement does not include Medicaid-specific targets, the Maryland Department of Health (the Department) and the Health Services Cost Review Commission (HSCRC) are committed to utilizing the infrastructure and programs established by the All-Payer and ensuing Total Cost of Care Models to improve financial efficiencies and the quality of care specific to the Maryland Medicaid program, in tandem with the quality and savings realized by Medicare under the model to date.

In support of this effort, Section 20 of the Budget Reconciliation and Financing Act of 2018 (Chapter 10 of the Acts of 2018) required:

(a)(1) The Maryland Department of Health and the Health Services Cost Review Commission shall develop 5–year and 10–year Medicaid–specific cost savings targets, which shall include a reduction in total hospital costs, total cost–of–care, and quality measures.

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Medicare Total Cost of Care in the New Model

The new Total Cost of Care Model builds upon the Medicare savings achieved under the previous All-Payer Model (2014-2018), with a look forward to further incentivizing health system transformation in Maryland by imposing both Medicare savings targets as well as a guardrail for Medicare fee-for-service (FFS) growth—Parts A and B—in addition to an all-payer hospital revenue

growth limit of 3.58 percent annually. The new savings target for Medicare total cost of care departs from the previous iteration of the model by placing risk on Maryland's 47 acute care hospitals for non-hospital Medicare services.[1]

Total Cost of Care Financial Targets

Under the Total Cost of Care Model, the State intends to save a cumulative minimum of $1 billion to Medicare in its first five years (2019-2023), over a 2013 baseline that includes all spending under Medicare FFS Parts A and B. To achieve the savings, the federal Centers for Medicare and Medicaid Services (CMS) require annual targets, beginning at $120 million of savings in 2019 and building to $300 million in 2023. These savings targets were determined to align Medicare savings in Maryland with the performance of comparison states, *i.e.,* other high-income states in the northeastern United States. In the fifth year of the Total Cost of Care Model (2023), CMS and the State will determine a methodology for calculating an annual savings target for the compounded growth in Medicare total cost of care (Parts A and B) per Maryland beneficiary, to ensure that Maryland's per beneficiary Medicare spending growth does not exceed the nation.

In addition to Parts A and B, the baseline and the annual Medicare savings goals also consider non-claims-based payments, such as payments made under the Maryland Primary Care Program (MDPCP) and the Medicare Shared Savings Program (MSSP), among others. If such non-claims based payments would adversely affect the State's ability to meet the Total Cost of Care Model's financial targets, CMS has the authority to adjust the trend factors or benchmarks applied in programs such as MSSP. Outcomes-based credits under the population health plan will also be included in the calculation of annual Medicare savings under the model to potentially offset investments.

The total cost of care guardrail limits the total cost of care growth rate per Maryland Medicare FFS beneficiary from exceeding the national Medicare total cost of care growth rate by no more than one percent in a given year or by any amount for two or more consecutive years. To leverage accountability on the health system for the guardrail, the HSCRC developed the Medicare Performance Adjustment (MPA). The MPA applies a scaled penalty or reward to each acute care hospital in Maryland, depending on the hospital's performance in controlling the Medicare total cost of care growth rate within an attributed population, defined by a methodology that links Medicare FFS beneficiaries with non-hospital providers, then those providers with hospitals. The State has the flexibility to adjust the MPA methodology on an annual basis, subject to CMS approval. The current methodology applies a three-tiered approach of accountable care organization (ACO)-like attribution followed by MDPCP-like attribution, with the residual attributed via a hospital's geographic primary service area.

Similar to CMS's authority to adjust shared savings programs, the MPA provides risk management options. Should the State appear at risk of breaching the total cost of care guardrail for a given year but otherwise appears on track to meet its savings and other all-payer metrics, the HSCRC can modify the MPA to avert a breach on a Medicare-only basis.

[1] Excluding Medicare Advantage beneficiaries.

HSCRC Quality Programs

Under the Total Cost of Care Model, the State is exempted from several major Medicare quality programs, with the understanding that the State, through the HSCRC, will implement similar quality programs that better serve Maryland's unique approach and with at least as much revenue at risk as without the model. These programs—which include the Readmissions Reduction Incentive Program (RRIP), the Maryland Hospital-Acquired Conditions (MHAC) Program and the Quality-Based Reimbursement (QBR) Program—currently apply to all payers. However, their design and targets have, to date, given greater weight to quality improvements for Medicare. As a model for other states, Maryland has the opportunity under the new Total Cost of Care Model to broaden the metrics and improve performance in alignment with other payers, including Medicaid.

For the upcoming model period, the State is responsible for developing and administering hospital quality and value-based payment programs, using hospital performance to adjust hospital budgets on an all-payer basis. Unlike the previous CMS agreement, the Total Cost of Care Model is less prescriptive, requiring the State to:

- Select targets that meet or exceed the results achieved under the All-Payer Model;
- Utilize similar categories of quality measures as the national Hospital Value Based Purchasing, Hospital Acquired Condition Reduction and Hospital Readmissions Reduction programs, with a focus on delivery system alignment and reductions in potentially-avoidable utilization, in addition to the incorporation of population-level measures; and
- Achieve or surpass the patient outcomes and cost savings under those federal programs.

The Potentially-Avoidable Utilization (PAU) Savings methodology constitutes another program under the Total Cost of Care Model to realize savings to payers under the global budget revenue system. The current approach effectuates a prospective percentage decrease to hospital revenue at the outset of every fiscal year, which is divided proportionally among hospitals based on each hospital's performance during the slated performance year. The current PAU Savings definition includes avoidable readmissions through the Agency of Health Care Research and Quality's (AHRQ's) Prevention Quality Indicators (PQIs). It also includes observation readmissions at the receiving—second—hospital, to bring accountability for readmissions across the health system.

Total Cost of Care for the Medicaid Population

Challenges in Total Cost of Care Rate-Setting for the HealthChoice Population

The HSCRC underwent an intensive stakeholder process spanning over two years to develop and fine-tune the total cost of care benchmarks, applicable methodologies and Care Redesign Programs (CRPs) approved by CMS in the summer of 2018. Maryland Medicaid would require, at minimum, the same amount of time to develop savings targets and conduct a similar stakeholder process, with major caveats related to health care financing regulations and the nature of a Medicaid managed care program.

In contrast to Medicare, which is funded solely with federal funds, Medicaid programs are a state-federal partnership, with CMS serving as both a regulating entity and federal funding source. Each state Medicaid program is required by federal law to provide health insurance to specific populations as determined by federal poverty level and to ensure that their health insurance benefit package meets certain minimum criteria. Aside from these minimum requirements, state Medicaid programs have the flexibility to mold their own benefit packages, set service and provider definitions, expand coverage to new populations, and select the health care financing model best suited to their program. Significant differences between state Medicaid programs do not allow for straightforward peer-to-peer comparisons across states or to a national Medicaid benchmark.

Approximately 85 percent of Maryland Medicaid's enrolled population is covered via a capitated managed care program authorized through Maryland's §1115 HealthChoice demonstration program. First implemented in 1997, the HealthChoice program is comprised of nine managed care organizations (MCOs) that receive actuarially-sound prospective capitated payments for each Medicaid beneficiary attributed to their organizations. Unlike FFS models which typically pay health care providers directly for each service provided, MCOs contract with the state Medicaid program to develop provider networks through which somatic services are delivered and to manage the total cost of care for each enrolled Medicaid beneficiary. In Maryland, dental and behavioral health services are carved out of managed care contracts and administered on a FFS basis through administrative service organizations (ASOs).

§1903(m) of the Social Security Act and 42 CFR §438.4 require that capitation rates be actuarially-sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate and attainable costs that are required under the terms of each MCO contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract. Under capitation rates, Maryland MCOs are fully at-risk for the cost of somatic health care provided to each enrolled participant. As at-risk entities, MCOs are incentivized to reduce unnecessary health care utilization and improve the health of beneficiaries; any savings garnered from capitation rates are folded into MCO revenue. Without major changes to federal regulations, Maryland Medicaid cannot set arbitrary savings targets that might alter these actuarially-sound rates. The State's actuary provides the State with an actuarially-sound range for establishing the payment rate. It is in the State's discretion to select the payment rate within the range. Thus, while Medicaid can implement changes to the rate-setting process and quality outcomes that encourage increased efficiency, Maryland Medicaid cannot set arbitrary gross total cost of care savings targets across the entire HealthChoice population without violating federal regulations related to sound and reasonable rate-setting.

There are several internal levers and mechanisms by which Maryland Medicaid can work to improve the efficiency of the HealthChoice program and improve quality outcomes associated with managed care. Different strategies are outlined in a FY 2018 Joint Chairmen's Report, conducted by a third-party contractor, which analyzes Maryland Medicaid's managed care rate setting process and provides recommendations for improved rate-setting among the Maryland Medicaid MCOs. Those strategies are summarized in Table 1 in the following section.

Importance of Care Integration for the Dually-Eligible Population

Dual eligibles (dually-eligible, duals) are individuals who are enrolled in and receive benefits from both Medicare and Medicaid. Duals experience some of the highest rates of chronic illness and the highest rates of health care utilization of any population group in the country. Even though they have coverage from both Medicare and Medicaid, duals in Maryland, as in most states, experience misaligned care and are typically excluded from the care coordination programs that could help them most. This uncoordinated and costly care exacts a heavy toll on beneficiaries, their families, communities and federal and state budgets.

Duals in Maryland are an extremely heterogeneous population reflecting individuals with low-income and limited assets who are enrolled in Medicare. Generally, individuals become eligible for Medicare when they turn 65 years old. Individuals can also become eligible for Medicare when they are between the ages 18 and 64, if they qualify to receive Social Security Disability Insurance (SSDI) for two consecutive years. In CY 2016, 58 percent of the full-benefit duals were aged 65 or older.[2]

In relation to the size of the population, full duals represent a disproportionate share of both the Maryland Medicaid budget and Medicare expenditures in the state. According to national statistics, in CY 2013, total Medicare spending on all duals reflected around 32 percent of Medicare expenditures for services to only 18 percent of the Medicare population.[3] In CY 2016, Medicaid expenditures for full duals in Maryland totaled approximately $2.18 billion; similarly, Medicare expenditures for full duals for CY 2016 totaled $1.38 billion. As noted, services for full duals where Maryland Medicaid is the primary payer compose more than half of the total expenditures on this population. Medicare is the primary payer for all emergency services, primary care and the majority of acute care and prescription drugs for the duals population. Consequently, the associated Medicaid expenditures are a reflection of high utilization of Medicaid-funded behavioral health and long-term services and supports (LTSS) among this population. The data indicate that Medicare spending on duals is also disproportionately high.

The vast majority of Maryland Medicaid's expenditures for duals are on LTSS, reflecting not only the frailty and complexity of the full duals population, but also the division of responsibility between Medicare and Medicaid. Medicare does not cover LTSS beyond the limited post-acute care benefit and does not cover any specialized home- and community-based services like those covered under Maryland's Medicaid program. For example, expenditures for home health services, including Medicaid state plan and home- and community-based waiver personal care services, accounted for 40 percent of Maryland Medicaid's total expenditures on full duals in CY 2016. Similarly, residential nursing facility expenses accounted for 46 percent of Maryland Medicaid's expenditures for full duals in CY 2016. Together, these two modalities of LTSS, which are not covered by Medicare, represented a full 86 percent of Maryland Medicaid's $2.18 billion expenditures for duals in CY 2016.

[2] Full duals receive comprehensive benefit packages from both Medicare and Medicaid; those known as partial duals receive Medicare benefits but only financial cost-sharing support from Medicaid.
[3] Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. (June 2018). A Data Book: Health Care Spending and the Medicare Program.

It is difficult to measure the true impact of cost-shifting within the All-Payer Model—and by continuation, the Total Cost of Care Model—on both a population level and across the health system as a whole. Cost-shifting is most apparent among the Maryland duals, which comprise the majority of the Maryland Medicaid population served through a FFS payment arrangement outside of the HealthChoice program. The duals are one of the few populations that do not benefit from any care management services within Maryland's health care system. As duals are mostly FFS Medicare beneficiaries, Maryland providers are inherently incentivized to reduce Medicare expenditures by moving beneficiaries to services which are primarily paid for by Medicaid.

For example, the newest CRP under the Maryland Model, called the Episode Care Improvement Program, attempts to incentivize post-acute care in lower-acuity settings such as home health, in place of skilled nursing facilities (SNFs). While moving care to a lower-acuity setting may reduce the Medicare total cost of care, it is unclear how decreased statewide utilization of SNFs will affect the rates that Medicaid pays for residential stays at these same facilities. In particular, Medicaid reimburses nursing facilities—which also generally operate as Medicare SNFs—based on a methodology that accounts for capital costs. A decrease in Medicare paid SNF volume could result in the state Medicaid program paying increased nursing facility rates to cover the relatively-stationary capital costs borne by SNFs, regardless of volume. Without shared accountability and shared provider-hospital risk for the combined Medicaid and Medicare spend, Maryland's Total Cost of Care Model may shift costs to the Medicaid program, which represents one third of Maryland's annual state budget. Most importantly, cost-shifting leads to poor quality of care and can lead to high utilization and mortality, as frail and vulnerable Marylanders are shunting between settings.

Dual eligibles are recognized as a high-need, high-cost population. Many face complex medical, social and behavioral challenges that demand extraordinary care coordination efforts to generate favorable outcomes. Dual eligibles often receive services that could be avoided with the right early and sustained interventions. For example, the Maryland Medicaid program is currently seeking CMS approval for a limited dental benefit package for Maryland duals aged 21 to 64 years—a pilot program that aims to determine the effect of dental coverage on health outcomes and expenditures for this vulnerable population. This initiative is a small example of a far-larger set of possible interventions that could help this population and reduce expenditures for both programs. The Maryland dually-eligible population represents an ideal opportunity for financial and quality alignment between Maryland Medicaid and the All-Payer and Total Cost of Care Models; however, to prevent cost shifting between public payers—with the resulting poor outcomes for patients—Maryland must seek shared accountability for the dually-eligible population as a whole.

Incorporating Medicaid Quality and Efficiency Targets into the Total Cost of Care Model

HealthChoice

Although the HealthChoice population is already in an at-risk structure, there are opportunities to further increase efficiencies and improve health outcomes under the managed care approach.

Managed Care Rate-Setting

The nine MCOs participating in Maryland's HealthChoice demonstration are already subject to the risk and the capitation ranges described above. However, there exist some areas of flexibility within the managed care system that could foster additional improvements in efficiencies and the quality of care, as identified in the Joint Chairmen's Report. Table 1 enumerates some recommendations toward that end. Medicaid is continuing to review the recommendations and meeting regularly to determine the appropriate path forward.

Table 1. Summary of Recommendations for Strengthening the Maryland Medicaid Rate-Setting Process

Recommendation
1. Define a vision and outline top priorities and goals for value and quality in Medicaid managed care.
2. Sustain and strengthen the existing quality incentive program.
3. Evaluate whether to vary profit margin consistent with MCO performance on State priorities.
4. Improve encounter data and enhance use of encounter data to drive value.
5. Validate the existing outlier adjustment aligns with cost, quality and value adjustments.
6. Select the most recent and appropriate base data.
7. Include the estimated mid-year hospital adjustment in the initial rate development.
8. Leverage available tools to develop and implement a standardized framework for evaluating and determine risk of high-cost drugs.
9. Strengthen requirements for coordination of behavioral and physical health.
10. Build more flexibility into state regulatory framework.

Behavioral Health Integration

Over the course of 2018, the Department has worked with an external contractor to develop recommendations for increasing the operational efficiency of the Maryland Medicaid program. One of the proposed strategies in the resulting report suggests that there may be opportunities in the area of increased integration of behavioral and somatic health services.

Inclusion of Medicaid Metrics and Targets within Total Cost of Care Model

The Department applauds the inclusion of all payers in the Total Cost of Care Model's quality programs and supports not only maintaining the all-payer nature of these quality programs but also updating their components so as to include more metrics that target Medicaid-specific services and populations, especially through the PAU Savings and RRIP.

The PAU Savings program, which realizes decreases in the annual global budget update factor to recognize decreases in potentially-avoidable utilization, has historically considered avoidable hospital admissions and readmissions—the latter to the receiving hospital—in its calculation of

potentially-avoidable utilization. The HSCRC is currently revisiting the formula in the interest of expanding the definition, including measures that focus on children under 18. Potential measures under discussion include:

- Pediatric Prevention Quality Indicators (PDIs): Admissions for asthma, short-term diabetes complications, gastroenteritis, perforated appendix and urinary tract infections;
- Prevention Quality Indicators (PQIs) (new): Admissions for low-birth weight newborns; and
- Admissions from nursing home-sensitive conditions.

These metrics align well with the Department's stated priorities of addressing diabetes, asthma and infant mortality, as well as improving care for dual eligibles. The development of a measure around repeat visits to hospital emergency departments is of interest as well.

The 2014-2018 All-Payer Model set a rigorous target for Maryland to meet or fall below the national Medicare readmissions mean by the end of the model period. With the end of 2018 approaching, the State is on track to achieve that target. While the All-Payer Model Agreement's target was Medicare-only, the HSCRC operated the RRIP on an all-payer basis, converting the annual Medicare target to an all-payer goal. The HSCRC heard yearly proposals to convert the RRIP into a Medicare-only program; while the Maryland Medicaid program advocated annually to maintain its all-payer nature. The removal of Medicaid from the RRIP would force the Maryland Medicaid program to rely upon Medicaid authorities to create a separate, Medicaid-only readmissions program with different methodologies—such as non-payment of readmissions—from the all-payer program, rendering readmissions programs more difficult for Maryland hospitals to implement and track.

The HSCRC intends to re-visit the RRIP methodology in the next year. Medicaid is pleased to participate in that process and advocate for the inclusion of Medicaid-specific targets within the program. Factors for consideration include a new Medicaid HEDIS measure—*Plan All-Cause Readmissions*—which is also part of the CMS Medicaid Adult Core Set, thereby promoting measure alignment.

Integrated Care for Kids Application

In summer 2018, CMS announced the upcoming release of a new funding opportunity, the Integrated Care for Kids (InCK) Model. State applications are anticipated to be due in early 2019, with funding anticipated in spring 2019. Funding will be awarded to eight states, with each cooperative agreement up to $16 million maximum for a seven-year period. A condition of funding is the development of an alternative payment model; states and local providers must also share accountability for cost and outcomes.

The Department views the InCK opportunity as an additional strategy to develop innovative alternative payment models within its managed care structure. In applying for these design monies, the Maryland Medicaid program intends to leverage the HSCRC's Regional Partnerships. Specifically, Maryland Medicaid has been in active discussions with Johns Hopkins Hospital, University of Maryland Medical Center and Anne Arundel Medical Center to determine if there is a willingness to build on their existing Regional Partnerships. Johns Hopkins has expressed strong

interest in serving as the lead applicant for CMS funding to create a pediatric model focusing on social and health needs, to respond to the opioid epidemic and positively impact the health of the next generation, as well as reduce Medicaid expenditures. CMS awards under the InCK opportunity are designed to build on existing delivery system innovations; broadening the scope and financing of the Regional Partnerships to focus on Medicaid will leverage not only existing infrastructure but also the cross-setting relationships that are foundational to the modernization efforts under the Total Cost of Care Model and its predecessors.

Individuals Dually-Eligible for Medicare and Medicaid

There are several existing avenues in the state that could be leveraged to advance an integrated care approach—or approaches—for the dually-eligible population. In the meantime, while the State and its partners focus on the design of upcoming programs—detailed in the paragraphs below—the Medicaid program is focused on increasing the focus on the duals in the HSCRC's CRPs, namely, through the introduction of a duals identifier in the data analytics tools that support those programs. Additionally, unlike the non-dual Medicaid population, it is more straightforward to benchmark performance for the dual population, and therefore set improvement targets, against the nation.

Chronic Health Home – Maryland Primary Care Program Alignment

The Affordable Care Act created the option for state Medicaid programs to establish health homes. Health Homes provide an integrated model of care that coordinates primary, acute, behavioral health and LTSS for Medicaid participants who have two or more chronic conditions, one chronic condition and a risk for developing a second chronic condition or a serious and persistent mental illness.

The Maryland Medicaid Chronic Health Home program builds on statewide efforts to integrate somatic and behavioral health services, with the aim of improving health outcomes and reducing avoidable hospital utilization. The program targets populations with behavioral health needs who are at high risk for additional chronic conditions, offering them enhanced care coordination and support services by providers from whom they regularly receive care. The program focuses on Medicaid participants with a serious and persistent mental illness; Medicaid participants with an opioid substance use disorder (SUD) and risk of additional chronic conditions due to tobacco, alcohol or other non-opioid substance use; and children with a serious emotional disturbance. In a Chronic Health Home, the center of a patient's care—instead of being in a somatic care setting—is a psychiatric rehabilitation program (PRP), mobile treatment service (MTS) or an opioid treatment program (OTP). This service delivery method is intended to include nurses and somatic care consultants into these programs and to make sure individuals in PRPs, MTS and OTPs receive improved somatic care as well.

The MDPCP will serve Medicare FFS beneficiaries in Maryland who are attributed to practices accepted into the program, using a plurality of evaluation and management utilization. The care coordination goals of the MDPCP parallel the principles of the Medicaid Chronic Health Homes. To avoid inciting confusion among the vulnerable individuals already receiving care coordination and support services through the Chronic Health Homes, the Total Cost of Care Agreement excludes the

approximately 2,000 dually-eligible beneficiaries currently-enrolled in the Medicaid Chronic Health Homes. The Medicaid program is engaged in discussions with CMS and the MDPCP's Program Management Office to establish the Chronic Health Homes as practices within the MDPCP, eligible to receive the care management and quality investments for their enrolled dual eligibles. The Medicaid program will develop additional requirements for Chronic Health Homes who join as practices in the MDPCP. The Department sees this as a key opportunity to transform an alternative provider type not typically reimbursed by Medicare—in this case, community-based behavioral health providers.

Total Cost of Care Agreement: Post-Acute and LTSS Requirement

The Total Cost of Care Agreement includes language requiring the State to submit a proposal for payment and delivery transformation involving post-acute care and LTSS by January 1, 2021. Under this requirement, Maryland must provide a plan to progressively increase accountability for its Medicaid participants, in addition to the existing Medicare accountability under the Total Cost of Care Model. The dual eligibles constitute a major proportion of the Medicaid enrollees who utilize care across the post-acute and LTSS continuum; therefore, the State envisions the ensuing proposal to target the duals as a population of focus.

Global Budget Revenue: Rate Mandates

The contracts between the HSCRC and individual hospitals that govern the global budget revenue system serve as a policy lever for influencing hospital programs, including program alignment around Medicaid. For example, in 2018, the HSCRC granted Johns Hopkins Hospital a lump-sum increase to its global budget, as well as an increase in rates. As part of this rate arrangement, the HSCRC included language in its contract with Johns Hopkins Hospital, requiring the hospital to work with the HSCRC and Medicaid to develop Medicaid total cost of care targets for its primary service area.

The Department views this contractual mandate as an opportunity to work with Johns Hopkins Hospital—as well as the broader Johns Hopkins health system—to develop an intervention or set of interventions to pilot for dual eligibles. Representatives from Medicaid and Johns Hopkins have formed a working group that is formulating ideas for consideration. Previously, in 2017, Johns Hopkins committed to partnering with the Medicaid program and applying to a CMMI opportunity to create a Medicaid-Medicare ACO. CMS ultimately canceled this national opportunity, but the Department intends to leverage Johns Hopkins' interest in that partnership opportunity in developing and piloting approaches to better serve the duals.

Population Health

In recognition of the growing importance of improving health outside of health care settings, the Total Cost of Care Agreement directs the State to select a minimum of three population health priorities, for which it must develop a methodology for assessing the State's performance. A unique component of the Total Cost of Care Model was the creation of outcomes-based credits for improved population health. These outcomes-based credits aim to quantify the savings achieved by improving the health of the population and will be applied to the savings targets and total cost of care guardrail calculations, *i.e.*, to offset the federal investments into the MDPCP. The Agreement

excludes the Medicaid HealthChoice population—and their related health care expenditures—from the outcomes-based savings credit, as savings for that population have already been negotiated under the authorizing §1115 waiver and cannot be double-counted.

While these calculated savings and credits will be specific to the Medicare FFS population, the Medicaid program is committed to aligning in addressing the population health priorities selected by the State. For example, the first identified priority is diabetes prevention. In addition to promoting proactive chronic care of participants with diabetes as a staple of its managed care program, since 2016, the Medicaid program has been working in close partnership with the Department's Center for Chronic Disease Prevention and Control (the Center) on a CDC-funded demonstration to test the provision of the National Diabetes Prevention Program (DPP) to Medicaid MCO participants. Pending the culmination of these grant funds, the Medicaid program worked with the Department of Budget and Management to identify funds to continue the demonstration on a pilot basis; a corresponding §1115 waiver amendment to secure federal matching funds was submitted in July 2018 and is awaiting CMS approval. Accordingly, after a successful national demonstration, CMS launched Medicare reimbursement for the DPP in April 2018. Based on their collective experience in implementing the DPP, the Medicaid program and the Center submitted joint comments to CMS on the final Medicare rule and look forward to continuing to streamline the provision and reimbursement of the DPP across payers and health systems.

Other areas under consideration as population health priorities under the Total Cost of Care Model include behavioral health, Hepatitis C and falls. All three are of critical importance to the Medicaid program, across both the HealthChoice and dually-eligible populations. Similar to diabetes prevention, the Medicaid program will continue to align its interventions toward the improvement of health outcomes in these areas, while attributing savings due to Medicaid investments back to the Medicaid budget. The attribution of savings achieved by the dually-eligible will need to be carefully ascertained as the specifications for each priority measure are developed, as the Medicaid program provides related services—such as community-based behavioral health and LTSS—for that population.

Planning for Appropriate Growth for Medicaid Expenditures

Key to the design and implementation of new or enhanced Medicaid initiatives is the availability of data for robust analysis. In Table 2 below, the Department presents a per capita analysis of Medicaid total cost of care by population: HealthChoice, full duals and partial duals.[4] Table 3 highlights the specific contribution of costs related to behavioral health services for these populations.[5] Assessing the year-over-year per capita spend provides an analytical foundation from which to determine reasonable and valid growth rates—with the caveat that the data must be interpreted within the context of new Medicaid programs or changes in eligibility definitions. The Department is also developing an historic-facing total expenditure summary to supplement the per

[4] "HealthChoice Population" includes all Medicaid participants enrolled in HealthChoice for at least one day, removing any participants who were also enrolled in: 1) Limited benefit coverage groups: X10 and/or P10; 2) Dually-eligible for Medicare and Medicaid; and 3) Greater than 65 years of age as June 30th of the fiscal year.
[5] These costs are also included in Table 2; Tables 2 and 3 are not mutually-exclusive.

capita analysis as it continues to evaluate priority areas of focus. As the tables presented below only contain information from the most-recent three years, the data contained therein are intended to serve as a baseline for analysis and discussion.

Table 2. Medicaid Total Cost of Care Expenditures Per Person, Per Year (FY 2015 – FY 2017)

	HealthChoice Population			Full Duals			Partial Duals		
Service	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2015**	**FY 2016**	**FY 2017**
Managed Care Capitation									
Total MCO Payments	$4,037	$4,067	$4,413	-	-	-	-	-	-
Fee-For-Service (FFS)									
Rx Total	$372	$426	$419	$116	$132	$130	$91	$101	$94
Long Term Care Total	$16	$21	$15	$11,043	$11,115	$11,055	$24	$26	$19
Inpatient Total	$416	$484	$391	$793	$726	$859	$260	$271	$249
Outpatient Total	$216	$248	$214	$508	$529	$550	$371	$383	$407
Physician Total	$427	$534	$543	$1,553	$1,585	$1,663	$423	$449	$483
Home Health Total	$324	$360	$355	$9,726	$10,498	$11,060	$44	$58	$60
Special Services Total	$310	$314	$334	$895	$883	$904	$670	$754	$816
Grand Total (FFS)	***$2,080***	***$2,385***	***$2,272***	***$24,636***	***$25,469***	***$26,221***	***$1,884***	***$2,040***	***$2,128***
Grand Total PPPY	**$6,117**	**$6,452**	**$6,684**	**$24,636**	**$25,469**	**$26,221**	**$1,884**	**$2,040**	**$2,128**

Table 3. Medicaid Total Cost of Care Behavioral Health Expenditures Per Person, Per Year (FY 2015 – FY 2017)

	HealthChoice Population			Full Duals			Partial Duals		
Service	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2015**	**FY 2016**	**FY 2017**
Inpatient									
Inpatient Mental Health	$142	$142	$141	$69	$55	$53	$44	$42	$40
Inpatient RICA	$3	$3	$2	$0	$1	$0	$0	$0	$0
Inpatient Residential Treatment Center	$20	$23	$19	$3	$3	$4	$0	$0	$0
Substance Use	$8	$15	$14	$793	$726	$859	$3	$4	$4
Outpatient									
Outpatient Mental Health	$84	$87	$89	$34	$33	$32	$21	$20	$24
Outpatient Substance Use	$11	$23	$23	$10	$13	$14	$4	$5	$6
Physician									
Psychiatric Rehab Program	$88	$100	$109	$729	$721	$745	$28	$28	$31
Physician Mental Health	$46	$47	$47	$34	$35	$38	$20	$21	$21
Other Mental Health	$232	$318	$338	$204	$250	$280	$36	$50	$60
Total Behavioral Health Spend PPPY	**$634**	**$758**	**$780**	**$1,876**	**$1,837**	**$2,024**	**$157**	**$170**	**$187**

Tables 4 and 5 utilize the expenditure data from Tables 2 and 3 to display year-over-year growth per service line. The figures in Table 5 reflect recent Medicaid policy initiatives in behavioral health—specifically, the expansion of community-based substance use treatment services and a waiver to the prohibition of SUD treatment in specialized residential treatment facilities.

Table 4. Medicaid Total Cost of Care Expenditures Per Person, Per Year – Year-Over-Year Growth (FY 2015 – FY 2017)

	HealthChoice Population		Full Duals		Partial Duals	
Service	**FY 2016/FY 2015**	**FY 2017/FY 2016**	**FY 2016/FY 2015**	**FY 2017/FY 2016**	**FY 2016/FY 2015**	**FY 2017/FY 2016**
Managed Care Capitation						
Total MCO Payments	0.8%	8.5%	-	-	-	-
Fee-For-Service (FFS)						
Rx Total	14.6%	-1.5%	13.3%	-1.5%	10.6%	-6.1%
Long Term Care Total	33.1%	-26.6%	0.6%	-0.5%	9.5%	-27.4%
Inpatient Total	16.4%	-19.2%	-8.4%	18.2%	4.3%	-8.1%
Outpatient Total	14.8%	-13.7%	4.1%	3.8%	3.2%	6.3%
Physician Total	24.8%	1.8%	2.1%	4.9%	6.0%	7.6%
Home Health Total	11.0%	-1.1%	7.9%	5.4%	30.3%	2.9%
Special Services Total	1.3%	6.2%	-1.3%	2.3%	12.4%	8.3%
Grand Total (FFS)	***14.7%***	***-4.8%***	***3.4%***	***3.0%***	***8.3%***	***4.3%***
Grand Total PPPY	**5.5%**	**3.6%**	**3.4%**	**3.0%**	**8.3%**	**4.3%**

Table 5. Medicaid Total Cost of Care Behavioral Health Expenditures Per Person, Per Year – Year-Over-Year Growth (FY 2015 – FY 2017)

	HealthChoice Population		Full Duals		Partial Duals	
Service	**FY 2016/FY 2015**	**FY 2017/FY 2016**	**FY 2016/FY 2015**	**FY 2017/FY 2016**	**FY 2016/FY 2015**	**FY 2017/FY 2016**
Inpatient						
Inpatient Mental Health	0%	-1%	-21%	-4%	-5%	-4%
Inpatient RICA	-8%	-39%	0%	0%	0%	0%
Inpatient Residential Treatment Center	15%	-19%	13%	38%	0%	0%
Substance Use	79%	-7%	-8%	18%	42%	9%
Outpatient						
Outpatient Mental Health	3%	3%	-4%	-3%	-6%	20%
Outpatient Substance Use	111%	2%	31%	6%	19%	16%
Physician						
Psychiatric Rehab Program	14%	9%	-1%	3%	-3%	13%
Physician Mental Health	2%	-1%	1%	9%	6%	1%
Other Mental Health	37%	6%	23%	12%	38%	20%
Total Behavioral Health Spend PPPY	**19%**	**3%**	**-2%**	**10%**	**8%**	**10%**

The development of specific savings targets is challenging without dedicated programs in place to improve health outcomes and thereby generate savings. While Tables 4 and 5 display quantitative trends for identifying potential areas for increased efficiencies, Table 6 presents the areas of focus for which the Department proposes to develop savings targets over the next three-to-five years. The Department is committed to analyzing these areas of focus—and consulting with corresponding stakeholders and subject matter experts—over the course of CY 2019 for the feasibility of conducting the qualitative analysis necessary to define savings targets.

Table 6. Areas of Focus for Medicaid Total Cost of Care Savings

Program Area	Intervention	Timeline
Increasing Managed Care Efficiencies	Adoption of Milliman Recommendations	CY 2019
	Behavioral Health Integration	CY 2020
	Incorporation of Pediatric and Obstetric Targets under HSCRC Quality Programs	CY 2019 – CY 2020
	Incorporation of Medicaid Populations under Regional Partnerships	CY 2019 – CY 2020
Integrating Care for the Dually-Eligible	Chronic Health Homes	CY 2019
	Post-Acute Strategy	CY 2020
	Hospital-Based Integrated Care Programs	CY 2019
Population Health	Departmental Priorities - Diabetes - Asthma - Infant Mortality	CY 2019
	Total Cost of Care Model Population Health Metrics - Diabetes Prevention - To be determined (potentially related to behavioral health, Hepatitis C and falls)	CY 2020

The Department looks forward to further engagement with its State partners and other stakeholders to support the design and sustainability of new Medicaid initiatives that will improve the health of Marylanders while achieving meaningful total cost of care savings for the state Medicaid program.