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Achieving Equity and Cost Reduction: Priority Partners Managed Care Organization (PPMCO)

- Overview - PPMCO
- Medicaid Policy & PPMCO Reimbursement
- PPMCO Utilization Stats
- PPMCO Cost containment Alignment with MD Total Cost of Care

Background:

- PPMCO is one of the 9 MCOs in the State
- Jointly-owned by Maryland Community Health System (MCHS) & Johns Hopkins Health Care (JHHC)
- Largest Maryland Medicaid MCO with ~ 300,000 members statewide

Medicaid Policy & PPMCO Reimbursement:

- As all MCOs we are guided by the Medicaid policy and MCO agreement requirements as set forth by the State
- MCOs are paid a set capitation payment by the State to PROVIDE COVERAGE for specific services for ENROLLED beneficiaries/members
  - this includes professional services (preventive, primary care, & specialty) – IP & OP, other ancillary services & DME, and pharmacy payment

Medicaid Policy & PPMCO Reimbursement:

- There's also a ~2% rural bonus payment for rural counties
- We also have to comply with the agreement requirements which outlines the financial requirements & incentives aligned with Medical Loss Ratio (MLR) and Value Based Purchasing (VBP) targets.
- Like most MCOs, expenditures are controlled under this capitation system.
- So to meet the 85% MLR target, we review our utilization trends

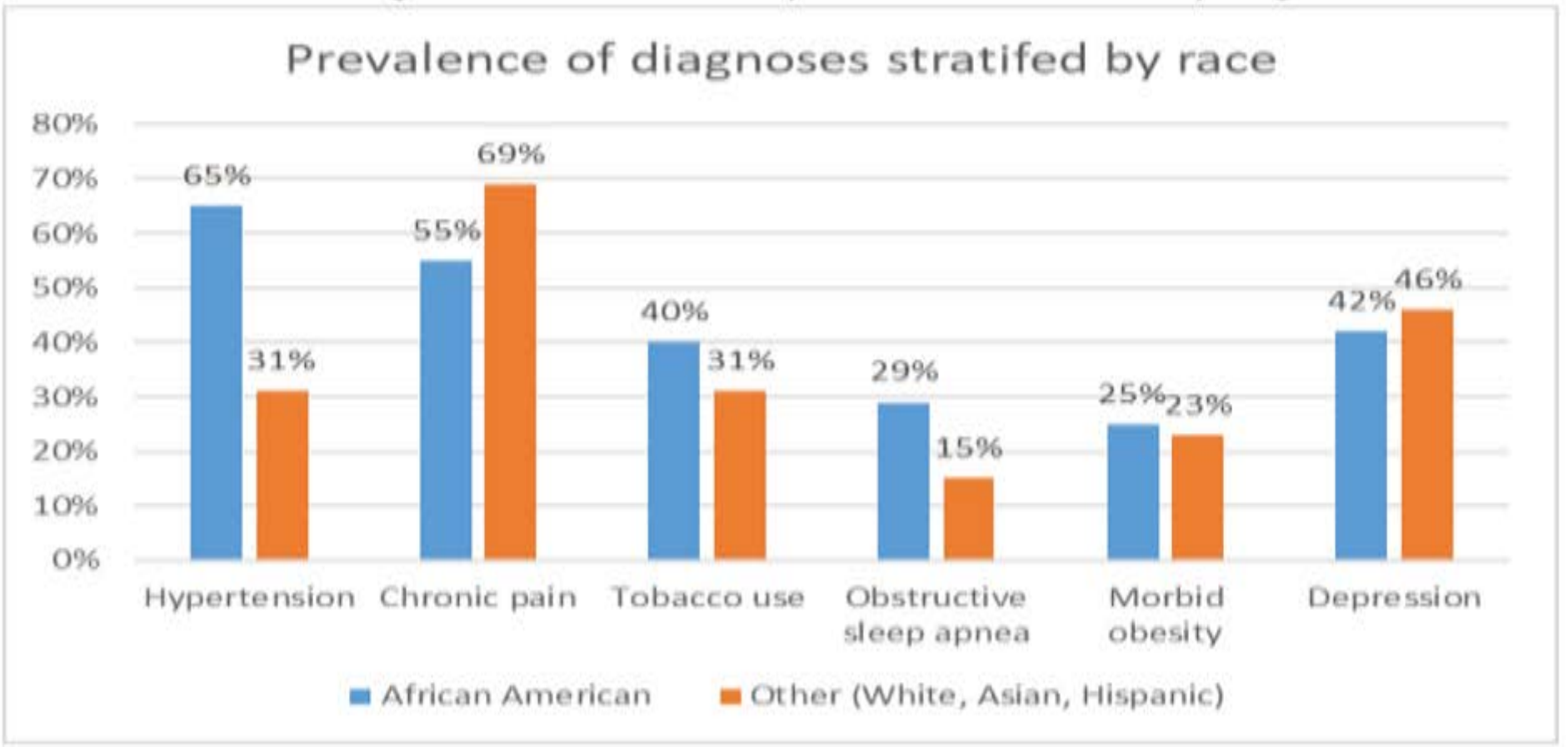
PPMCO Utilization Stats:

- PPMCO Utilization: IP & ED accounts for > 85% of total MEDICAL cost;
  - and about 15% of members account for about 75% of total cost
- Disparity in total cost is observed across geographic locations served

PPMCO Utilization Stats:

- Among members with high complex and multimorbidities, the % distribution is as follows:
- Severe Polypharmacy – 73%
- Cardio Metabolic Risk – 72.6%
- Behavioral Health – 60.3%
- Tobacco use – 45%
- Substance use – 43.2%
- Lack of primary care – 22.2%
- Poor care coordination – 9.9%
- Cancer treatment – 4.8%

Prevalence of diagnosis stratified by Race for our AIC program – shows health disparity in the AA population:



Cost savings opportunities:

- Opportunities are identified while reviewing our preventable utilization data
- Our cost containment Innovation programs are designed to better manage “financial risk”; while providing quality medical care services
- The key considerations include not only ensuring the **Right Care, at the Right place, at the Right time**
- BUT from the payer’s perspective it is also Identifying the -- **Right initiatives, with the Right partners, for the Right investment**.

Cost savings opportunities:

- We've launched about 5 cost-containment/advanced primary care initiatives in the past 5 years
- ranging from community support program to ambulatory intensive care programs for our members in different risk tiers.
- I'll expand on the PP-FQHC Primary Care Collaborative Model

FQHC-PPMCO Primary Care Collaborative

- We entered into a collaborative agreement about 5 years ago with 7 FQHCs under MCHS to implement a QI and Cost containment initiative.
- Target Population: All Members on the 7 FQHCs; with focus on:
  - Unengaged, High-risk members
  - Members with high ED utilization

FQHC-PPMCO Primary Care Collaborative

- Performance measures include improved:
  - Inpatient admission rates
  - Emergency room utilization
  - Value-Based Purchasing (VBP/HEDIS) Performance
  - Access to Care
  - Data sharing

FQHC-PPMCO Primary Care Collaborative

- Care Services: Provide integrated, value-based care delivery for all patients across the 5 primary care functions.
  - **The FQHCs decide on the resources they would like to invest in and the modifications to be made to their care delivery process.*
- Monthly bi-directional data sharing: on Utilization, Care gaps, and Costs
- Outcome: 34% Reduction in ED visits; 12% Reduction in IP Admits; **with cost savings at a 3:1 ROI**

Alignment with Total Cost of Care

- Throughout implementation of these cost-containment and innovation initiatives, we made effort not to innovate in a silo but to stay abreast with national and state care innovation/transformation efforts.
- For example: I was fortunate to support CMS leadership with implementation of the national primary care innovation model (CPC+), and was able to share insights from the our cost-containment models at Priority Partners and conversely share insights from the national program with our Priority Partners team to modify our models over time.

Alignment with Total Cost of Care

- As a result, we see clear similarities between the FQHC Primary Care Collaborative and the State-wide MDPCP

	PPMCO-FQHC Collaborative	MDPCP
Model	▪ Like Advanced PCMH Model ▪ Identified POC for each CHC	▪ Advanced PCMH Model ▪ Identify POC for Practice (and CTO)
Performance Measures	▪ **Utilization**: Reduce Inpatient admission rates & ED utilization ▪ **CQMS**: Improve Value-Based Purchasing Performance ▪ Improve Access to Care ▪ Bi-directional Data Sharing	▪ **Utilization**: Reduce unnecessary IP admissions & ED utilization ▪ **eCQMS**: Hb A1c control, Hypertension Control, Initiate Rx for substance abuse ▪ Patient Experience
Payments	▪ Payment: PPMCO payout to FQHCs ▪ Frequency: Upfront (Quarterly) ▪ Methodology: Based of attribution volume ▪ Report expenditures to PPMCO/MCHS ▪ Must meet performance thresholds to avoid reduction in payments	▪ Payment: CMS payout to Practices & CTOs ▪ Frequency: Upfront (Quarterly) ▪ Methodology: *CMF: PBPM rate based on risk-level of attributed beneficiaries; PBIP: PBPM rate based on quality/patient experience of care, AND on utilization performance; CPCP: Hybrid Payment* ▪ Report expenditures to CMS ▪ Must meet performance thresholds to keep PBIP

Alignment with Total Cost of Care

- This approach of
  - adopting best practices,
  - our ability to pay close attention to our data in a meaningful way and
  - adopt a flexible & strategic approach in partnering with providers
- has helped align our care delivery design with key elements of the TCOC model.

Alignment with Total Cost of Care

- So we do see a huge cost savings opportunity for Priority Partners (and MCOs) within Medicaid as more practices become part of the Maryland TCOC Model because it will result in **two key things**:
  - An aligned payer-mix payment structure that's required for us to see a SUSTAINED reduction in TCOC.
  - A high-level of practice readiness, and an accelerated path to attaining cost-savings that are aligned with desired healthcare outcomes and patient experience