



*Maryland Office of Minority Health and Health Disparities*  
**16<sup>th</sup> Annual Health Equity Conference: “Achieving Health Equity  
and Cost Reductions Through Clinical-Community Partnerships”**  
***The Business Case for Addressing Health Equity and Cost  
Reduction by Targeting Preventable Utilization***

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Office of Minority Health and Health Disparities**

December 5, 2019

# The Dilemma of Sustainability in Public Health

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- Funders always ask for a sustainability plan to keep interventions going after the end of grant funding.
- But if the mission is to provide services to those who are unable to buy those services for themselves, how can that be sustained?
  - It must be perpetually subsidized, or
  - It must save enough money to pay for itself ... in which case it can become part of some organization's solvent business plan.
    - Those who reap the savings should pay for the program that creates the savings.

# Preventable Utilization

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- This refers to ED visits and hospital admissions that would not need to occur if everyone had access to and used high quality primary care. Some other names for this are:
  - Potentially Avoidable Utilization (PAU),
  - Ambulatory Care Sensitive Conditions (ACSC's)
  - Prevention Quality Indicators (PQI's)
- In health equity, we can extend this idea to the utilization that would not occur if rates in a disadvantaged group (minority, poor, etc.) were the same as an advantaged group (e.g. Whites, high income)

# Preventing Chronic Disease Preventable Utilization

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- There are three steps:
  - Getting into the provider's office
    - Insurance, transportation, local providers, etc.
  - Getting the right evidence-based treatment plan from the provider
  - Carrying out the treatment plan at home
    - Patient education, patient resources, and other patient support
    - *This third step is often the step forgotten by the system*

# Preventable Utilization, Health Equity, and Cost

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- **What makes preventable utilization important enough to be the focus of a conference on health equity and a discussion of cost savings?**
  - **Utilization disparities are some of the largest racial and ethnic minority health disparities we have in Maryland.**
    - **In particular, for some conditions, Black utilization rates are between 3 and 4 times as high as White rates.**

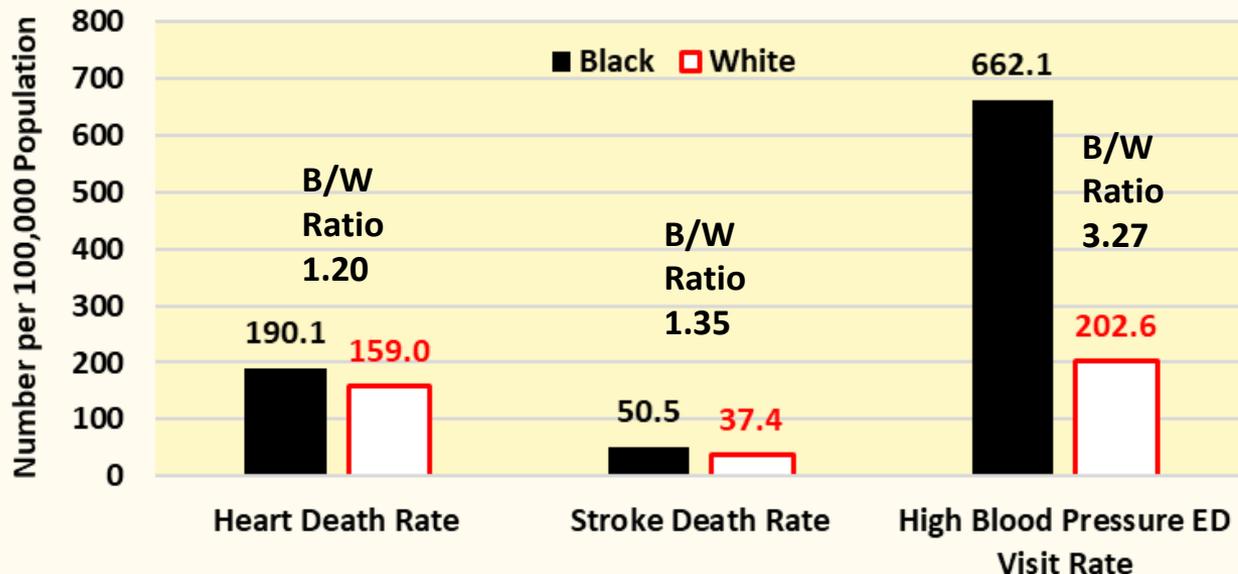
# Preventable Utilization, Health Equity, and Cost

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- Utilization rate ratios of 3 to 4 mean that the percent of the Black utilization that is excess
  - Is between 67% and 75%
- Utilization rate ratios of 3 to 4 mean that for some categories of utilization, the percent of the total that is happening in the Black population
  - Is between 56% and 63%
  - Even though Blacks are only 30% of our population
- *(In Maryland, Asian and Hispanic utilization rates are generally similar to or lower than White rates)*

# Black vs. White Cardiovascular Disease Disparities in Maryland

Age-adjusted Event Rate (death or ED Visits) for Selected Cardiovascular Conditions, by Black or White Race, Maryland 2017 (VSA and HSCRC)



17% of Black Heart Disease Deaths are excess

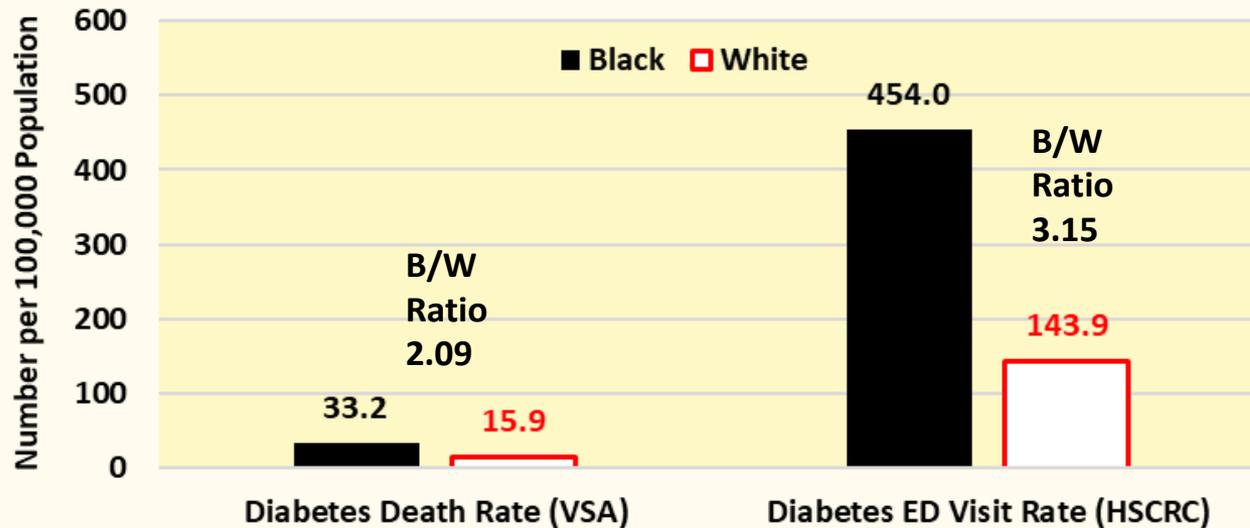
26% of Black Stroke Deaths are excess

69% of Black High Blood Pressure ED visits are excess

Compared to what we would see if Black rates matched White rates

# Black vs. White Diabetes Disparities in Maryland

Age-adjusted Event Rate (death or ED Visits) for Selected Diabetes Indicators, by Black or White Race, Maryland 2017 (VSA and HSCRC)



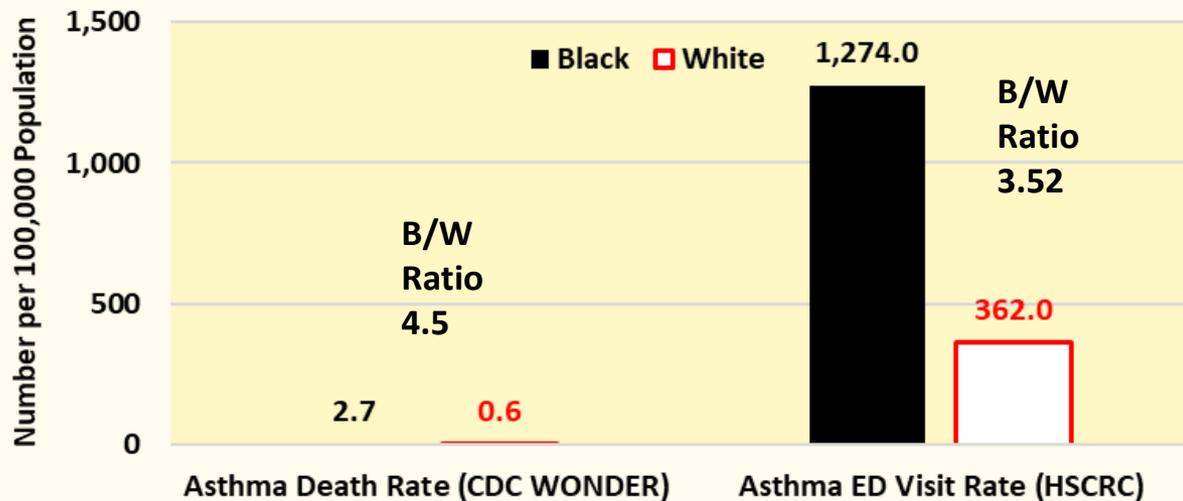
52% of Black Diabetes Deaths are excess

68% of Black Diabetes ED visits are excess

Compared to what we would see if Black rates matched White rates

# Black vs. White Asthma Disparities in Maryland

Age-adjusted Event Rate (death or ED Visits) for Selected Asthma Indicators, by Black or White Race, Maryland (CDC WONDER 2016 and HSCRC 2017)



**78% of Black Asthma Deaths are excess**

**72% of Black Asthma ED visits are excess**

**Compared to what we would see if Black rates matched White rates**

# What Savings is 60% to 70% of Black ED Visits?

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- Before global budgets, people and insurers paid fee for service PRICES to hospitals for each visit, and cost savings could be estimated from visit charges.
- Under global budgets, hospitals have a set budget for the year.
  - So what is saved from reducing preventable utilization is no longer the PRICES paid by insurers for avoided services
  - But now is the PRODUCTION COST to the hospital of providing those avoided services
  - Only the hospitals know that for sure

# Is There Enough Savings to Pay for Programs?

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- That is the bottom-line question
- It depends on the program and the condition targeted
- It also depends on the reimbursement and incentive system structure for hospitals, medical practices, and Medicaid Managed Care Organizations (MCO's)
  - This panel addresses the reimbursement and incentive structure
  - After lunch we will hear from successful community-clinical collaborations doing this work on preventable utilization



December 5, 2019

# Maryland Total Cost of Care Model: *Statewide Alignment and Success*

Tequila Terry  
Deputy Director

Health Services Cost Review Commission

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# HSCRC - Who We Are

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The State of Maryland Health Services Cost Review Commission (HSCRC) is the State agency responsible for regulating the quality and cost of hospital services in order to ensure all Marylanders have access to high quality healthcare services.

We help lead the State's efforts to transform the delivery system and achieve population health improvement goals under the Total Cost of Care Model.

Under this Model and through our previous All-Payer Model, we aim to improve health outcomes, enhance the quality of care, and ultimately reduce the total cost of care for Marylanders.

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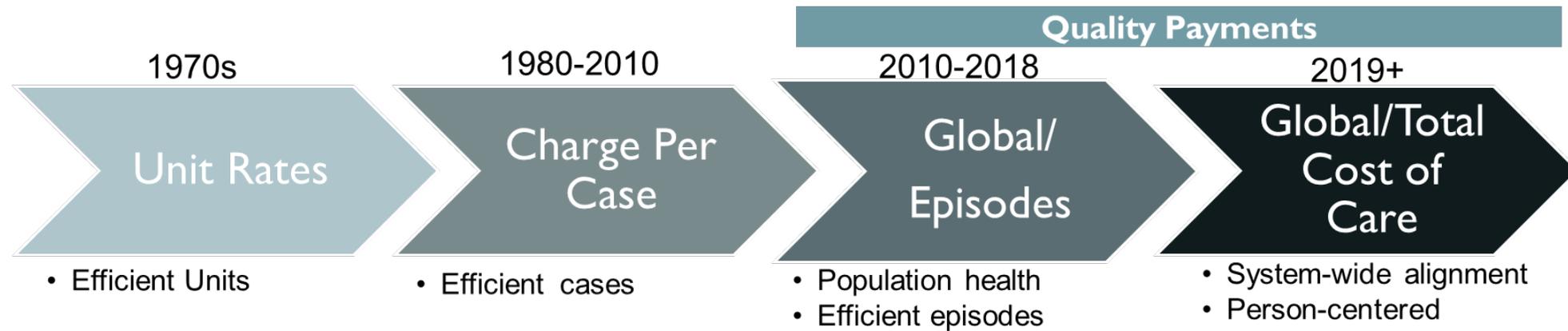
Maryland All-Payer Model  
(2014-2018)



# All-Payer Hospital Rate Setting and Maryland's All-Payer Model

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**Since 1977, Maryland has operated an all-payer, hospital rate setting system**



- ▶ In 2014, Maryland updated its rate setting approach through the All-Payer Model:
  - ▶ Patient-centered approach that focuses on improving care and outcomes
  - ▶ Per capita, value-based payment framework for hospitals
  - ▶ Stable and predictable revenues for hospitals, especially those providing rural healthcare
  - ▶ Provider-led efforts to reduce avoidable use and improve quality and coordination
  - ▶ Contractual agreement between Maryland and federal government

# All-Payer Model Results, CY 2014-2018

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ \$330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)	\$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	\$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓

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# Maryland Total Cost of Care Model (2019-2028)



CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/15/18

By: Adam Boehler, Director, Center for Medicare and Medicaid Innovation

GOVERNOR OF MARYLAND

Date: 7/9/18

By: Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

By: Nelson Sabatini, Chairman



# TCOC Model Agreement

Signed on July 9, 2018!



# Changes from All-Payer Model to Total Cost of Care Model

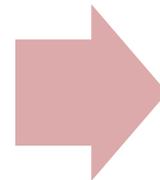
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## All-Payer Model 2014 - 2018

Hospital Focus

Hospital Savings

Hospital Quality



## Total Cost of Care Model 2019 - 2028

System Wide  
Focus

Total Cost of  
Care Savings

Hospital Quality &  
Population Health

## Total Cost of Care Model Overview

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### A 10-year agreement (2019-2028) between Maryland and CMS

- Five years (2019-2023) to build up to cost savings
- Five years (2024-2028) to maintain Medicare cost savings and quality improvements
- Opportunity to “expand” the model (that is, to make it permanent) based on how we perform over the next 3-5 years

Limits growth in total cost of care per capita and improves quality and population health by:

- Continuous quality improvement in setting hospital global budgets
- Engaging non-hospital providers in care transformation and TCOC responsibility
- Targeting specific population health goals and interventions

## Total Cost of Care Targets

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### Reduce Medicare Costs

- Achieve \$300 million in Medicare savings annually by 2023 (from 2013 base year)

### Limit Hospital Revenue

- Continue to limit growth in all-payer hospital revenue per capita at 3.58% annually

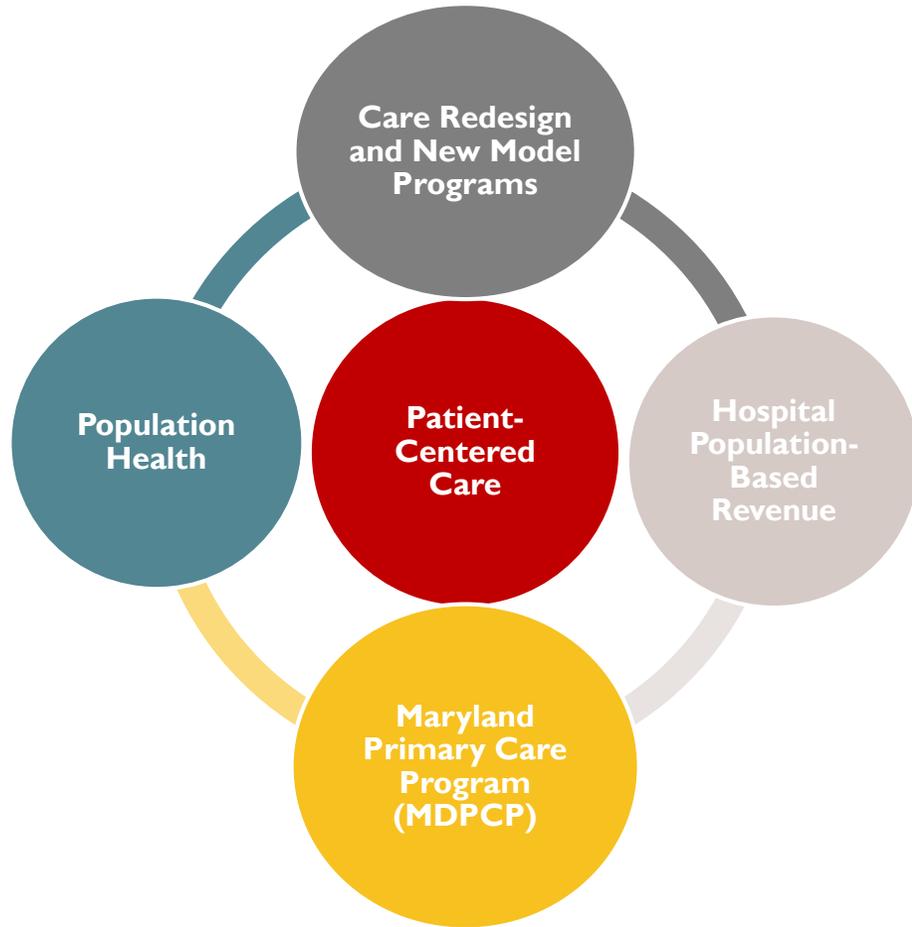
### Transform Care

- Coordinate care for patients across both hospital and non-hospital settings to reduce disparities, improve health outcomes, and constrain the growth of costs

### Improve Population Health

- Address Maryland's highly prevalent chronic conditions

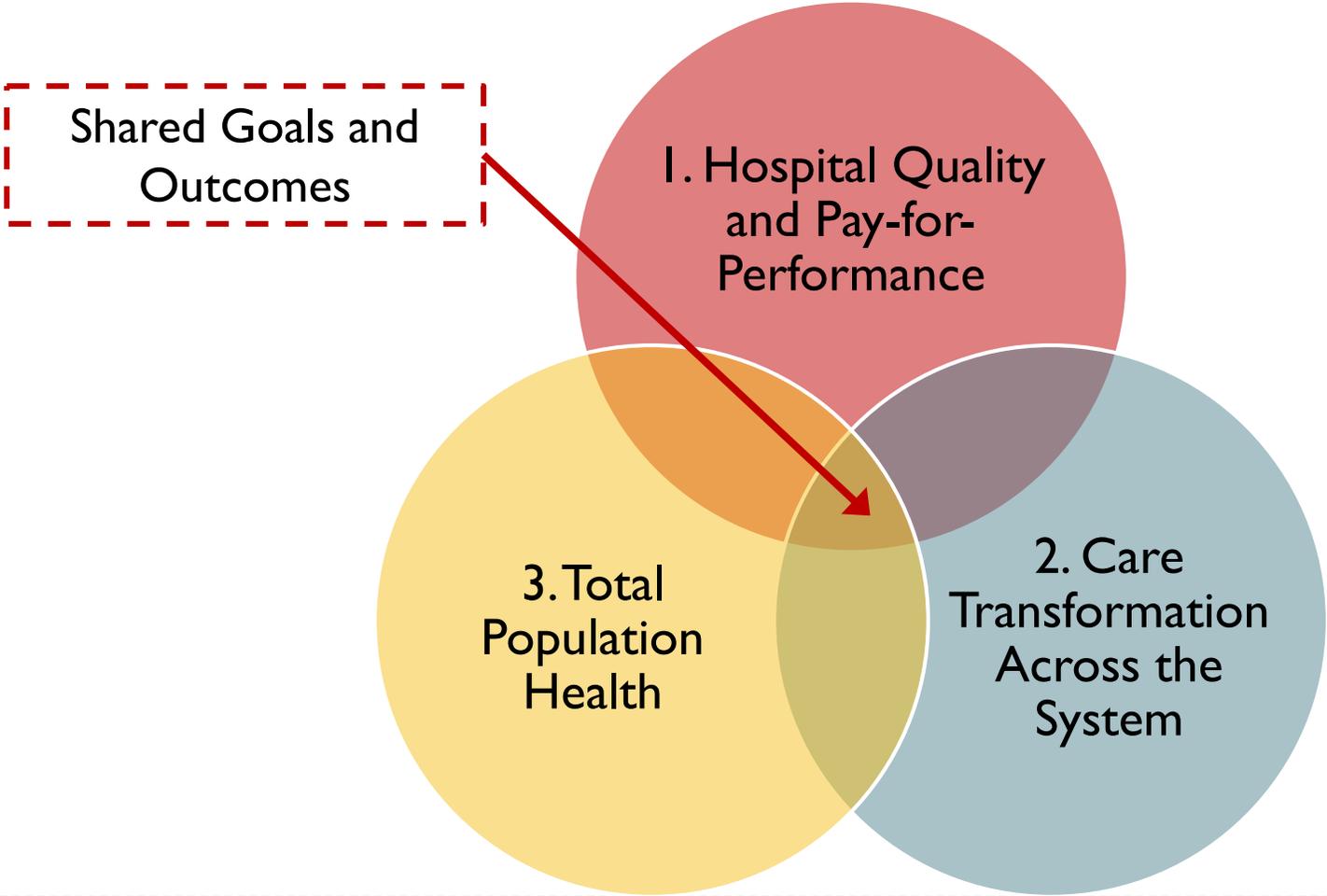
# Total Cost of Care Model Components



Component	Purpose
Hospital Population-Based Revenue	Expands hospital incentives and responsibility to control total costs through limited revenue-at-risk  Incentivizes improved quality care and reduction of potentially avoidable utilization, reduced readmissions, and avoidable complications
Care Redesign and New Model Programs	Fosters care transformation <i>across the health system</i> <ul style="list-style-type: none"> <li>Expand incentives for hospitals to work with others</li> <li>Opportunity for development of “New Model Programs” for non-hospital providers (EQIP)</li> <li>MACRA eligibility with participation</li> </ul>
Maryland Primary Care Program	Enhance chronic care and health management for Medicare enrollees
Population Health	Encourages programs and provides financial credit for improvement in statewide diabetes, opioid addiction, and other priorities

# Total Cost of Care: Statewide Integration Health Improvement Strategy

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# Maryland's Population Health Priorities

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## ▶ **Diabetes prevention and management**

- ▶ Identified as a priority by Maryland State Secretary of Health
- ▶ Initiative being led by the Maryland Department of Health
- ▶ Maryland's statewide ***Diabetes Action Plan*** is now available on MDH website

## ▶ **Opioid screening, prevention, and treatment**

- ▶ Opioid Task Force convened under Lt. Gov. Rutherford in 2015
- ▶ State of Emergency declared by Governor Hogan in 2017
- ▶ State coordinating body, the Opioid Operational Command Center (OOCC), established in 2017

## HSCRC Regional Partnership “Catalyst Grant Program”

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- The Regional Partnership Catalyst Grant Program is an HSCRC grant program designed to create hospital-led partnerships in the community to support infrastructure needs, reduce costs, and improve population health.
- Funding will be issued to hospitals but meaningful community partnerships (e.g., funding, resource sharing, and/or in-kind support) will be required as a condition of grant eligibility.

### Funding Stream I: Diabetes Prevention & Management Programs

- Support implementation of CDC approved diabetes prevention programs
- Support diabetes management programs

### Funding Stream II: Behavioral Health Crisis Services

- Support implementation or expansion of behavioral health models that improve access to crisis services

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Total Cost of Care Model  
What's Next?



# Total Cost of Care Model: What's Next?

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## Build on the All-Payer Model Success

- Sustain and improve high quality care under hospital finance model
- Achieve cost savings targets

## Improve Population Health

- Finalize MOU with CMMI to identify targets and milestones for hospital quality, care transformation, and population health
- Work with partners to implement strategies/interventions

## Foster Hospital & Community Partnerships

- Encourage hospital and community partnerships to address population health priorities
- Grants available January 1, 2021

## Engage Non-Hospital Providers

- Develop value-based payment models for non-hospital providers
- Programs start January 1, 2021

## Reduce Disparities

- Establish formal goals around reducing disparities and promoting health equity under TCOC model
- Expand disparities focus on new methods to assess and include patient-level social exposures/adversity
- Include disparity metrics in hospital monitoring or payment programs



# Thank You!

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Tequila Terry

Deputy Director

Health Services Cost Review Commission

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**Nkem Okeke, MD, MPH, MBA, MSPM**  
Director, Special Projects  
Priority Partners MCO

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

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- ❖ 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





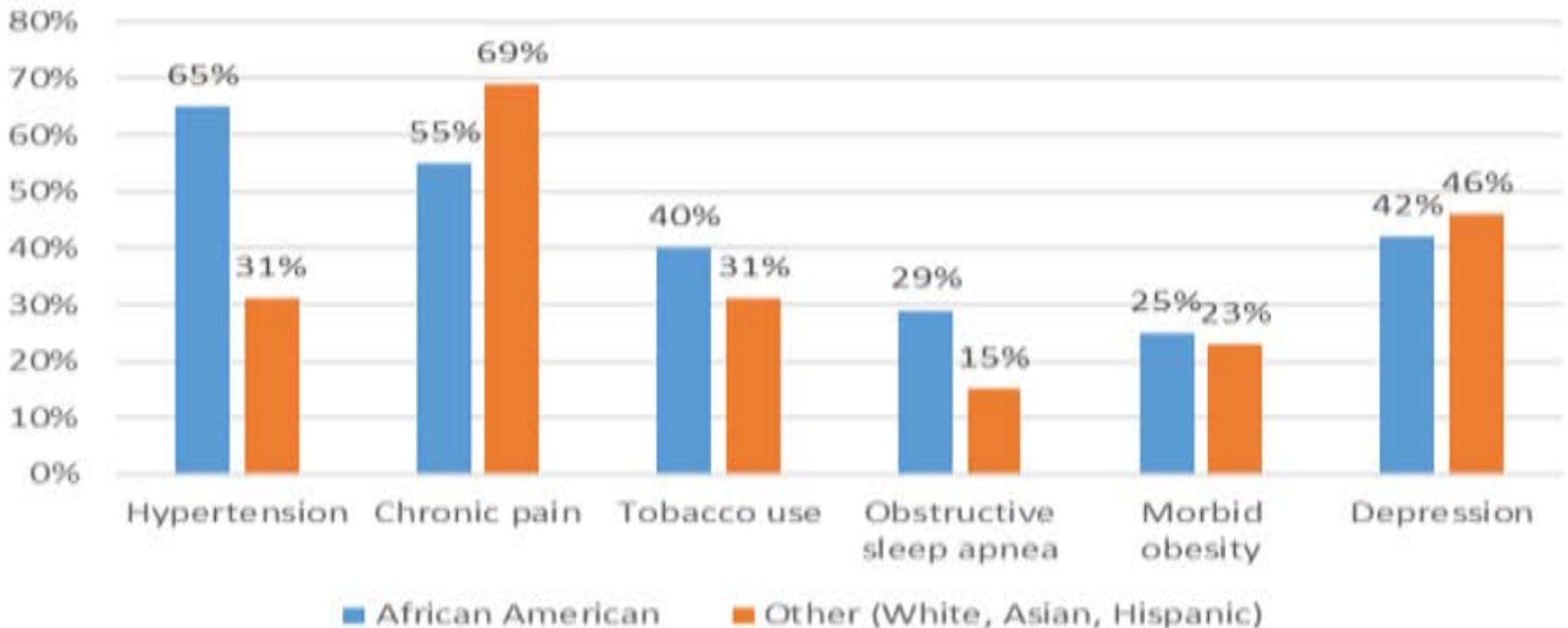
# PPMCO Utilization Stats:

- 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:

Prevalence of diagnoses stratified by race





# 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
<b>Model</b>	<ul style="list-style-type: none"> <li>Like Advanced PCMH Model</li> <li>Identified POC for each CHC</li> </ul>	<ul style="list-style-type: none"> <li>Advanced PCMH Model</li> <li>Identify POC for Practice (and CTO)</li> </ul>
<b>Performance Measures</b>	<ul style="list-style-type: none"> <li><b>Utilization:</b> Reduce Inpatient admission rates &amp; ED utilization</li> <li><b>CQMS:</b> Improve Value-Based Purchasing Performance</li> <li>Improve Access to Care</li> <li>Bi-directional Data Sharing</li> </ul>	<ul style="list-style-type: none"> <li><b>Utilization:</b> Reduce unnecessary IP admissions &amp; ED utilization</li> <li><b>eCOMS:</b> Hb A1c control, Hypertension Control, Initiate Rx for substance abuse</li> <li>Patient Experience</li> </ul>
<b>Payments</b>	<ul style="list-style-type: none"> <li>Payment: PPMCO payout to FQHCs</li> <li>Frequency: Upfront (Quarterly)</li> <li>Methodology: Based of attribution volume</li> <li>Report expenditures to PPMCO/MCHS</li> <li>Must meet performance thresholds to avoid reduction in payments</li> </ul>	<ul style="list-style-type: none"> <li>Payment: CMS payout to Practices &amp; CTOs</li> <li>Frequency: Upfront (Quarterly)</li> <li>Methodology: <i>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</i></li> <li>Report expenditures to CMS</li> <li>Must meet performance thresholds to keep PBIP</li> </ul>



# 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

