Encompassing Medicaid and Uninsured in Your Value-Based Care Initiatives

Thursday, April 11, 2024 at 10:30-12:00 pm

NAACOS 2024 Spring Conference

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Agenda

- Introduction & Learning Objectives
- Community Health Provider Alliance (CHPA)
- Iowa Primary Care Association
- Montana Health Plus
- Valley Health
- Wrap-up & Questions

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Speakers

Brandi Apodaca, RN, BSN

Chief Operating Officer

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Leslie Southworth

Director of the MT Health Plus

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Michaela Holmes

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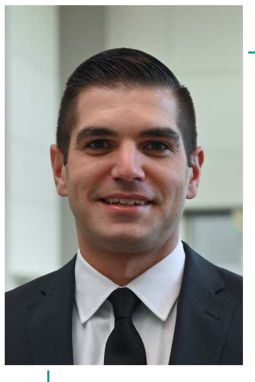

Christian Gomes

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Valley Health System

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Learning Objectives

- Explore strategies for aligning Medicaid and uninsured populations with your ACO's value-based care goals.
- Hear from ACOs comprised of FQHCs and RHCs as they share innovative techniques, including data analytics, pilot programs, and practice transformation strategies.
- Learn how to strengthen your ACO's relationship with Medicaid through effective data utilization.
- Gain practical insights and connect with peers in the evolving landscape of value-based care.

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Community Health Provider Alliance (CHPA)

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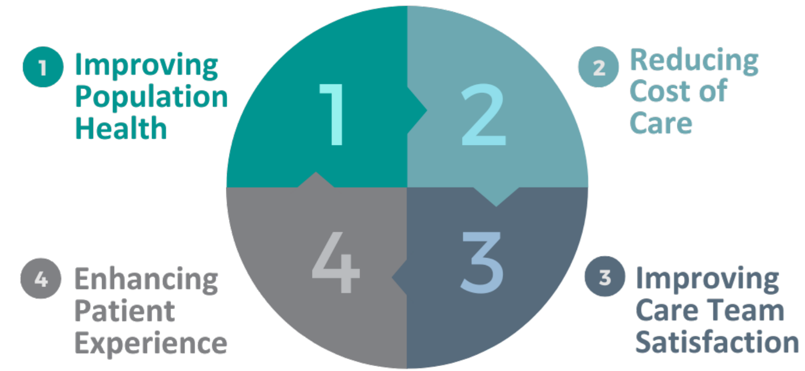
Community Health Provider Alliance (CHPA)

- Community Health Provider Alliance was formed in 2014 as a 501(c)(3) organization and is focused on value-based contracts and the quadruple aim
- CHPA's network is comprised of Colorado Federally Qualified Health Centers (FQHCs)
    - 243 locations and over 1,000 medical and behavioral health providers
    - 20 FQHCs serving over 832,000 community members with a focus on those who are uninsured, underinsured, and under-resourced
    - All participants are fully integrated with Medical, Dental and Behavioral Health services
    - Over 75% of population with co-morbidities and are struggling with the social determinants of health (SDoH)



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Our **mission** is to *improve the quality and cost of care for the people our members serve.*

Vision

To be an admired nonprofit leader in value-based care focused on individuals and communities.

Values

Accountability

We rely on one another to deliver excellence and are mindful of our impact on patient care.

Adaptability

We innovate, informed by data and network needs.

Community

We build a diverse environment that is equitable and inclusive.

Compassion

We act with empathy, kindness, and understanding.

Learn more at chpanetwork.com

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Members

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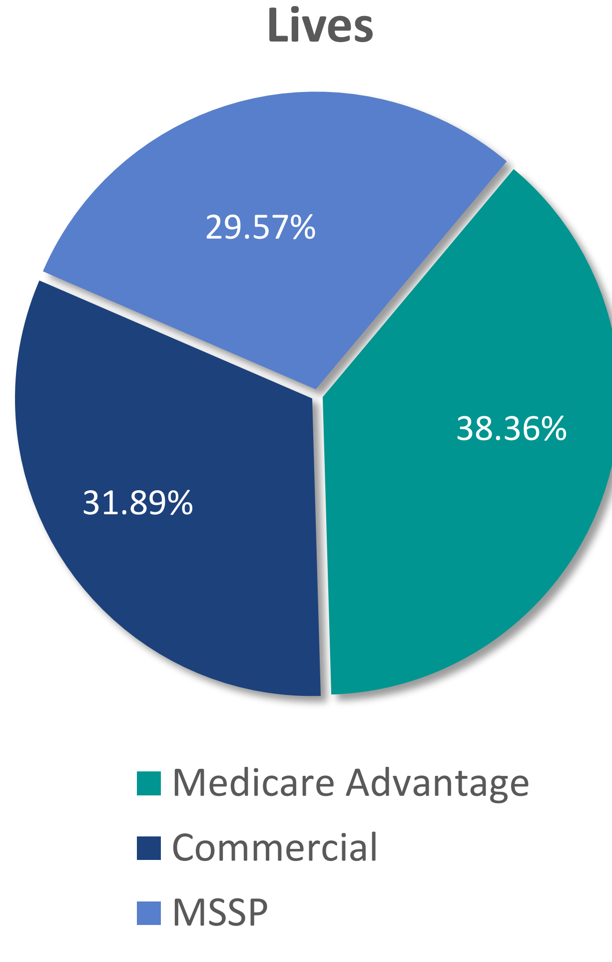
Member Locations

Colorado

CHPA Snapshot

- Participating in MSSP since 2017
  - Started in Basic Track, currently Track E
  - Started earning savings in the third performance year, earned for the fourth consecutive year in 2022
  - Providing $52 million in total savings for CMS over the last four years
- Participating in 6 Medicare Advantage contracts
- Participating in 2 commercial contracts
- 8 EHRs but each Community Health Center (CHC) on their own instance even if on same electronic health record (EHR)



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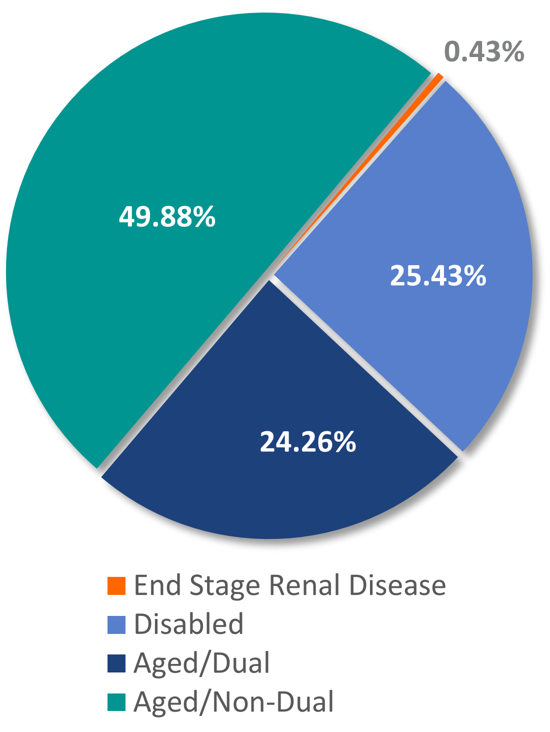
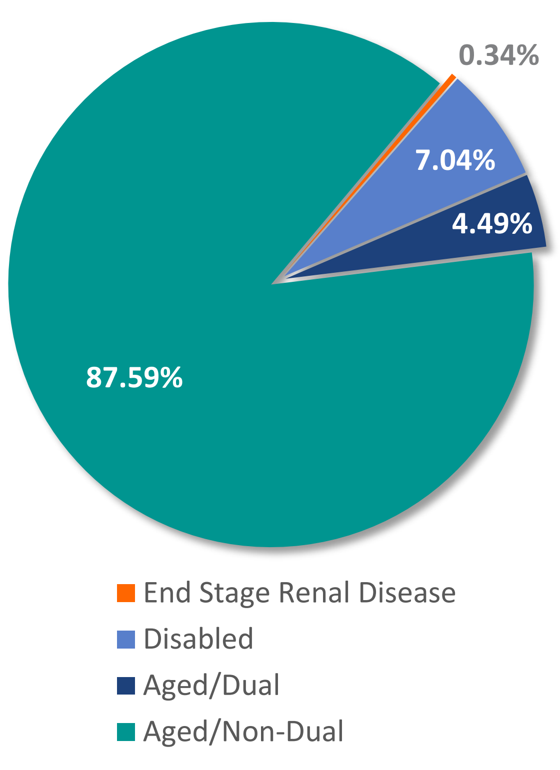
CHPA MSSP Lives

Currently Track E

	CHPA	MSSP
End Stage Renal Disease	53	44
Disabled	3,143	905
Aged/Dual	2,998	577
Aged/Non-Dual	6,164	11,259
Total lives	12,358	12,854





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CHPA Value-Based Care Initiatives

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Measure Alignment

MSSP eCQMs align with Utilization Data Set (UDS) and Colorado Medicaid

Focus on Full Population Performance

- Shared Savings goals/distributions align
- Practice Transformation and supports
- Data reporting monthly

Practice Transformation/ Quality Improvement

- **Pilots**
  - AWV
  - Total Population Solution
  - Attribution Outreach Mailer
- **Care Managment Learning Lab**
  - June - December
- **Lunch & Learn Webinars**
  - 1/24, 2/28, 3/27, 5/22, 6/26, 8/28, 9/25, 10/23, 12/18
- **EHR User Groups**
  - NextGen 4th Thursday of odd months
  - eCW 4th Thursday of even months
- **EDU Work Group**
  - February 6
  - May 1
  - August 7
  - November 6
- **AWV Learning Lab**
  - March -November
  - Representative from disciplines doing AWV
  - Revision of AWV Tool kit
- **Quality Action Labs***
  - CBP [March, April, May]
  - A1c [June, July, August]
  - ED Utilization Metric [Sept, Oct, Nov]
  - Encourage participation of QI/Project Team
- **Operational Excellence Webinars***
  - April 4, 2024 8-9:30
  - July 11, 2024 8-9:30
  - November 7, 2024 8-9:30
- **Quarterly Performance Review Meetings***
  - Q1 2024 (reviewing Q4 data): 2/26/24-3/29/24
  - Q2 2024 (reviewing Q1 data): 6/3/24-7/12/24
  - Q3 2024 (reviewing Q2 data): 8/26/24-9/4/24
  - Q4 2024 (reviewing Q3 data): 12/2/24-1/10/24
- **One on One Practice Transformation Meetings***

**Attendance required*

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Quality Action & Learning Labs

Both focus on the full patient population.

Quality Action Labs	Learning Lab

• **Rapid cycle improvement**
• Six one-hour sessions every other week (3 months)
• Meeting structure:
  • Didactic exercise
  • Activity
  • Assignment
	• **Continuous improvement**
	• 6-9 monthly meetings
	• Meeting structure:
	  • Best practice sharing
	  • PDSA
	  • Results report-out

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Placeholder: Completed Expedition Plan

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Pharmacy Support

- Pharmacist to support Medication Adherence
- Education on impact of medication compliance on positive outcomes
- Support in 340B pharmacies and commercial contracting
- Education on medicaton changes and concerns (med shortages, new med prescribing protocols, etc.)
- Outreach to patients at-risk for non-compliance to include assistance with SDoH barriers

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Questions?

Leslie Southworth
Director of the MT Health Plus
Montana Primary Care Association

Official in 2018 as a 501(c)3 as an IPA

Purpose: Improving population health, providing a formal statewide system of care, increasing optimal clinical outcomes and decreasing overall healthcare costs for people in Montana regardless of income or coverage status, by providing integrated, high-quality, patient-centered care in a network of community-based health centers to the citizens of the State of Montana and private and public payers.

MONTANA COMMUNITY HEALTH CENTERS

MONTANA COMMUNITY HEALTH CENTERS
SATELLITE CLINICS
SEASONAL/MIGRANT CLINICS
URBAN INDIAN HEALTH CENTERS

HAVRE
KALISPELL
GREAT FALLS
MISSOULA
HELENA
BUTTE
BOZEMAN
BILLINGS

Partnership with Medicaid

2010: MT Health Improvement Program

2017: PCMH/CPC+

2023: Developing New Primary Care Model

32,046 Medicaid Patients

Ensuring Access. Lowering Costs. Improving Outcomes.

Network Strategy

Strengthen & Leverage Medicaid Relationship

- ✓Move to Total Cost Data
- ✓CHC's "shining beacon" of high quality integrated primary care
- ✓Data Strategy

Commercial

MT Health Plus

Medicaid

2018

2020

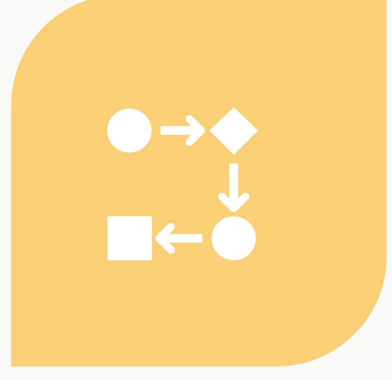
2021

Azara DRVS

Payer Integration

Lessons Learned

RELATIONSHIPS



REPEATING

REALLY GOOD DATA

Questions?

iowa health+
SM
Michaela Holmes, RN MSN MHA
Clinical Informatics Consultant
Iowa Health Plus

What is IowaHealth+?

- IowaHealth+ is a clinically integrated network of primary care providers owned and managed by 11 Iowa health centers and the Iowa Primary Care Association.
- The organization is a voluntary business venture dedicated to providing payor agnostic and value-based care while furthering the unique mission of community health centers.

204,000+
Patients served in 2020

72,000+
Attributed Medicaid lives in 2022

6,700+
Attributed Medicare Fee-For-Service (FFS) in 2022

The Value of IowaHealth+

We are building and better leveraging capacity and economies of scale, sharing investment, and risk.

Our statewide primary care-focused system of care leverages our integrated model and reinvests in it.

We provide a one-stop shop for patients, payors, and partners.

We are empowering and sustaining practice transformation and value-based payment reform.

Network Model of Care

IowaHealth+ Model of Care

Integration of Care	Ensure patients' timely access to care	Manage patient care transitions	Improve high risk care coordination	Provide high quality care	Social Determinants of Health

Supported by Health Information Data and Analytics
Maximizing the benefits of healthcare applications, VBC Analytics, & Enli Population Health

Supported by Patient Engagement Strategies
Motivational interviewing, teach-back, & health coaching

Health Center Staff's Role in IowaHealth+

Teams of dedicated health center staff...

+

provide high quality care and patient experience...

+

to Medicaid and Medicare patients.

=

The Value of IowaHealth+

Earn your health center money for meeting quality targets to enhance services & resources you provide to patients.

Value Based Care Agreements

- **Wellpoint Shared Savings Agreement (Medicaid)**
  - Annual agreement since 2019
  - Includes data sharing agreements
- **Iowa Total Care Pay for Performance (Medicaid)**
  - Annual agreement since 2019
  - Includes data sharing agreements
- **Molina Health Care of Iowa Pay for Performance (Medicaid)**
  - Started partnership in 07/01/2023
- **Medicare Shared Savings Program**
  - Annual agreement since 2022
  - Includes data sharing ingestion

We are Owning our Data Future

The more IH+ health center analytic teams and population health team members understand how to use and navigate Arcadia, the higher the likelihood of meeting the goals within their value-based care contracts, grants, and UDS goals.

Arcadia ensures health centers and IH+ can access timely, comprehensive, actionable data to make population health and value-based care business decisions and consider research opportunities.

Data Sources for Arcadia

EMR Data

UDS Data

Claims Data
- Medicaid
- Medicare FFS

ADT Data

Telehealth Data

SDOH Data

ENLI Usage Data

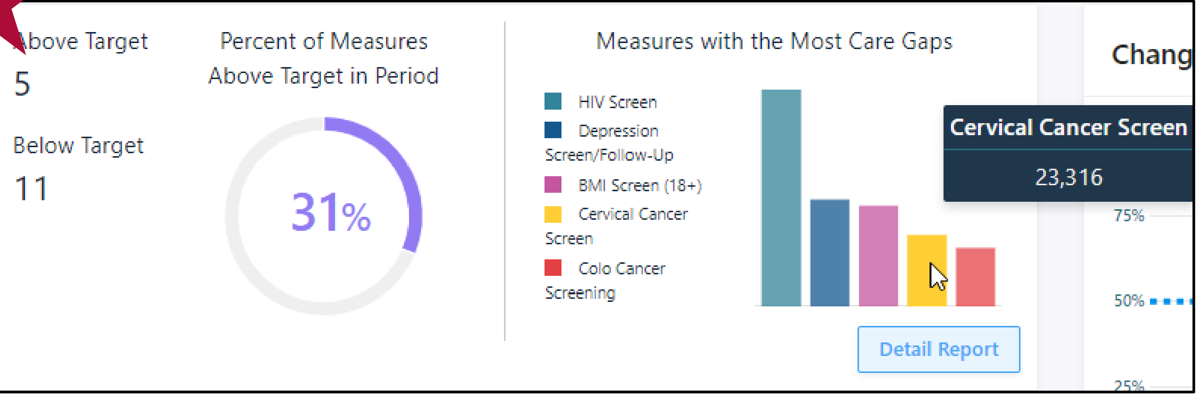
Organization-Wide Dashboards

Arcadia aggregates multiple forms of data and provides point-and-click and slice-and-dice reporting and dashboards for network and health center team members.

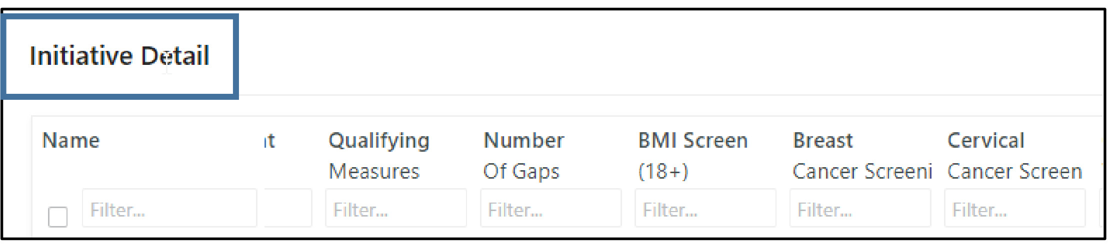
Performance	Utilization	Patients	Risk	Operations
Community Health Priorities 2020	Medical Expense Management	Pre Visit Planning	Network Summary	Attribution Mismatch Detail
HEDIS 2020	ED High Utilization Report	COVID-19 Vaccination Registry	Patient Browser	Charge Capture
IowaHealth+ 2021	Discharge Follow Up Report	High Cost	Risk Gaps	Medication Management
Medicare ACO QM 2021	Utilization Detail	High Risk		Medications and Prescriptions
UDS 2019		Non-Engaging (18 Months)		Member Roster
UDS 2020		Past Visit		Order Management
UDS 2021		Patient Registry		Pharmacy Fills Report
		Significant Event		Visit History
		Thirteen Year Old Immunization Registry		
		Two Year Old Immunization Registry		
		Upcoming Visit		

Performance Module

1. **Scrolling Banner**: The Quality Performance dashboard features a scrolling banner which appears at the top of the page and presents summary information about organizational performance on the measures within the selected initiative.

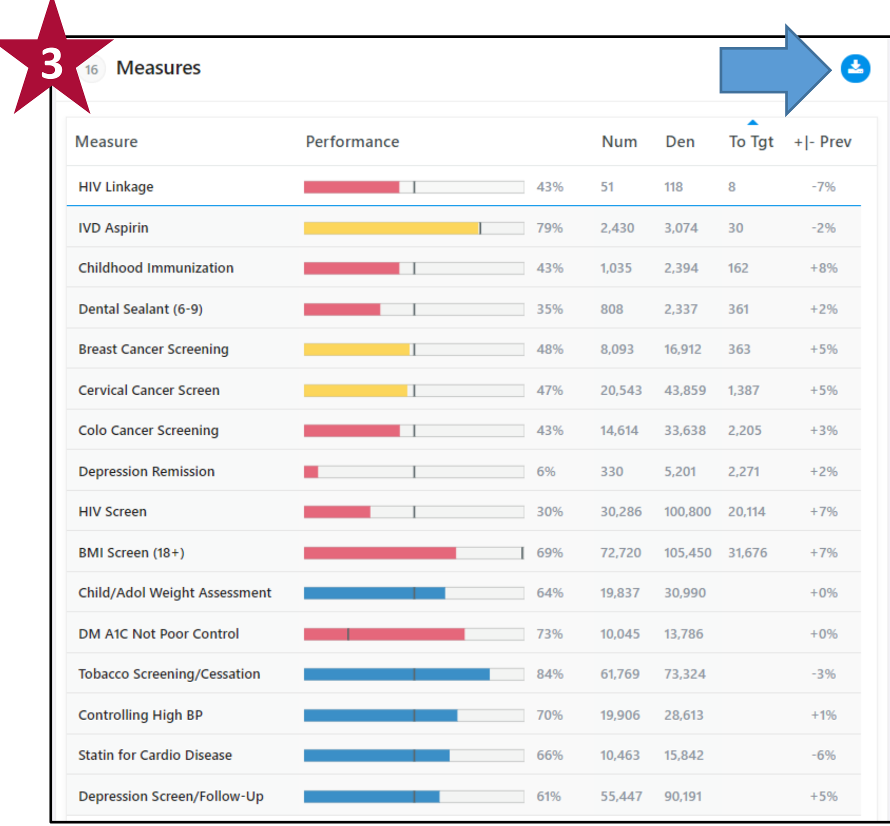


2. **Measure Summary:** To help organizations track and summarize quality performance, Arcadia rolls up an organizations' performance to a measure summary card.



Performance Module

3. **Measure Grid:** The measure grid lists all the measures configured for this quality measure grouping or scorecard along with their performance for the selected global filters.



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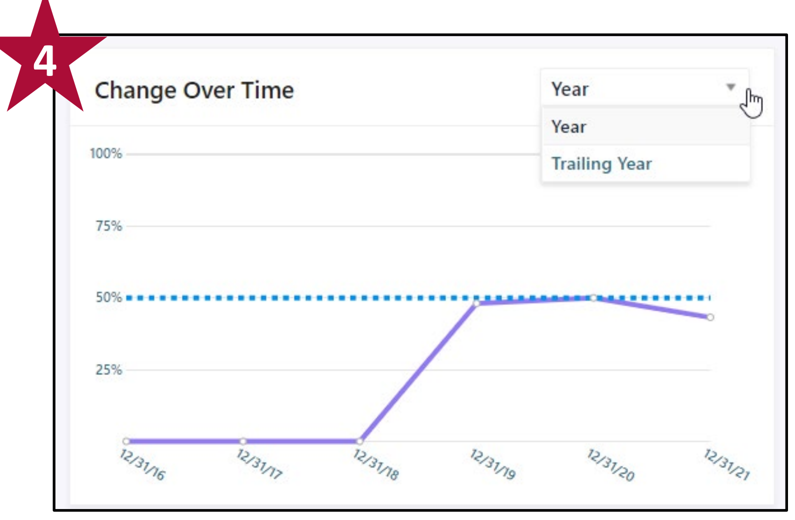
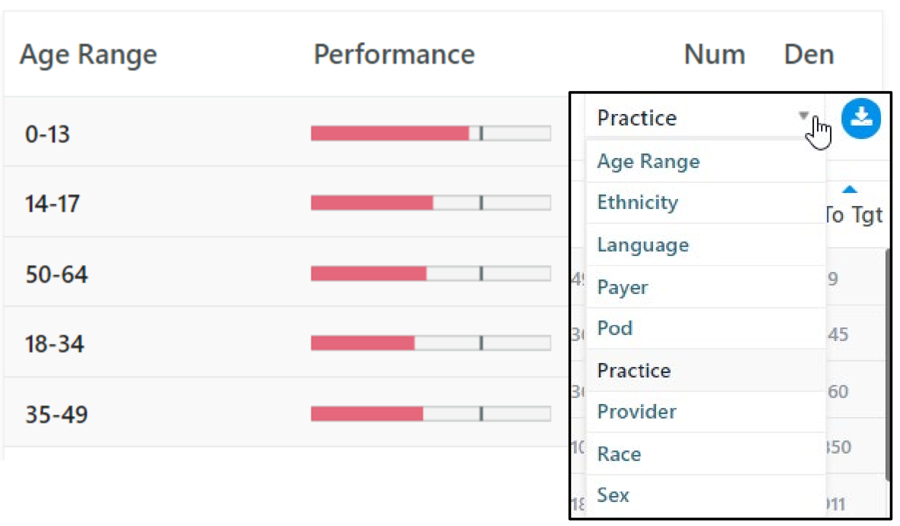
16 Measures

Measure	Performance	Num	Den	To Tgt	+|- Prev
HIV Linkage	43%	51	118	8	-7%
IVD Aspirin	79%	2,430	3,074	30	-2%
Childhood Immunization	43%	1,035	2,394	162	+8%
Dental Sealant (6-9)	35%	808	2,337	361	+2%
Breast Cancer Screening	48%	8,093	16,912	363	+5%
Cervical Cancer Screen	47%	20,543	43,859	1,387	+5%
Colo Cancer Screening	43%	14,614	33,638	2,205	+3%
Depression Remission	6%	330	5,201	2,271	+2%
HIV Screen	30%	30,286	100,800	20,114	+7%
BMI Screen (18+)	69%	72,720	105,450	31,676	+7%
Child/Adol Weight Assessment	64%	19,837	30,990		+0%
DM A1C Not Poor Control	73%	10,045	13,786		+0%
Tobacco Screening/Cessation	84%	61,769	73,324		-3%
Controlling High BP	70%	19,906	28,613		+1%
Statin for Cardio Disease	66%	10,463	15,842		-6%
Depression Screen/Follow-Up	61%	55,447	90,191		+5%

4. **Timeline View:** Shows the percentage performance of the selected measure over time based on the selected period.

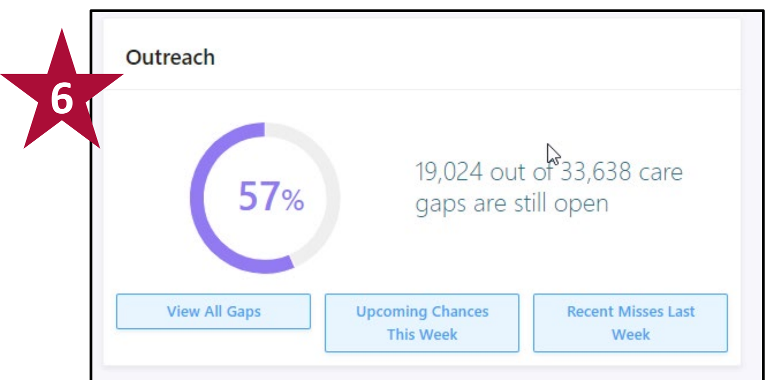


Performance Module



5. **Comparison View:** Allows the user to see performance of the selected measure broken down by several groupings.

6. **Outreach:** Directs users to reports that include lists of patients who are compliant and/ or non-compliant in a measure. Default is to show all the patients who are non-compliant in a measure using inline filters. The user can adjust the inline filter to show both compliant and non-compliant patients.



Population Health Realignment:

By focusing our network Provider and Care Team population health strategy to revolve around the health center workflows, the interventions will not only impact the value-based care patient population, but also the uninsured patient population.

Population Health Education Realignment

- The IowaHealth+ admin team developed a network strategy that identifies the greatest opportunity for success and aligns resources to provide education/support for health centers to achieve their aims.
- Focused work around three to five quality goals that will achieve results regardless of payer.
  - Diabetes
  - Hypertension
  - Immunizations
  - Prevention/Screening
- Realign work to support health center staff in achieving quality targets.
  - Fewer required group meetings in favor of more personalized consultation
  - Reimagining monthly dashboards to provide more insights for action
  - Fully utilizing the Arcadia tool, through education and personalized reports, to help drive change

2024 IowaHealth+ VBC Strategic Goals		2023 Projected Results	Goal 1	Goal 2	Goal 3	Payer
Hypertension	Controlling High Blood Pressure					
Diabetes	HbA1c for Patients With Diabetes – Control (<8)					
	Statin Therapy for Patients With Diabetes – Adherence					
	Kidney Health Evaluation for Patients With Diabetes					
Immunizations	Immunizations for Adolescents - Combo 2					
	Childhood Immunization - Combo 10					
Prevention/Screening	Colorectal Cancer Screening					
	Well Child Care – BMI%					

Questions?

Christian Gomes

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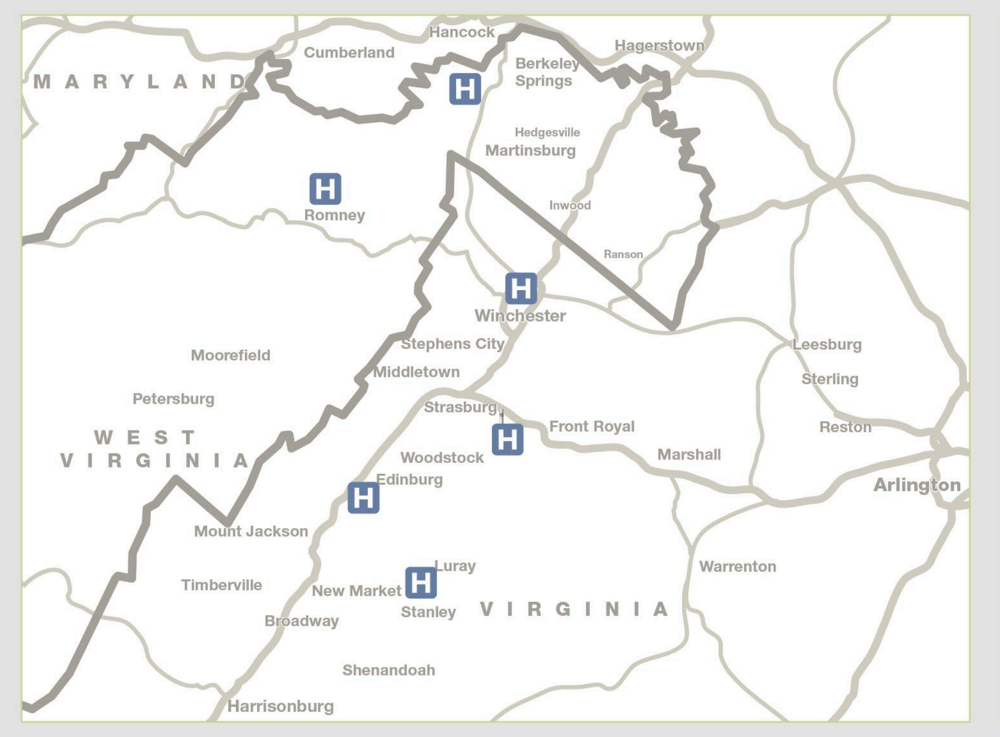
Valley Health at a Glance



6 HOSPITALS

- **Hampshire Memorial Hospital**
  Romney, WV
- **Page Memorial Hospital**
  Luray, VA
- **Shenandoah Memorial Hospital**
  Woodstock, VA
- **War Memorial Hospital**
  Berkeley Springs, WV
- **Warren Memorial Hospital**
  Front Royal, VA
- **Winchester Medical Center**
  Winchester, VA

74 PHYSICIAN PRACTICES

9 URGENT CARE & URGENT CARE EXPRESS CENTERS

10 OUTPATIENT REHABILITATION CENTERS

1 INPATIENT REHABILIATION CENTER

5 WELLNESS & FITNESS LOCATIONS

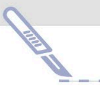
2 LONG-TERM CARE FACILITIES

6,000+
Employees
Largest Private Regional Employer

850+
Credentialed Physicians and Advanced Practice Providers

140,000
Emergency Department Visits

170,000
Urgent Care Center Visits



17,000
Surgical Cases

2,500
Births

29,000
Hospital Admissions

644
Inpatient Beds

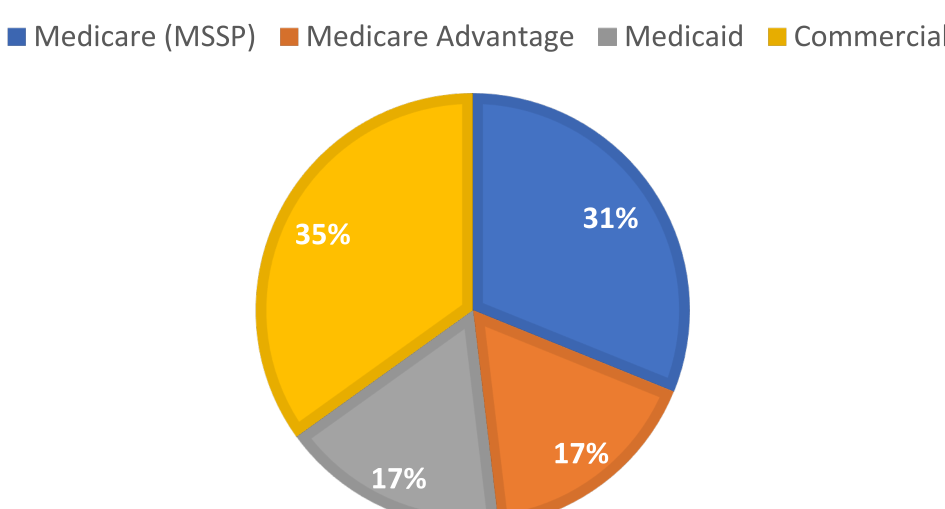
7,500
Home Health Admissions

Value-Based Care Overview

VBC Agreements

- MSSP BASIC Track Level E
- 6 Medicare Advantage plans
- 3 Commercial payers
- Valley Health Employee Health Plan
- 7 Medicaid MCOs

53,000+ VBC Lives



Primary Care-Embedded RN Care Coordinators

- Priority = MSSP
  - 2-3 Annual Wellness Visits/day (+SDOH assessment!)
  - 3 Chronic Care Management calls/day → Aged/Duals high-priority!
- Covers annual resource expense
- Leaves at least ½ day for work with high-needs patients, including those with Medicaid or uninsured

Two More Things Impacting Medicaid Lives…

eCQMs for Provider Quality $

- All eligible patients are targeted for intervention/screening, not just those in a specific VBC program
- Supports MSSP Quality reporting requirement

Risk Coding

- Medicare risk adjustment (HCC) tactics trickle down to Medicaid risk adjustment (CDPS)
- Supports shared savings models with more accurate pool/budget

Uninsured Clinical Integration Program

- Partnership with free clinics in community
- Calculate total cost of care at Valley Health for uninsured individuals under the care of each of those clinics
- Establish shared savings pool/target
- Share savings if successful (if not, no harm to Valley Health or free clinics)

Questions?

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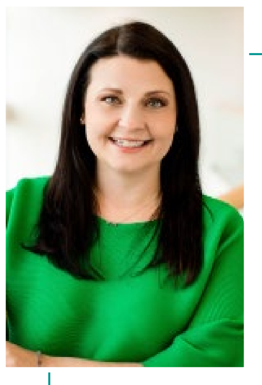

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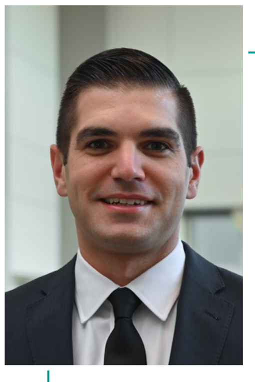

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