Working to Deliver Better Health Outcomes and Healthier Lives: Lessons Learned from a Clinically Integrated Network

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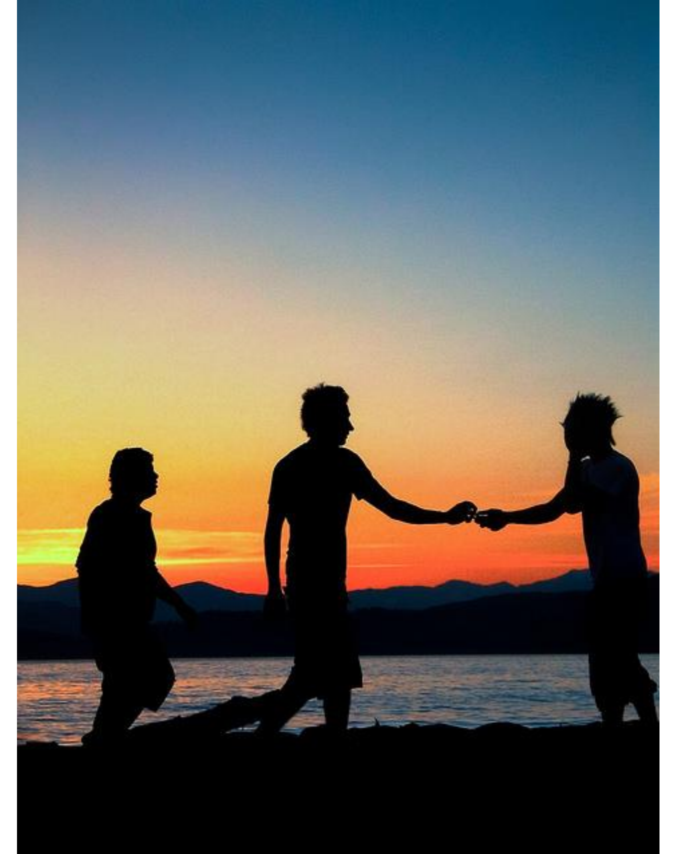
Background- Demographics

- 80% of the size of Los Angeles (per square mile)
- Substantial rural areas, especially in east county
- Substantial Native American populations/reservations
- Geographic boundaries of:
    - Mexico (south)
    - Pacific Ocean (west)
    - Camp Pendleton and Riverside County (north)
- Total Medi-Cal beneficiaries- 740,000
- 90% in managed care- 665,800



Background – Health Plans

7 Medi-Cal Managed Care Plans – Geographic Managed Care (GMC) model. All have a direct contract with the state.

- Community Health Group (local) - 265,000
- Molina Healthcare - 205,000
- Care1st (purchased by Blue Shield) – 71,700
- Health Net (purchased by Centene) – 71,700
- Kaiser Permanente – 50,000
- United Healthcare – new start
- Aetna – new start

Background – Health Center Contracting

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<u>Messenger Model since late 1990's</u>

- Contract negotiation support
- Grants to improve clinical and operational performance
- Performance benchmarking
- Regular meetings for CMO's, COO's, CFO's, Billing and Compliance staff
- Trainings/technical assistance on broad range of topics

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Background – Health Center Performance

- 42% of the Medi-Cal managed care market
- Predominant providers for Seniors and Persons with Disabilities & Medi-Cal Expansion Populations
- PCP+ capitation strategy
- County-wide coverage, including rural east county

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Why Build a Clinically Integrated Network?

- Increased health plan instability, competition over our patients brings opportunities and risks
- Health plans are looking for market-differentiating strategic partnerships capable of delivering value
- Fixed payment system is ending soon – pressure is “on” to evolve
- Commercial IPAs have not been historically successful with higher-acuity Medi-Cal populations
- Medical management of large patient pools enable greater predictability of business performance and greater certainty in assessing population health metrics
- Service and performance based revenue will sustain this replicable model

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Clinical Integration: Essential Features

Clinical Performance

- Practice standards, protocols
- Clinical quality measures

Network Management

- Credentialing
- IT participation & data access standards
- Management of complaints/grievances

Peer Review and Counseling

- QI Reviews, process for education, training, monitoring performance

Terms and Conditions for Continued Membership

- Criteria for notification, remediation and termination

Shared Risk

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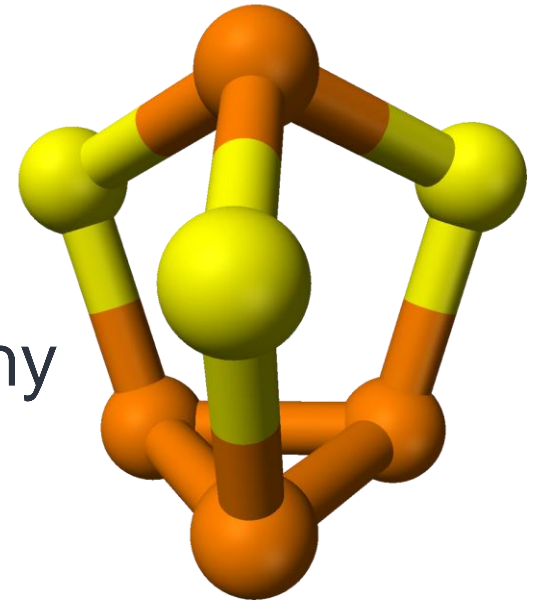
The New Model

- Single Contract for 11 health centers, 70+ sites
- Primary care + model, all products
- Building full professional risk network for possible later deployment
- All encounters and claims funneled through MSO (MedPOINT Management).
- Health Centers will decide how to distribute P4P and any surplus revenue within IHP.



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Lessons Learned – Formative Stages

- Data
- Governance and Operating Rules
- Financial Impact
- Communication

Data Sources

EMR Data

Lab

Encounters / Claims

Pharmacy

Healthcare Data

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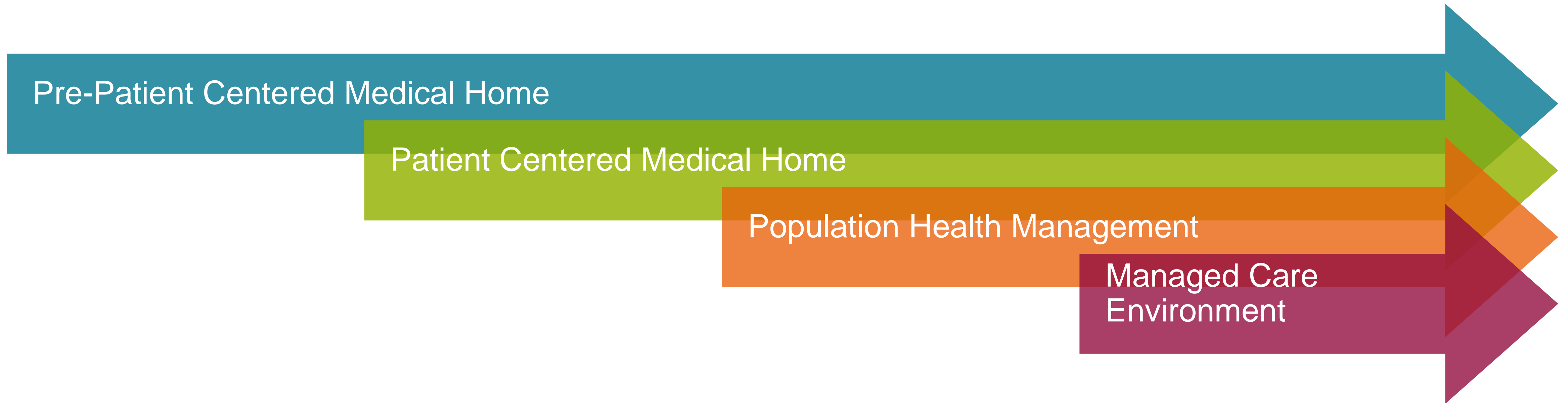
Centerprise – Assessing Readiness

- Consulting firm that works with FQHCs nationally
- Engaged services in December 2015
- Partnership with IHP to transform health centers to provide Population Health delivery through optimization of current Health IT and PCMH infrastructure
- Health centers assessments initiated in Q1 2016

Transformation to Value-Based Integration



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Centerprise Assessment Launch

Identify Key Staff

Organization Execution Assessment

- IT infrastructure, Data Analytics Team, alignment of data with organizational goals, staff practicing to maximum scope of licensure, meaningful data sharing with team

PCMH Assessment

- Leveraging EMR, Access evaluation, Care Coordination, data gathering of patient population, UM, Patient Satisfaction

Centerprise Assessment Launch

Data submission from the health centers included:

- Quality reports
  - QI dashboard, UDS measures, provider incentive data
- Claims data reports
  - HEDIS reports, Rx data
- Patient satisfaction survey and results
- Cost reports
  - BOD reports, Payer P4P reports

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Centerprise Assessment Factors

Health centers were rated on the following factors and assigned a 1-3 based on their readiness:

- Data / Analytics
- Quality Metrics
- Care Coordination
- Workforce
- Culture
- PCMH Recognition Level

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Centerprise Assessment Factors

Clinical quality metrics for year 1 include:

- Cervical cancer screening
- Colorectal cancer screening
- BMI – childhood obesity
- HbA1c > 9%
- BP control for patients with hypertension

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Health Center Data Submission Integrity

Large variation in the clinical quality data reports that were furnished to Centerprise

- HEDIS
- UDS
- PCMH application rates
- P4P performance from their respective plans

Difficult to utilize performance across health centers that wasn’t “apples-to-apples”

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Data Submission Lessons Learned

Health centers struggled with the ability to provide additional asks/reporting and were in the midst of UDS

In hindsight:

- IHP manage the data submission to Centerprise
- Identify one measure set, rather than have health centers provide multiple quality performance reports

Moving forward:

- Utilize 2015 UDS reporting for initial reporting rates

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Health Center Overall Performance

Performance results were initially tiered Level 1-3

- Level 1 being optimal for health center readiness
- One Level 4 was identified

Level Readiness	HC Count	Assessment Outcome	Intervention
Tier 1	3	CIN ready – limited transformation needed	Webinar participation Access to tools Collaborative learning
Tier 2	5	Moderate Remediation Required	1-2 site visits Monthly coaching call Bi-monthly assessment
Tier 3	3	At Risk – Intensive Remediation Required	Quarterly site visits Bi-monthly coaching call
Tier 4	1	Not ready for CIN participation	Suspension of IHP Membership

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Health Center Optimization Work

Centerprise next steps:

- Position all IHP Health Centers to meet current and future goals
- Train and develop staff to function in a population health environment
- Building Health Center processes and workflows which make an impact on the Triple Aim and can be measured through alignment of claims and clinical data

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MSO Engagement

MedPOINT Management Services Provided

- Reconcile Eligibility Reports
- Process PCP Capitation Payment
- Claims Processing and Payment
- Facilitate FTCA and Managed Care Credentialing
- Prepare Financial Statements
- Quality Management Consulting
- Report Preparation

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Encounter and Claims Data

- Working directly with health centers to establish encounter submission process
- Reconciliation of claims/encounters
- Validate and ensure complete data transfer at plan level
- Work health plan rejections

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Optimized Data Sources

Leveraging structured data fields and incorporating CPT & diagnosis codes on claims

QA and data reconciliation

EMR Optimization

Lab

Coding to the highest level of specificity

Encounters/Claims Integrity

(MedPOINT)

Pharmacy

Robust repository of actionable information

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Role of IHP Physician Leaders

Monthly Meetings:

- Review of network credentialing
- Identification of the clinical needs of patients
- Selection of desired data
  - Selection of unified “process” and “outcome” set of metrics
  - Standardize definition of numerators and denominators
- Collective and open review of clinical performance by CHC
- Identification and sharing of best practices
- Identify benchmarks and set goals
- Harmonize processes of care with best practices
  - Preventive care
  - Chronic disease

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Governance

- Board of Directors – not all health center CEOs represented. Clinical representation
- Operations, Finance, Clinical Committees advise Board.
- Health Centers transitioning from individual needs to group mentality-not always the same pace or results.
- Health Center C-Suite has differing levels of comfort with speed of change.
- Health Center C-Suites have different degrees of involvement in IHP decisions.

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Operating Rules

- Need to be vetted by the health centers to be truly adopted.
- Minimum entrance criteria established for the benefit of the others at risk.
- On-going commitment to IHP improvement goals essential in demonstrating value to payers.
- Health center performance data is shared un-blinded with other participating health centers.

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Financial Impact

- How is the start-up capitalized?
- Contract changes may have a short-term cash flow implications
- When is the right time to make adjustments with budgetary impact?
- How are financial rewards shared and when?

Communication

IHP is moving fast to establish contracts under the new structure and limit the burn rate on the health centers’ upfront investment.

Communication with all necessary clinic staff regarding decisions and timelines has been a challenge.

Thank you!

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