Medicaid Learning Lab

December 1, 2023
2:00 pm to 3:30 pm ET

Staff Facilitators

Melody Danko-Holsomback, Vice President of Education, NAACOS
Melody Danko-Holsomback, MSN, CRNP is the Vice President of Education for NAACOS. She has over 12 years of population health experience and was the CAO and Director of Keystone ACO prior to her current role. She has over 30 years of experience in nursing, including positions in outpatient and inpatient care, as a CRNP healthcare provider and as an IT analysts and performance consultant.
mdholsomback@naacos.com

Emily Perron, Education Manager
Emily is the education coordinator at NAACOS where she works directly with the director of operations on tasks related to the day-to-day running of the organization and with the vice president of education on the boot camp and the two annual conferences along with overseeing marketing and registration. Before starting at NAACOS, she previously worked at Police and Firemen's Insurance Association (PFIA) in new business where she handled all incoming new life and disability insurance plans. While at PFIA, she obtained two Life Office Management Association (LOMA) certificates. She received her bachelors of science in elementary education from Liberty University.
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Welcome!

AGENDA

Medicaid Accountable Care Contracting Learning Lab Virtual Series

December 1, 2023
2:00 pm – 3:30 pm

Location: Zoom Meeting **Sent to participants**

		Speakers
2:00 pm – 2:15 pm	Learning Lab Opening Introduction	Melody Danko-Holsomback, NAACOS
2:15 pm – 3:10 pm	Medicaid Value-Based Care: Can We Replicate the Medicare Experience?	Art Jones, MD, Principal, Health Management Associates, and Chief Clinical Officer for Medical Home Network (MHN) and MHN ACO
3:10 pm – 3:25 pm	Q and A	Attendee participation
3:25 pm - 3:30 pm	Adjourn	Melody Danko-Holsomback

Housekeeping Items

- The learning lab is meant to be a classroom type of setting
- We request that participants be on camera whenever possible. This helps keep you engaged in the meeting material and place faces with names of participants.
- Questions are not only welcomed, but they are also imperative to enhance everyone's learning experience.
- We may call on you at any time for your opinion on the current topic of discussion
- Please mute your microphone when not speaking and unmute when speaking.

Learning Lab Documents

- Agenda
- Learning Lab Educational Plan
- Learning Lab Note Template
- Monthly Presentations – will be distributed after each meeting
- Meeting recordings and documents found on Learning Lab webpage on the NAACOS website

Presenter

Art Jones, M.D., Principal

Art Jones, M.D. has 27 years of experience as a primary care physician and CEO at a Chicago area community health center. The health center has taken a population health approach from its beginning, addressing the social drivers of health as well as the medical needs of the community it serves. The health center was an early adopter of advanced alternative payment models dating back to 1987. Dr. Jones was an architect for the first capitated Federally Qualified Health Center (FQHC) alternative payment methodology in the country in 2001. Dr. Jones was one of the founders and continues to serve as the Chief Clinical Officer for Medical Home Network (MHN) and MHN ACO comprised of thirteen FQHCs and three health systems serving 180,000 Chicago area Medicaid recipients. MHN is completely delegated for care management and successfully operates under a global risk arrangement on total cost of care. MHN supports about 50 FQHCs in ACO REACH and will support another 18 in MSSP in 2024. Dr. Jones is also a principal at Health Management Associates where he focuses on helping FQHCs and their clinically integrated networks succeed in advanced alternative payment models. Dr. Jones is a graduate of the University of Illinois Medical School and completed internal medicine residency, chief residency, and a cardiology fellowship at the University of Chicago.

MEDICAL HOME NETWORK

Medicaid Value-Based Care: Can We Replicate the Medicare Experience?

December 1, 2023

Agenda

December 1, 2023

- Status of Medicaid value-based care
- Medical Home Network background, approach and ACO results serving the Medicaid population
- Transitioning from fee-for-service to population prospective payments
- Addressing health-related social risk factors
- Partnership with payers.

Introductions

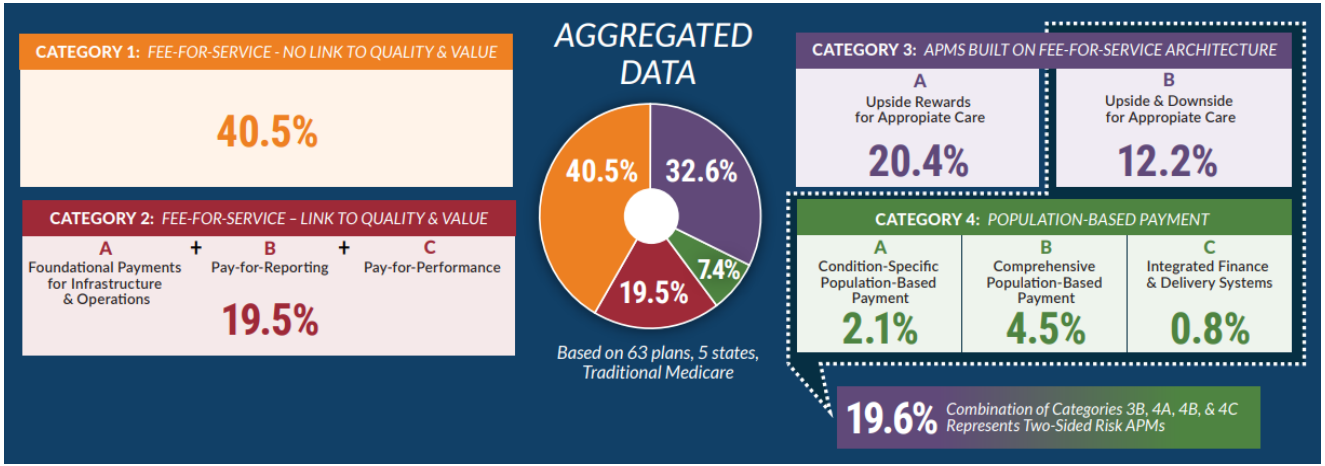
Dr. Art Jones

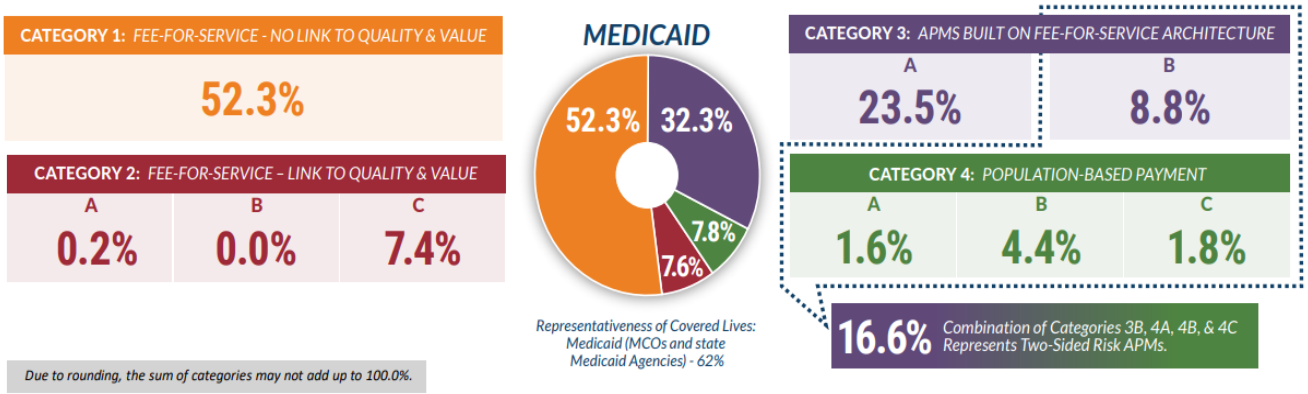
Chief Clinical Officer, Medical Home Network

Dr. Jones has more than 27 years of experience as a primary care provider and CEO of an FQHC that has contracted for advanced alternative payment models since 1984. He helps build clinically and financially integrated provider organizations, supports providers in their transition to value-based care and creates patient-centered medical homes and integrated delivery systems. Dr. Jones is both Chief Clinical Office of MHN and a Principal at Health Management Associates.

ajones@healthmanagement.com

Medicaid Lags Adoption of Value-Based Care





- Over half of all payments, across lines of business are associated with providers in a pay-for-performance or more advanced valued-based models, as of HCP LAN's 2021 industry survey.
- The Medicaid line of business lags the overall trends still having a higher level of payments tied to providers in FFS arrangements.
- However, in the past four years, the Medicaid line of business has been increasing its presence of LAN category 3 and 4 value-based models.

Source: https://hcp-lan.org/apm-measurement-effort/2022-apm/

Medicare Shared Savings Trends

Medicare Shared Savings Program (MSSP) Trends and Insights

- Increasing participation and lives covered under the ACO model
- Improved performance
  - Increasing % of ACOs achieving savings relative to benchmark
  - Increasing % of ACOs earning shared savings
- Physician group-led ACOs were more likely than hospital-led or jointly led ACOs to realize savings relative to their benchmark and to receive bonus payments
- **Shared savings per capita and the percentage of ACOs achieving shared savings were higher among ACOs that had a high number of FQHCs in the network**

Historical MSSP Results

Performance Year	Number ACOs Participating	Percent in Upside-Only Risk	Percent Achieving Savings Relative to Benchmark	Percent Receiving Shared Savings Bonus	Net Program Savings Per Capita
2012 - 2013	220	98%	54%	24%	-$21
2014	333	99%	54%	26%	-$9
2015	392	99%	52%	30%	-$30
2016	432	95%	56%	31%	-$5
2017	561	92%	60%	34%	$35
2018	548	83%	66%	37%	$73
2019		67%			
Legacy MSSP Tracks)	475	82%	50%	50%	$88
Pathways Tracks)	205	53%	57%	57%	$85
2020	513	63%	83%	67%	$190
2021	475	59%	81%	58%	$190

2021 MSSP Results by # of FQHCs in Network

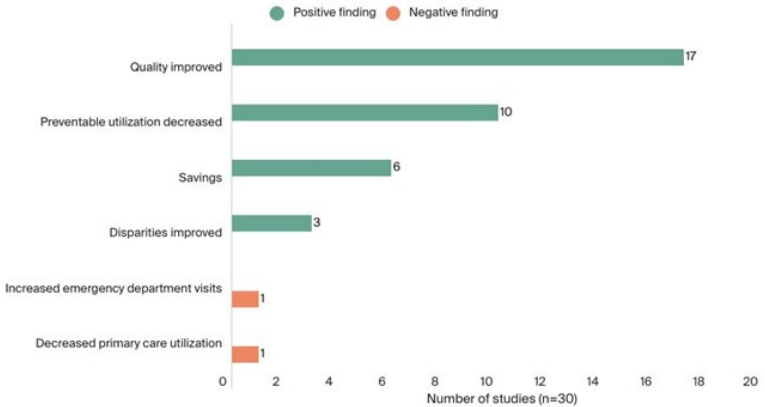
FQHCs in ACO Network	Average of Net Savings Per Capita	Percentage of ACOs Achieving Shared Savings	Count of ACO
<1	$183.32	58%	363
1-5	$134.80	41%	32
6-10	$166.35	41%	17
11-16	$201.18	61%	23
>16	$302.34	75%	40

Source: Health Affairs – Performance Results Medicare Shared Savings Program 2021

Medicaid ACO Shared Savings Trends

EXHIBIT 1

Findings on the Impacts of Medicaid ACOs



Download data

Notes: Studies with significant findings across multiple measure types are counted more than once. Only findings that were deemed by the study authors to be statistically significant (typically at the 95% confidence level) were included.

Data: Authors' tabulations based on review of published literature.

Source: Meredith B. Rosenthal et al., *Realizing the Potential of Accountable Care in Medicaid* (Commonwealth Fund, Apr. 2023). https://doi.org/10.26099/jx0w-4q30

Challenges:

1. Lower disease burden
2. Lower premium
3. Assigned but never seen membership
4. Risk adjusting for health-related social factors
5. Regulatory complexity
6. Competing state priorities
7. Resistance from Medicaid managed care plans
8. Risk aversion by safety net providers

Proven, Replicable & Scalable Approach to Care Transformation

Medical Home Network creates community-based systems of care that succeed under value-based care

2009
Founded by Comer Family Foundation to serve Medicaid and Chicago's most vulnerable

2012-13
IL Medicaid pilot of delegated care management to providers using MHNConnect care management platform

2014-present
MHN ACO: Established first provider-owned **Medicaid ACO** in Illinois, one of the highest performing in the U.S. First NCQA delegated Medicaid ACO for Care Management.

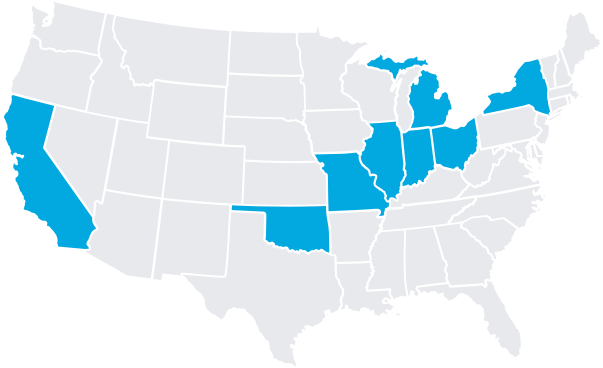
2019
Expanded geographically to scale & replicate our proven model

2022
Approval of Medical Home Network REACH ACO

2023
Today

MHN is in eight states impacting over 300,000 Medicare, Medicaid and uninsured lives.

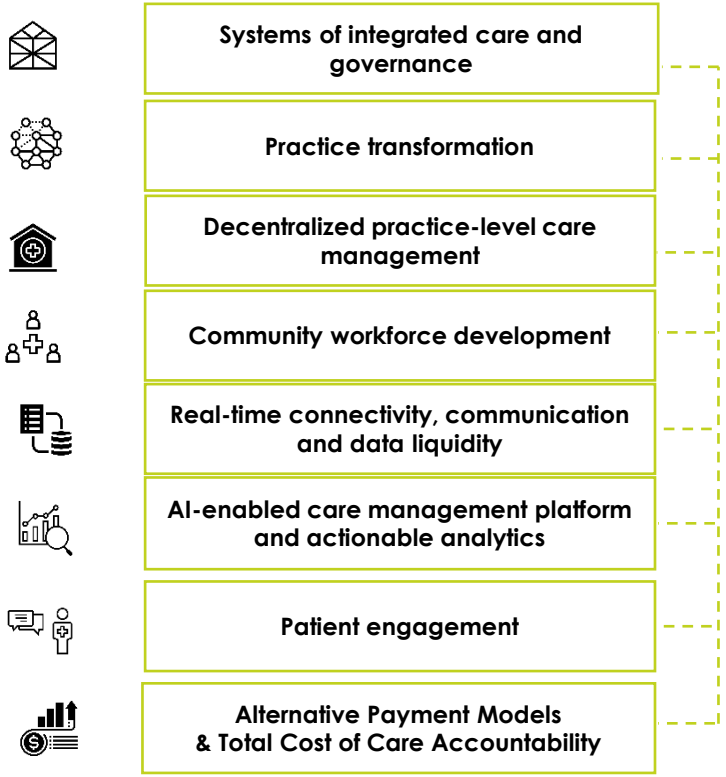
Impacting
300,000+
lives



MHN: Supports MHN ACO, a provider-owned organization comprised of 13 FQHCs and 3 Health Systems

- Founded in 2014 to offer MHN participants an opportunity to contract in a multi-payer value-based arrangements.
- **Wholly provider owned (13 FQHCs, 3 health systems);** Egalitarian governance on Board of Managers
- Evolving partnership with CountyCare (top-performing health plan in Illinois) into full-risk arrangement
- **"Premier example of multi-stakeholder, Medicaid clinically integrated delivery system in the country" – CountyCare Chief Administrative Officer**

A Scalable and Replicable Approach to Transforming the Safety Net



MHN's Building Blocks for Driving Care Transformation

MHN ACO Care Model: Outperforms MCOs on Key Medicaid Quality Metrics

ACO was a key driver of Illinois HFS designating 50% of auto-assigned members to CountyCare

	MEASURE	MCOS	MHN-Supported ACO	ACO DIFFERENTIATORS
WOMEN'S HEALTH	Breast Cancer Screening	★★★	★★★★	➢ Screenings: Lead all MCOs on Cervical Cancer, a top performer for Breast Cancer ➢ Care Management focus on preventative screening to address historically poor outcomes in our population
	Cervical Cancer Screening	★★★	★★★★★	
KEEPING KIDS HEALTHY	Doctor Visits for Kids Ages 3 to 6 Years	★★★	★★★★★	➢ Lead MCOs in each metric ➢ Performance greatly contributes to Medicaid plan's success on this key domain ➢ Child health is a core component of ACO model: driving population health outcomes, engaging whole families in care, and combating systemic inequities in care
	Kids Received Immunization Combo 3	★	★★★★★	
	BMI Percentile for Kids, Teenagers	★★	★★★★★	
ACCESS TO CARE	Outpatient or Preventative Care Visit	★★	★★★★	➢ Primary-care focused model has increased outreach, better access ➢ Practice-level, integrated CM engages patients in their health
	Adult BMI	★★	★★★	

MHN ACO's Proven Results: Medicaid care model and outcomes under risk contracts

Risk-adjusted decreased utilization
(Medicaid)

51%
Inpatient Hospital Days
per 1,000

42%
Admissions
per 1,000

11%
Readmissions

4%
ER Visits

$105.3M reduction in Medicaid shared savings over 6 years

% decrease in Total Expenditures (Claims and Rx)

180,000 Medicaid lives

Increased patient engagement
(Medicaid)

84%
Total HRA Completion Rate

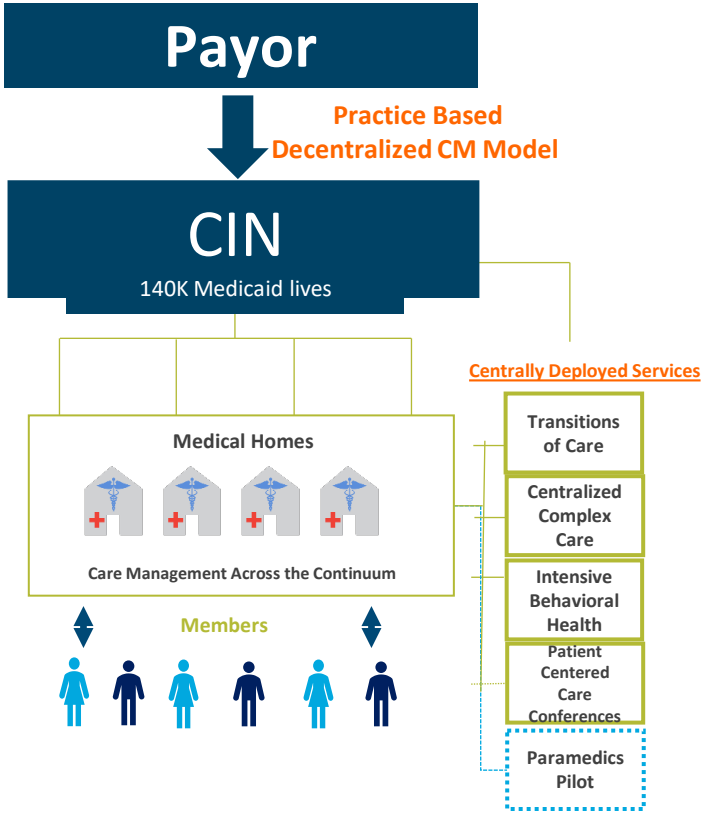
82%
Post-ER follow-up
within 7 days

80%
Post-hospitalization follow-up
within 7 days

37%
Increased PCP Visits

MHN ACO is NCQA Accredited for Case Management with a passing score of 99.6

Integrated Community Delegated Care Management & Practice Transformation



Benefits

Patients

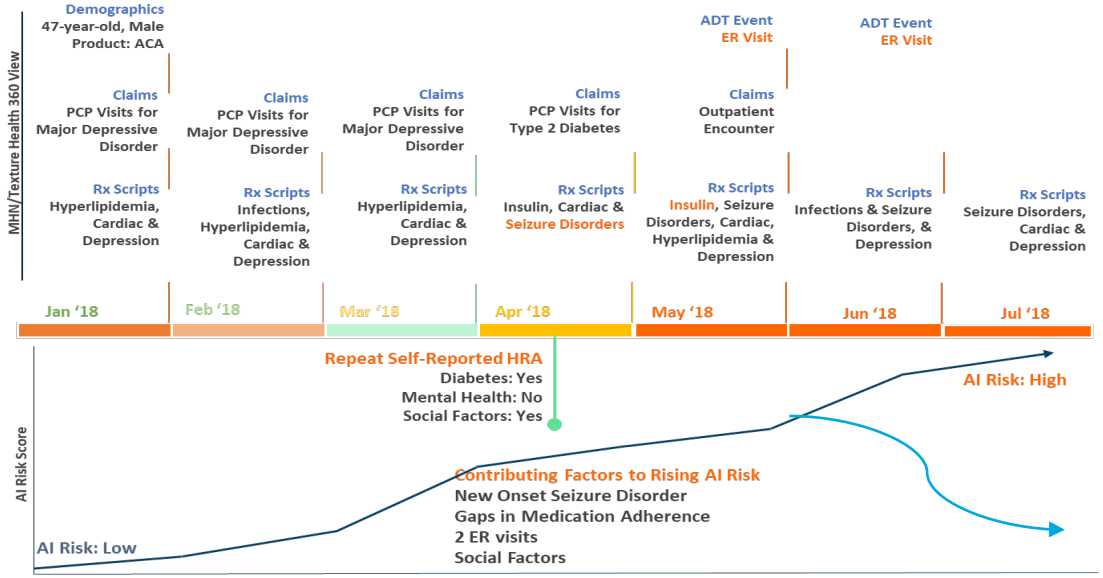
- ✓ Personalized, whole-person care
- ✓ Better navigation to access health care needs
- ✓ Engagement and trust

Providers

- ✓ Build trust with provider
- ✓ Allow care manager to be part of the medical home
- ✓ Facilitate free flow of timely information and warm handoffs

AI-enabled Dynamic Risk Stratification to Proactively Manage Utilization and Costs with Clinical Interventions

- MHN's model of whole-person care is based on **social, medical, and behavioral determinants** and powered by **dynamic, daily AI risk stratification**
- AI identifies trends in patient outcomes and utilization and **triggers clinical workflows** that respond to them



AI-identified rising risk clinical intervention prevented escalation to "High"

Proven Model: Risk Stratification

MHN uses AI-Powered risk stratification to proactively ensure the right patients are engaged in care management at the right time

Improving Risk Stratification Using AI and Social Determinants of Health

Objectives

To determine whether a risk prediction model using artificial intelligence (AI) to combine multiple data sources, including claims data, demographics, social determinants of health (SDOH) data, and admission, discharge, and transfer (ADT) alerts, more accurately identifies high-cost members than traditional models.

Study Design

The study used data from a Medicaid accountable care organization and included a population of 61,850 members continuously enrolled between May 2018 and April 2019.

Results

The AI model consistently identified a higher proportion of the highest-spending members. Members deemed highest risk by the AI model also had higher spending than members deemed highest risk by the CDPS model.

Conclusions

Identification of high-cost members can be improved by using AI to combine traditional sources of data (e.g., claims and demographic information) with nontraditional sources (e.g., SDOH, admission alerts).

Click here to read it online

Health-Related Social Risk Factors Help Identify the Rising Risk Population

Social Risk Factor Reduction of High & Medium Risk Adults

Social Risk Factor	Initial HRA	Latest HRA	% Change	Predictive of Future Cost and/or Utilization*
Total Social Factors	**11,124**	**6,963**	**-37.4%**	
Rates overall health as Fair or Poor	**2,019**	**1,578**	**-21.8%**	✓
Difficulty making appointments	685	396	-42.2%	✓
Difficulty getting to appointments or filling prescriptions	1,396	885	-36.6%	✓
Untreated Depression	1,172	511	-56.4%	
Untreated Drug/Alcohol Use	304	156	-48.7%	✓
Difficulty securing food, clothing, or housing	1,717	868	-49.4%	✓
Currently homeless or living in a shelter	126	68	-46.0%	✓
Difficulty paying for meds	1,000	270	-73.0%	✓
Does not feel physically or emotionally safe at home	213	143	-32.9%	
Refused Smoking Cessation program	607	226	-62.8%	

Results: Reduced social risk drivers that impact health by 37.4%

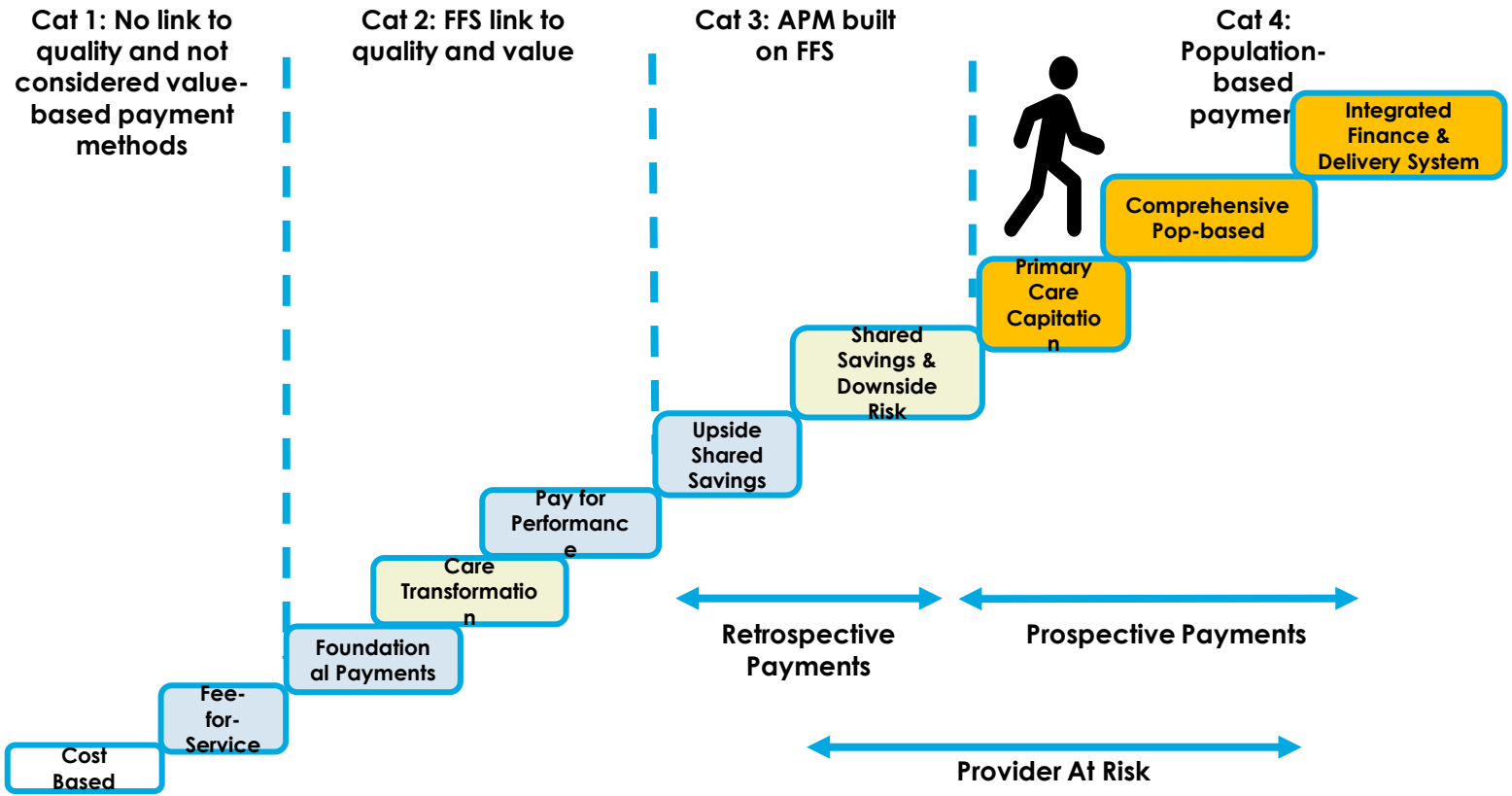
Member, Cost, and Utilization by Risk Level

HRA Risk Profile	Member Count	% Members Total	ER Visits / 1000	Inpatient Admits / 1000	Medical + Rx Cost PMPM	Relative Cost
Low	1,606	21%	415.3	56.66	$217.1	100%
Low-CHW	4,181	54%	620.2	96.39	$349.4	161%
Medium by Social Factors	**663**	**9%**	**742.1**	**143.29**	**$423.3**	**195%**
Medium by Utilization	320	4%	1,856.3	281.25	$479.9	221%
High by Social Factors	**127**	**2%**	**834.6**	**125.98**	**$404.7**	**186%**
High by Utilization	865	11%	1,653.2	679.77	$821.4	378%
Total	**7,762**	**100%**	**757.8**	**165.29**	**$387.2**	**178%**

** Note: This analysis includes ACA adults who were continuously enrolled for twelve months post Health Risk Assessment (7,762 observations) and their associated claims cost during that period.*

Capturing social-driven costs and utilization that would have been missed under a traditional approach

Moving From the Fee-for-Service Chassis



LAN Category 4: FQHC APM

PPS-derived revenue for primary care and BH services in the baseline year for Medicaid MCO members assigned at date of service

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# of Empaneled Medicaid MCO Member Months in Baseline Year

= **PER MEMBER PER MONTH APM RATE***

*rate is inflated to reflect change from baseline period and annually by MEI thereafter

Note: revenue for visits to Medicaid managed care members assigned to an external PCP at date of service are not included in calculating the PMPM rate and such visits will be reimbursed under FFS while the APM is in place.

Assumptions for Illustrative Purposes

Blended PCP visit rate	$160/visit
PCP productivity	3500 visits/yr.
PCP panel size	1000
% Medicaid	37%
Medicaid panel size	370
Total PCP visits	3.5—3.2—2.9

Demand for PCPs willing to serve Medicaid recipients allows panel expansion to fill resultant capacity at same payer mix

PPS FFS equivalent revenue	$207,200

($160/visit X 3.5 average annual visits X 370 Medicaid member panel size)

Financial Impact as "Billable" PCP Visits Decrease Under Practice Redesign

Per FTE PCP	Baseline Year	Year One	Year Two
PCP Visits PMPY	3.5	3.2	2.9
PCP Panel Size	1000	1094	1207
% Medicaid	37%	37%	37%
PCP Medicaid Panel Size	370	405	447
Medicaid Payment Equivalent PMPM	$46.67	$42.67 PPS $46.67 APM	$38.67 PPS $46.67 APM
PCP Panel Medicaid Revenue per FTE	$207,200	$207,200 PPS $226,625 APM	$207,200 PPS $250,069 APM
Increase PCP Panel Revenue per FTE		$0 current **$19.425** APM	$0 current **$42,869** APM

FFS or Capitation; Not a Little of Each

Medicare:

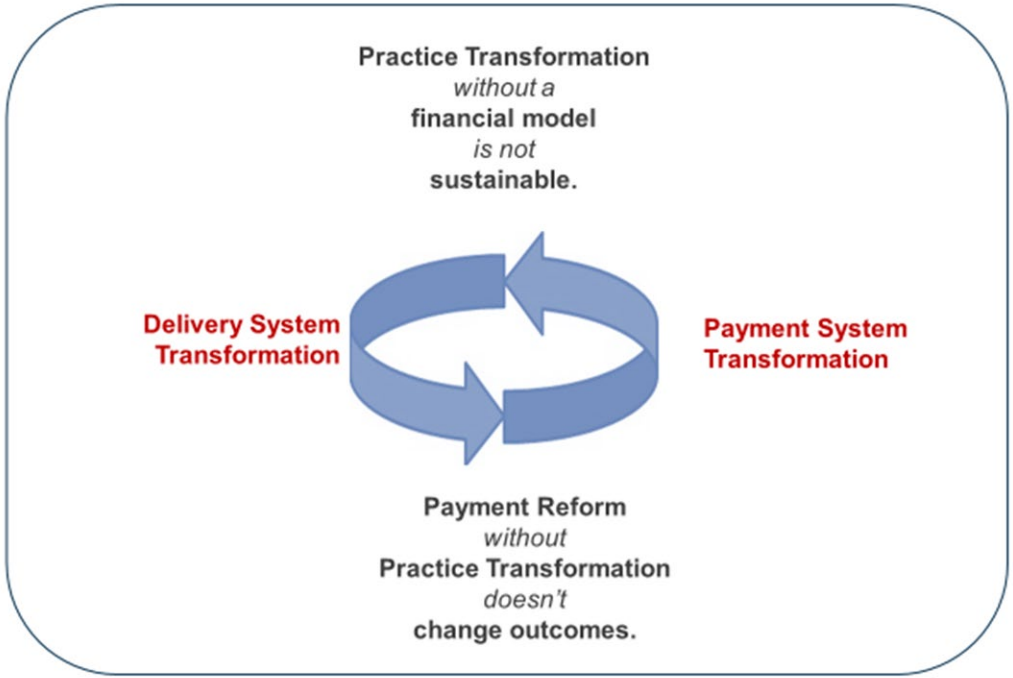
ACO REACH
Make Care Primary

Medicaid:

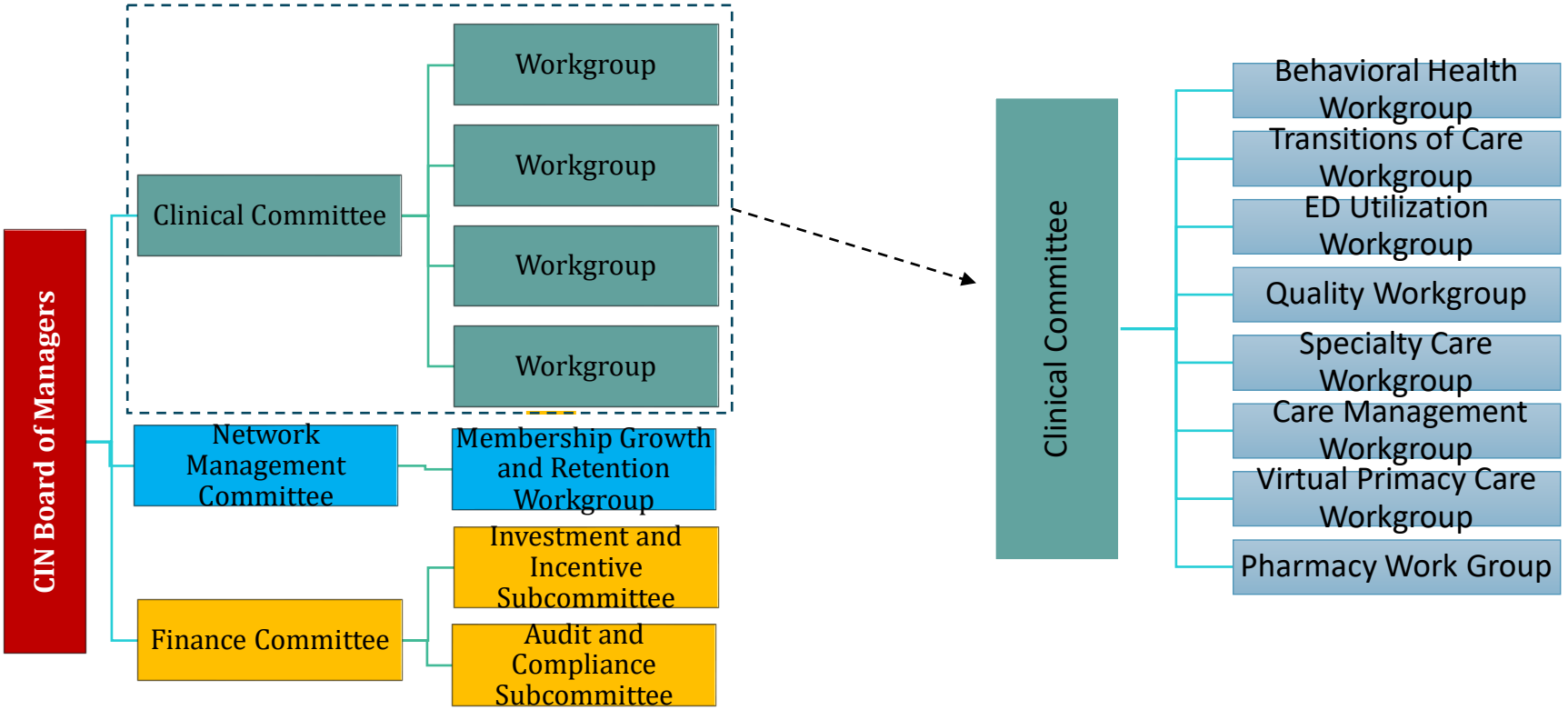
Chicago	2001
Oregon	2012
Washington	2017
Colorado	2023
Michigan	anticipated 2024
Illinois	anticipated 2024
California	anticipated 2024
New York	under negotiation
Arizona	under negotiation

Source: Arthur Sarnoff

Interdependence of Payment Reform and Practice Redesign



Provider Champions Redesign Care



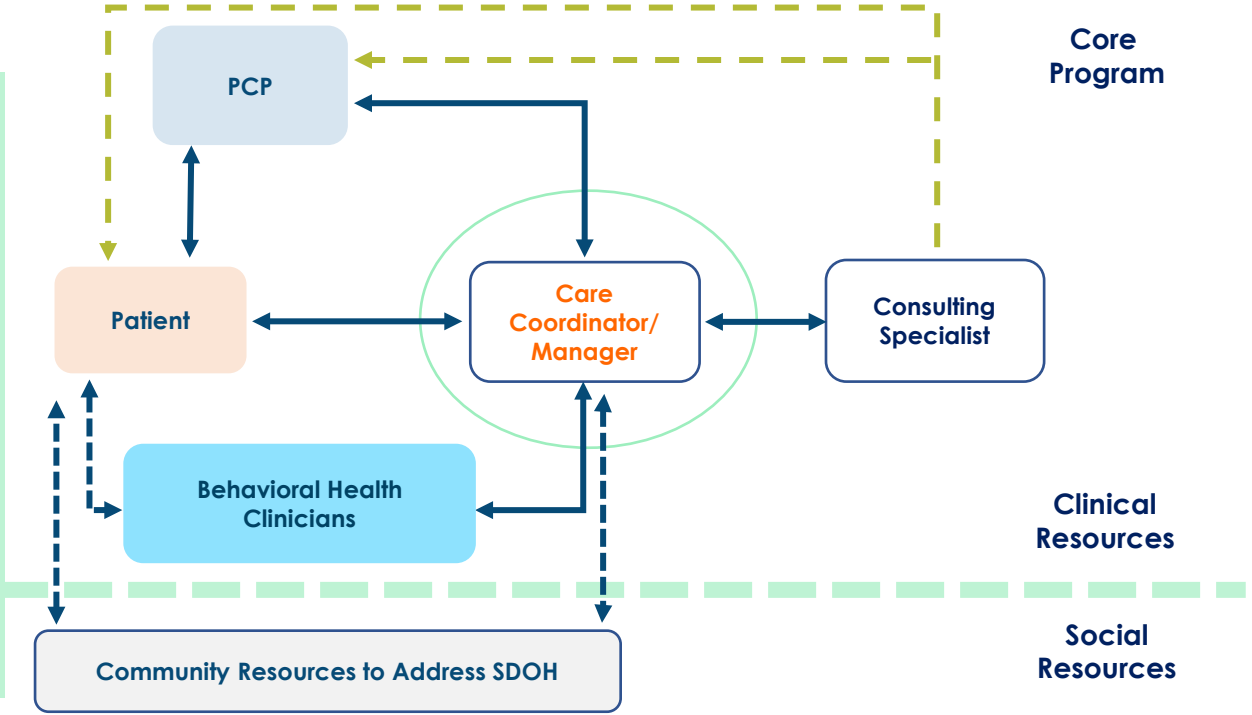
Practice-level Care Management Staff Employed and Embedded Within Primary Care Teams

Patients

- ✓ Personalized, whole-person care
- ✓ Better navigation to access health care needs
- ✓ Engagement and trust

Providers

- ✓ Build trust with provider
- ✓ Allow care teams to be part of the medical home
- ✓ Facilitate free flow of timely information and warm handoffs



Wellness West Focus Areas

Wellness West is a collaboration of major safety net health care providers and community-based organizations who aim to address health inequities.

Almost 200,000 Attributed Lives Across the West Side

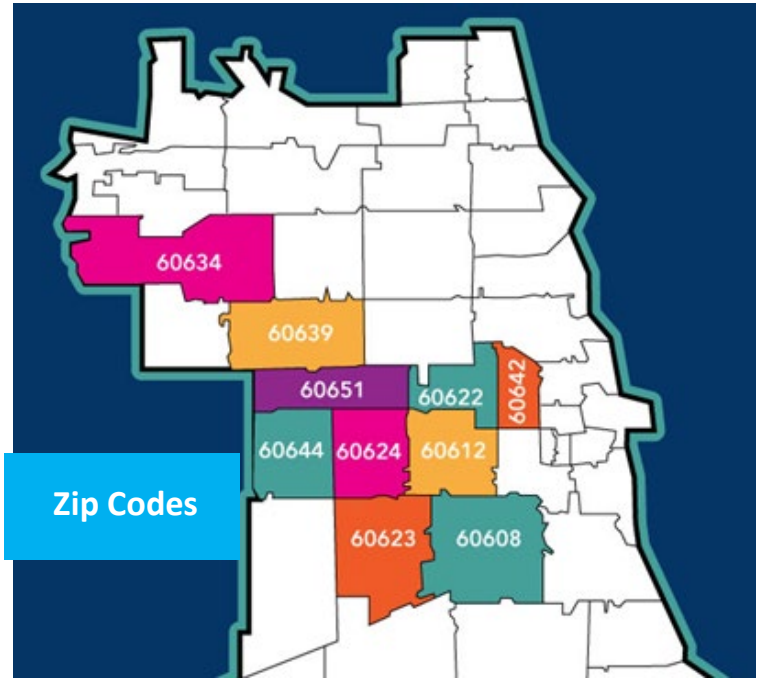
Insurance Status

- Medicaid or Uninsured

Medical Conditions

- Severe Mental Illness (SMI)
- Substance Use Disorder (SUD)
- Mild to Moderate Depression
- Adverse Childhood Experience
- Hypertension (HTN)
- Diabetes Mellitus (DM)

Zip Codes



Roles Across the Collaborative

Expanding the Healthcare Workforce - 142+ new jobs within our target area

At Medical Homes

Community Health Workers, Care Coordinators

At Community-based Organizations

Community Health Workers

At Community Mental Health Centers

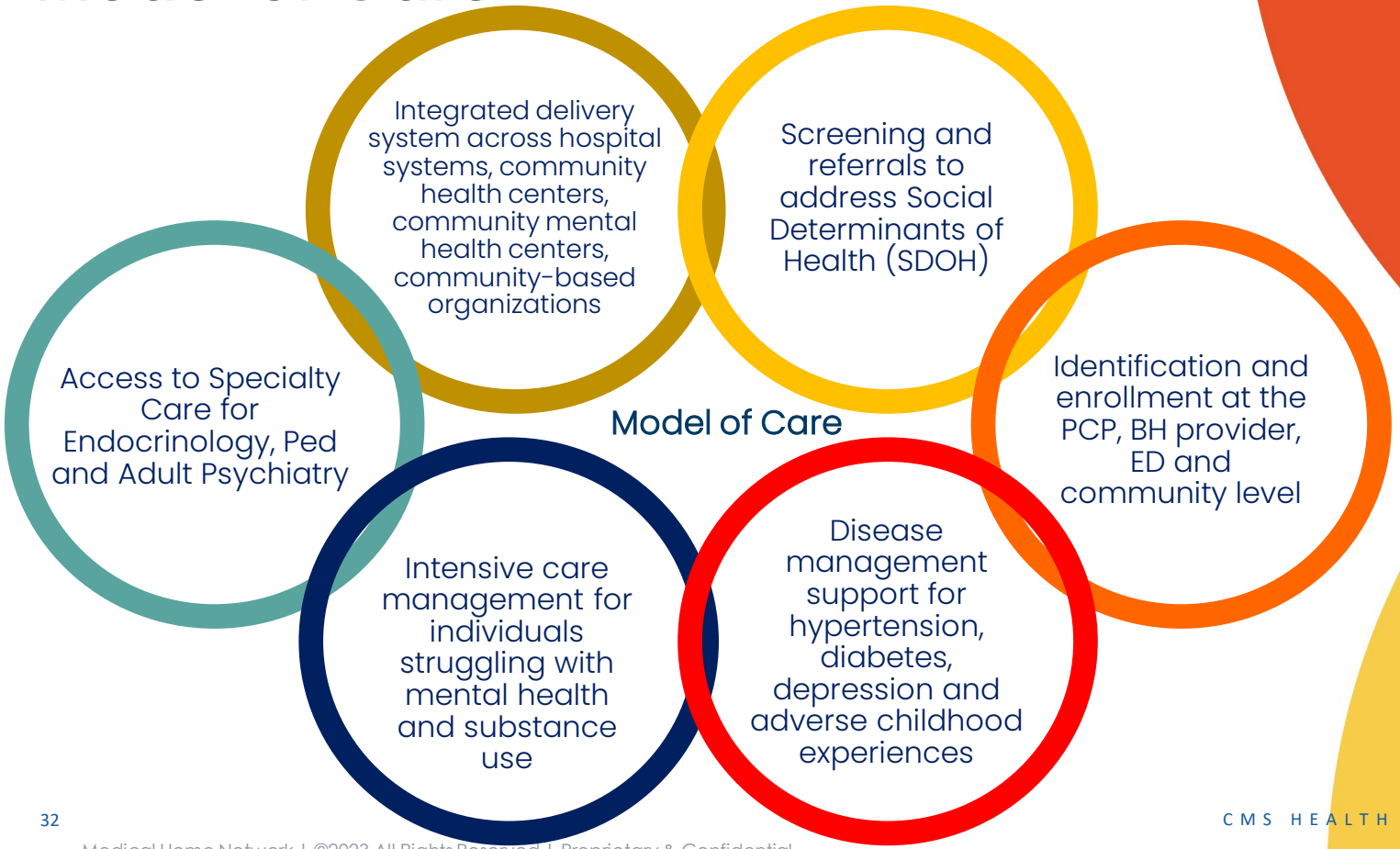
BH Care Managers

Peer Support Specialists

At Hospitals

Emergency Department Navigators

Model of Care



Criteria for Partnership with Payors

The potential payor partner should have:

- ✓ An **aligned mission**, including a focus on delivery redesign vs. cost management
- ✓ Commitment to long-term success with a multi-year deal and **clear value-based care transition milestones**
- ✓ Willingness to share timely and actionable **data;** claims inclusive of pricing and benchmarked
- ✓ **Direct negotiation** with decision-makers
- ✓ Willingness to delegate **Care Management** to qualified provider entities
- ✓ Deal terms that **cannot be unilaterally modified nor rebase to accrue all historical margin to the payer**
- ✓ **Commitment to regular meetings** to review outcomes and strategize for improvement

Questions and Comments

MEDICAL HOME NETWORK

Questions?

Upcoming Events

NAACOS Winter Boot Camps

- February 8-9, 2024
- Marriott Orlando Airport Lakeside, Orlando, FL
- 2 Concurrent Boot Camps
  - Clinical Operations in Care Transformation Boot Camp
  - Data and Analytics for Care Excellence Boot Camp

Registration Now Open!

Learning Lab

AWV Learning Lab series (six sessions)

- Next Meeting December 21, 2023
- Every third Thursday from 2:00 - 3:00 PM Eastern
- Sign-Up Here!

Thank you!

Contact Information

- **Melody Danko-Holsomback**, VP of Education, NAACOS, mdholsomback@naacos.com
- **Emily Perron,** Education Manager, NAACOS, eperron@naacos.com
- **Art Jones, MD** ajones@healthmanagement.com

Appendix

Learning Lab Objectives

- Learn about Medicaid contracting throughout the states
- Learn about care models to support your contract populations and networks
- Learn about various care settings to address population needs
- Learn workflow options for value-based care related to primary care, SDOH, BH and high needs people
- Learn how to improve quality in the Medicaid population
- Learn how to enhance patient engagement in the Medicaid population

Education Project Plan Document

Project Overview:

The Medicaid Learning Lab will provide NAACOS ACO members the time and platform to explore and learn about topics related to Medicaid value-based contracting and patient care models that include a focus of issues compounded by the socio-economic factors of the Medicaid population. The learning lab meetings will occur virtually each month for 90-minute sessions and will last for a minimum of 12 months and continue until objectives are completed. Additional in-person sessions may also occur at biannual conferences, if warranted.

Standards:

- Participants are asked to be engaged active participants in monthly meetings
- Participants are asked to share best practices and lessons learn from experiences with like populations, care model or topic of discussion
- Participants are expected to actively participate in surveys and document review to better enhance your learning experience and help staff understand your learning needs.
- Please be on camera and ready to participate in each meeting you attend.
- No question, thought, or example is a bad one. Learning is found in all examples weather a success or failure in the past.

Education Project Plan Document

Requirements/Task(s):

- Attend a minimum of 75% of the meetings to receive CEUs
- Actively participate in topic discussions where appropriate
- Develop a draft plan of what your Medicaid ACO looks likes including participants, Geographics and Medicaid population you are serving or would look like if planning a new contract. Then outline a 2-year strategic plan on how you will include at least 2 to 3 new initiatives based on information gathered during participation in the NAACOS Medicaid Learning Lab. (Turn completed plan in to NAACOS for Completion Certificate)

Record your notes/research here:

Use this section to note which initiative you may want to include in your strategic plan

Education Project Plan Document

Outline the steps/plan for your project:

- Use monthly meeting note templates to document your notes and options for your final strategic plan
- Start your project outline from the beginning of the learning lab to prevent an additional large time commitment at the end of the learning lab series to complete your strategic plan.
- Meet with others from your ACO throughout the project to get their input, suggestions, and support for possible implementation of learnings.
- Complete your strategic plan after the final meeting, you will have one month to complete and submit to NAACOS Education staff to receive your NAACOS Medicaid Learning Lab completion certificate. (This will be separate from CEUs for participation in live meetings)
- Your final plan will be reviewed by the NAACOS team and Education Committee for presentation and possible award at a future NAACOS event.
- The strategic plan completion is not a requirement to participate in the learning lab monthly session or to receive CEUs but will provide tangible materials from your participation that have potential for future ACO improvement efforts.
- To Receive the Event CEUs, you must be present and actively participate in a minimum of 75% of the monthly meetings.
- This event is only open to NAACOS members.

Group Discussion

Note Template Questions:

1. What problem does the topic address?
2. What population of patients could benefit from this?
3. What didn't I know or haven't thought about trying in my ACO?
4. Could any of this presentation work in your ACO or CIN?
5. If yes, how? If no, why not?

Take 10 to 15 minutes and create a paragraph describing what your next steps would be to investigate the use of presented material in one or more ACO processes.