Jennifer Nolty (00:00):

Good afternoon and welcome to today's webinar on accountable care, why our organization decided to develop an independent practice association or an IPA. My name is Jennifer Nolty and I am the director of innovative... Sorry, I'm the director of PCA in Network Relations for NACHC and I'd like to welcome everyone who's joining us. I'd like to wish you either a good afternoon or good morning depending upon where you are joining us from. Today's objectives of the webinar will be to, number one, identify ways to develop an independent practice association at your organization, discover the advantages of state and or regional collaboration, and to determine if an IPA may be an option for your organization. Next slide.

Jennifer Nolty (00:57):

So before I introduce our speakers I'd like to just say thank you to them in advance. We have three unique organizations, Missouri Primary Care Association, the Iowa primary Care Association, and Health Center Partners of Southern California. And, they're going to take a few moments and they each have information that's going to share with you their journey, what they've worked on in their organizations, and then they'll take questions at the end, but then I also will remind everyone that we have what's called office hours scheduled for a week from today for the same time at 12... I'm sorry, a week from yesterday, Wednesday the 22nd at noon Eastern time. And I'll have a reminder of that at the end.

Jennifer Nolty (01:53):

So at this time, I would like to introduce our first set of speakers, from Health Center Partners of Southern California, Mr. Henry Tuttle and Sparkle Barnes, and then we will have the Iowa PCA, which will be Sarah Dickson and the Missouri PCA, which will be Joe pearly and Heidi Robertson Cooper. So I'd like to turn it over now to Henry and Sparkle.

Sparkle Tuttle. (02:22):

Wonderful. Well, thank you Jen and thank you NACHC for this opportunity. We're certainly happy to be here with everyone today and to be able to share our experience in setting up our Clinically Integrated Network. I know this is a pretty quick panel, so with that I will go ahead and get us started, but we are pleased to be here today, and if we could move ahead to the next slide.

Sparkle Tuttle. (02:47):

So we're a family of companies at Health Center Partners. Our parent organization is Health Center Partners of Southern California. The primary purpose of that organization is policy and advocacy as well as technical assistance and training, but Health Center Partners wholly own three other organizations. From the far left is Connect, which is our national GPO. Then you see Health Quality Partners. That is where we design test and scale models of care. And then on the far right is why we're here today. So Integrated Health Partners is our Clinically Integrated Network. Next slide.

Sparkle Tuttle. (03:26):

So our mission is to be the thought leader and innovative influencer of change in the primary care marketplace, and our vision is to serve as the nexus for our members and partners to transform primary care. Next slide.

Sparkle Tuttle. (03:42):

So we really feel that it's foundational and a part of what we do in leveraging the synergies across the $50 million enterprise. We believe that the whole of the partnership is greater than the sum of its parts and we achieve more in partnership than we can achieve on our own. Next slide.

Henry Tuttle (04:01):

So this is Henry and again, thank you for having us join you today. Health Center Partners as some might understand it is a member of the Regional Associations of California or RAC or a regional PCA. We are representing a consortium of 17 primary care organizations including federally qualified health centers, Indian Health Services, and Planned Parenthood of the Pacific Southwest, the second largest in the country. We have an active PCA in Sacramento but because the state is so large, the state is divided into multiple regional associations or many PCA to implement strategy at the ground level.

Henry Tuttle (04:43):

As Sparkle already mentioned, we provide policy and advocacy on a regional, state, and federal level for our members as well as provide training and technical assistance. Per our bylaws members of Health Center Partners must have corporate headquarters in one of the three Southern most counties in California, San Diego, Riverside, and Imperial.

Henry Tuttle (05:07):

We operate multiple peer groups, 15 different peer groups for physicians, dental directors, COOs, CMOs, billing managers and so forth. This map helps illustrate where we are. Our members like to say that we're responsible for the Southern territory from Arizona to the Pacific, from Mexico to Los Angeles. And this slide provides the breakdown on the population. Because the end of the population in Southern California is so large we tend to outsize most similar sites or functioning organization. Next slide.

Henry Tuttle (05:46):

This is a breakdown of who our members are. Looking at UDS information, our members collectively serve over 800,000 patients in California. OSHPD information is 926,000 patients for over 3 million unduplicated patient visits per year at 135 sites of care in five counties. We wanted to kind of lay the ground a little bit for you first so that you can understand how our Clinically Integrated Network works. The next couple of slides show you our patient demographics, to give you a sense of scale and who we're here to serve in terms of gender and in terms of coverage or lack of coverage status.

Henry Tuttle (06:33):

The final slide here talks about our economic impact on the region totaling 1.7 billion per year and that has been increasing significantly year over year. We are a job creator, over 11,000 jobs, but at an extremely low cost for care. And we use this information on our Hill visits in Washington as well as our day at the Capitol in Sacramento developed in concert with Capitol Link.

Sparkle Tuttle. (07:07):

Great. So our value based model is our Clinically Integrated Network where we're responsible for both the financial and clinical components. And next slide.

Sparkle Tuttle. (07:20):

So our CIN is made up of 10 of the member health centers and was launched in March of 2016, but a whole lot of work happened prior to that before we could type that bullet on a slide. In fact, the work started in earnest in January of 2013 with the formation of the Strategic Partnership Work Group. That work group has three sub committees. We had an organizational design and governance committee. We had an MSO committee, a management services organization committee, we ran the RFP for our MSO through that committee and ultimately awarded Med Point Managed care.

Sparkle Tuttle. (07:57):

We also had to perform a committee where we did the actuary analysis. The initial startup fees to investigate and decide structure were split among those in the work group, and it was really a nominal cost to each participant and we did have some grant funding to help us with initial consulting fees. Ultimately, for those that opted to move forward with the CIN, we had year one minimum clinical thresholds in place and all participating members were evaluated and tiered out based on a standard set of criteria, a matrix of several factors and an organization's readiness. So we really looked at governance to finance as well as clinical to leadership. And in some cases, health centers were teared out until they could prove they meet the minimum thresholds. And our first contract went live in may of 2016 with the Molina Health Plan. Next slide.

Henry Tuttle (08:49):

The formation of the Clinically Integrated Network was one of the criteria in the search committee to fill the vacancy that I was chosen four, five years ago. The members really believed that their future growth would not be in more bricks and mortar, but in tighter clinical and financial integration and how we best serve the patients entrusted to their care. So why Integrated Health Partners? As I said, to really achieve that kind of optimal health outcome and financial sustainability, unlike most other areas in the state or in the country, it's important to point out that San Diego County does not fund or operate a public hospital or public health infrastructure. So our members and Health Center Partners make up the safety net for our region and have her over 40 years. The integrated network is really the next step for the safety net and the growth goals for our members overall.

Henry Tuttle (09:52):

Also, because of payment reform initiatives started in California a few years ago, for those who are familiar, CP3, our members wanted to have their own experience and data to inform Sacramento on what it would take based on real time experience, real time information, real time data, so as reform might be overlayed to a region, we wanted to make sure that that would be overlayed correctly based on our runtime and our run experience. So our goal is to improve health outcomes while reducing costs and creating shared savings across riskful.

Henry Tuttle (10:31):

The next slide shows the breakdown of our 141,000 patients managed directly through Integrated Health Partners through powers of attorney signed on behalf of our members to negotiate and manage those life on their behalf. And the pie chart gives you a sense of the status coverage for those 141,000 clearly largely Medicare or Medicaid live. Next slide.

Sparkle Tuttle. (11:04):

So here's how our system works today. It's really one network that can demonstrate value and effectively manage populations for primary care. So we're contracted through the CIN for primary care

capitation plus, a per member per month with a performance of pay for performance incentive on top. If you look at the maroon box where it says federally qualified health centers, so our 10 member organizations have signed a participation agreement with the Clinically Integrated Network with Integrated Health Partners, and as Henry said, we hold the power of attorney and we do joint negotiations with the payers on their behalf. And you can see we received one capitated rate for those patient lives to manage their primary care as well as cover the operating expenses of the network. Next slide.

Sparkle Tuttle. (11:59):

So, again, in the CIN we're responsible for both the clinical and financial elements of the network. And this is really what happens today. We operate five committees. We have a clinical committee, operations committee, a financial committee, an IT committee as well as the QI committee. And we have minimum clinical thresholds for participation and those thresholds ratchet up each year. So we're now on your four clinical requirements. Performance is evaluated across eight HEDIS measures that determine at your end our P for P distribution. So in this way we've elevated the HEDIS scores from the minimum performance level to above the median in the two years time. And we'll show you a sample of the actual HEDIS results in just a few slides, but it's already producing excess revenue to IHP above budget and how we utilize that excess revenue is an ongoing conversation. Next slide.

Henry Tuttle (12:57):

So we wanted to talk briefly about population health informatics and our journey to this point. We have an exhaustive RFP effort on behalf of our members who asked us to centralize the information and data gathering and analysis for a variety of technical tools on their behalf. And ultimately the members and staff of IHP selected Arcadia as the required solution that would help utilize our members information, aggregate that across the divergent EHR system. Our goal is no wrong door. So if a member patient lives in the South Bay but works in the North Bay, ultimately it won't matter which health center in the network the patient goes to, it's one network of patients, it's one standard of care, it's one data system, it's one reimbursement PMPM and P for P. So same care regardless of which health center in the network the patient visit.

Henry Tuttle (14:08):

Our KBS capabilities include realtime popups and members' EHR and master patient index, longitudinal health record and it's updated every 24 hours. So if a patient does move from health center to health center, we have that information right in the EHR for the provider at the time of the visit.

Henry Tuttle (14:30):

The population health goals through Arcadia include what you see on the screen. I won't read them to you in the interest of time. It's important to point out in the first bullet that the grant initiatives are across all of the members of Health Center Partners and how we capture synergies across the four companies. And in bullet number four, this will probably be coordinated across the network.

Henry Tuttle (15:00):

The slide is what Sparkle was referring to a little while ago. Here's a snapshot of some of the improvements in HEDIS measures over a three year period. You can see that they're steady improvements. It's also important to point out when talking about why forming a Clinically Integrated Network our members' clinical directors and CMOs have been working in peer groups for well over a

decade, sharing unblinded data, sharing best practices, and implementing those across the health centers, which made it much easier to begin to implement a Clinically Integrated Network as they were already used to working with one another and now through annual standards of care that are published and approved by the CMOs and put forward to the board for approval and implementation with centralized care management here at IHP, this process is clearly working. We have moved from the 25th percentile of minimum performance levels and HEDIS on these measures to over 50% and some of the measures are moving towards the 90th percentile, which is a significant improvement in a very short period of time. So it proves that investment in the CIN is working, the patients are getting better, they're maintaining that improvement, in fact, increasing that improvement over time while returning shared savings to the system. Sorry.

Sparkle Tuttle. (16:28):

So where are we headed? So for us right now, our proof of concept, as Henry just spoke to, we believe it's working in our primary care cap plus environment. So we're really beginning to explore professional risks. Next slide.

Sparkle Tuttle. (16:45):

And we're considering this risk for this transition for a multitude of reasons. Number one would be access to a robust specialty care network or potentially hiring our own regionally dispersed specialist, placed by demand and availability the opportunity to get and receive the encounter data clinical efficiencies. So being able to reduce avoidable, unproductive and duplicative services as well as the ability to create consolidated quality reports, utilization, review of gaps in care, etc. Next slide.

Sparkle Tuttle. (17:19):

So in evaluating risk outside of our four walls, we're beginning to position ourselves for professional risk. You can see the green buckets which is the professional risk bucket. So in this environment we would be at risk for not only the primary care and operating expenses that we're at risk for today, but for specialty care as well as ancillary care, that would be your lab, radiology, injectable meds as well as some medical supplies. This is really a separate bucket from facility risk, which you see in orange on the right hand side. That risk is inpatient hospital, outpatient surgery center, ASC, home health, so although IHP would share in facility risk pool profits we would not be at risk for the orange side. Next slide.

Henry Tuttle (18:15):

So the transition to a professional risk for IHP will have us looking at some of the following characteristics. Significant focus on preventive care, making sure that our members FQs our medical homes for their patients. I'm not going to read the slide to you. I know we're kind of of a little bit over. But, for positions in Integrated Health Partners in the members organizations, their real conversations today are including dialogue around necessary referrals, in-house practices, how to transition to value based care without outpacing the reimbursement. So at our committee levels, the conversations around risk and what will be required is what's happening today. We do have proposals out to our health plan partners to look at what they would fashion for us on the professional risk side to see if those terms would be acceptable to our members. Next slide.

Henry Tuttle (19:29):

So as I kind of said earlier, and this is our last slide, the investment in Integrated Health Partners is working with respect to the improvement in the HEDIS measures. Integrated health partners is posting

the highest HEDIS scores that Molina Healthcare in California has ever posted. Our MSL med point management manages the lives of over a million patients in Southern California and in their patient set, Integrated Health Partners' patients are scoring at the highest HEDIS levels in those million plus patients, and our members, P for P has increased. And our year over year P for P distribution has increased for those members who have joined IHP. So this is why we created the Clinically Integrated Network. Thank you.

Jennifer Nolty (20:23):

Thank you so much Henry and Sparkle. That was a great presentation and a lot of really rich information in a short amount of time. At this time, I'd like to introduce the Missouri Health Plus. We've got Heidi and Joe, go ahead. Okay.

Joe Pearly (20:54):

So it's looking a little different on my screen, but anyway, we'll get started. So we appreciate the opportunity, and as a side note, we're happy to follow up with any of you individually if you'd like to discuss our network, how we started and where we are today. So if you could advance the slide. So Missouri Health Plus is a Clinically Integrated Network of 19 health centers who are actually owners, but we also have three FQHCs who are participating health centers but they are not owners. It's a statewide network that we have about 170 locations and more than 300 primary care providers in the network.

Joe Pearly (21:40):

I don't know about your States, but Missouri has seen a steady decline in its Medicaid population due to a number of factors, but we now have just over 95,000 assigned lives. We have contracts with... We're lucky in that we only have three Medicaid Managed Care companies in the state of Missouri and they're all statewide, so they have a statewide presence. We do not have any MCOs that just have regional presence, but we have contracts with all three of them at this time. And we also have a contract with one commercial payer. We're going through a strategic planning process with the owners of Missouri Health Plus right now and are exploring the possibility of adding more commercial payers and maybe getting into the Medicare advantage space at some point in the future. In fact, a Medicare advantage plan reached out to us recently, said they're wanting to get into the Missouri market and they want Missouri Health Plus to be a part of their provider network.

Joe Pearly (22:57):

So we offer delegated credentialing and also our previous presenters have a centralized data analytics platform that is integrated payer and clinical data to support value based care. We have chose Azara healthcare, which actually came out of Arcadia. I want to say it was back in 2010. We've been happy with their performance and have seen them add more utility to their platform. It has grown significantly just over the past 12 months. So we have a common data analytics pop health platform that we use as well.

Joe Pearly (23:42):

And we are basically using this network to help our health centers thrive in a value based environment. So if you could go to the next slide, the motivation for development was significant and to be Frank with you, I was having dinner with an executive of a health plan in St. Louis and he turned to me and said, "Why don't you form an IPA?" And at the time, I think it was 2012, I did not know what an IPA was. And I should share that the Missouri Primary Care Association is managing Missouri Health Plus at this time.

Initially, they are two separate corporations. Missouri Primary Care Association obviously is a nonprofit, but the Clinically Integrated Network is a for profit network that was managed separately initially, but now MPCA today is managing the Clinically Integrated Network. And I'm happy to talk further about that.

Joe Pearly (24:48):

But it was really coming out of that dinner was also in a response to perceived threats and opportunities at the time related to healthcare reform. In the last bullet on that page we really saw it as a vehicle for health centers to get together and leverage their value together instead of in silos. We thought we're better together, we're stronger together, we have more leverage together.

Joe Pearly (25:15):

There were also talks about expanding Medicaid Managed Care statewide, which has happened. So that was part of the response why we created the network shifting to value based. We've had different discussions with our Medicaid agency about changing reimbursement in Missouri for FQHCs and moving into more value based relationship. So many of our health centers at the time were having challenges just with the contracting process. So again, being bigger, being able to leverage our value together were pretty much the drivers and really we wanted to create a vehicle. As we looked at the landscape, most healthcare dollars were going to be in the hands of insurers and we wanted to create a network that could leverage that value and get money out of their pockets and into our FQHC for value based care. So next slide.

Joe Pearly (26:19):

Really this is the support we provide, contract negotiation and management. Like I said earlier, we have a delegated credentialing program. We're spending a lot of time on payment denials and claims resolution, a significant amount of time on that front, providing them with a common population health tool and performing data analytics and then using that information to drive performance. We like to say in Missouri that we're drowning in data but starving for information, but this Azara drive tool has helped us on the ladder and we're now using that information to drive performance.

Joe Pearly (27:03):

And finally, Missouri Health Plus is an outward facing brand that we use with the state when we're talking to the state Medicaid officials, with the MCOs and other potential payers. And there's some discussion about it being a further brand that we can use directly with patients. So next slide and I'll turn it over to Heidi.

Heidi Robertson Cooper (27:29):

Good morning everyone. I'm going to talk a little bit about our governance model here. So Joe had mentioned our full membership is made up of owners but also some participants and there are certain responsibilities as an owner has to pass including budget and different capital and financial decisions. And then we have the board of managers who really supports Missouri Health Plus on day to day recommendations and also works closely with the committees that we have listed below. And similar to the previous presenter, we have numerous committees that help kind of guide the direction of Missouri Health Plus as well as making sure that our clinical integration status stays in place. So we have a finance committee that is typical for any organization reviews, financials, the budget, and makes

recommendations. It also helps make recommendations related to any care coordination payments or pay for performance.

Heidi Robertson Cooper (28:43):

We have our clinical committee who will set standards around HEDIS measures as well as any other measures that we have with the MCOs. We have our standards and compliance committee and this is in place to identify members or participants that are not meeting the participation standards that we have in place. They also oversee the corrective action policy that we have and make recommendations to the board on that. We have our contracting committee who reviews the contracts that we are working with, the managed care plans or any plan that we're working with. So that's the committee that has experience in vetting contracts at their health center level and provides guidance to Missouri Health Plus into the board of managers.

Heidi Robertson Cooper (29:39):

And then last we have our credentialing and this is specific to our delegated credentialing program. So this committee is made up of providers and they review new providers that will be going through the delegated credentialing process through Missouri Health Plus for approvals. Next slide please.

Heidi Robertson Cooper (30:03):

So as Joe mentioned earlier, the Missouri Primary Care Association manages Missouri Health Plus. And this wasn't always the case, however, we have been doing this for the past year and we've spent significant time and energy on finding organizational alignment so our joint members do not feel a strain of two different organizations asking for similar information or similar meetings or similar programs but just slightly different enough to make it a burden on them. So Missouri Health Plus, as Joe mentioned, we work on contract negotiations, population health efforts related to managed care, delegated credentialing, payment issues, claims remediation, and we have our population health management system that both looks at payer and EHR data, and then we have the Missouri Primary Care Association, which does all of the things that a PCA does across the country, and we're also a health center controlled network.

Heidi Robertson Cooper (31:05):

So you'll see at the bottom where we have found significant synergy and alignment between the two organizations and the different programs in a very concerted effort to make value based care delivery as painless as possible for our members because that is one thing that we've heard a lot about is that they're overrun with different programming, different measures, and so we're really making a concerted effort to streamline on their behalf. Next slide please.

Heidi Robertson Cooper (31:43):

So what you're looking at here are some initial things that since Missouri Health Plus has been in existence, we've been able to achieve. So we have clinical integration status which is a very legally intensive process and takes a lot of work, but we are to that point. We have contracts in place with all of the managed care organizations in Missouri and also the largest commercial payer in Missouri. We just wrapped up our three year participation in the Medicare ACO, and Missouri Health Plus earn shared savings, so we were happy to report that. We have access to payer data, so we have enrollment roster claims data. This is integrated into our data warehouse and our health centers and members are using this to inform their care delivery to the managed care patients. We are working on this still, but we

definitely have an engaged health center leadership who really wants Missouri Health Plus to succeed. And so this is always a work in progress, but we have made significant strides in the past year for more engagement. And then the last is we have an effective governance model that I described earlier. Next slide please.

Heidi Robertson Cooper (33:09):

So, where are we going from here? We are really focused on increasing health center capacity to help population health management for managed care patients. So we are supporting through other initiatives some additional revenue to support patient engagement and care coordination because one of the biggest areas of improvement is health centers needing to engage with patients who are assigned to them but yet unseen. And that brings us to the next goal is that we are wanting to increase the access for assigned patients.

Heidi Robertson Cooper (33:50):

In Missouri, we are finding due to issues around demographics, about 60% of patients are unreachable which makes it really challenging to engage with them. So we have some additional resources that we'll be providing health centers to support these activities. We're really continuing to focus on improvement on HEDIS. All of our contracts are pay for performance related with HEDIS measures, so we have a set of HEDIS measures that we are focusing on as a network. We know the next several years, Missouri Medicaid will be shifting towards more utilization and cost reduction measures, and so we are setting the stage for that and starting to prepare for what managing total cost of care would look like.

Heidi Robertson Cooper (34:42):

And the next slide gives you some information on how to get ahold of us if you have any questions about our IPA and where we've been able to go today. Thank you.

Jennifer Nolty (34:55):

Great. Thank you Joe and Heidi, that was really, again, great information. I just wanted to make sure that everybody if you have any questions you can pose them in the chat room, and also just to remind you that at the end of this last presentation, we are going to also look at the questions and you can again, please populate questions in that chat room. So last but not least is Iowa Health Plus and Sarah Dixon.

Sarah Dixon (35:31):

Yeah. Well, good morning or good afternoon to all of you. Great to be with you and I think you'll hear a lot of the same scenes and concepts from my presentation but hopefully some additional insights will come from it as well, and it was great to hear from California and Missouri. The next slide.

Sarah Dixon (35:52):

One of the things that we have focused on as well, and I think you can see commonalities between the presentations is really trying to get to some better organizational alignment to best serve our health centers, and so all of the staff here in Iowa do work for the Primary Care Association, but we have management services agreements with our health center controlled network and concert care, and then our Clinically Integrated Network, Iowa Health Plus and these three organizations are all structured to serve the needs of our health centers and I like to say that we are trying to do all of the things that allow

our health system are doing with a very small and nimble staff. And I think you can see that on the slide about all of the services we're trying to provide to the health centers. And similar to Missouri, our PCA and our health center controlled network, those are both nonprofits, and then Iowa Health Plus is set up as a limited liability company. The next slide

Sarah Dixon (36:54):

Just to give a sentence, I think in terms of why we formed a Clinically Integrated Network, we always like to think about the political environment that's kind of present in our state. So Iowa does tend to be a pretty moderate state, but we've had some pretty big swings over the last decade. I think that Iowans are also... they tried to be innovative and there's generally pretty good programming and favorable policies in our state legislature, but that has been flawed over the last decade or so with the, with the big political swings.

Sarah Dixon (37:37):

We were able to get Medicaid expansion when it was first available but it really required a huge political battle, really came down to the wire. And then we had our state really moving towards value based pay as the Medicaid agency and really pre-managed care, and so we actually had an ACO in place with our Medicaid agency prior to managed care. And then you can see that we moved into pretty much full managed care across the Medicaid population in 2016. The rollout has been pretty messy for us and I think really it was very favorable for us to have Iowa Health Plus in place to really be a collective voice for most of the health centers in the state of Iowa when we shifted to managed care and you can see the tumultuous environment we've been operating in where we had floor plans initially selected. One was forced out, two have now failed and we have a fifth now entering the market on July 1st.

Sarah Dixon (38:45):

And, we're similar to Missouri in that we have only statewide plans and starting July 1st we will have... The two plans that will be in place will be Amerigroup, and then Iowa Total Care, which has been seen entering the market for the first time. And the plan leaving our state, June 30th of this year is United Healthcare. You can see the role that we've tried to play with the MCO state and then the community health centers on the bottom of that slide. Next slide.

Sarah Dixon (39:16):

So the future state that we are preparing for, I think this is something that we really go back to and are thoughtful about with the leadership of our health centers within Iowa health Plus and in the staff as well, is that we know that most patients in this country have really found themselves and have been moved into value based payment arrangements. And that is increasing within the Medicaid population. Our health centers have a strong desire to be able to provide their agnostic care. And that is hard to get to, but it is easier to do within a Clinically Integrated Network where you can make investments around analytics and some of the other infrastructure that both in Missouri and California pointed to.

Sarah Dixon (40:02):

We also have faced uncertain federal funding and think we'll continue to have that as an issue and healthcare is just more competitive. And so our health centers really wanted to be well positioned to take advantage of that. And I think we feel like we are better prepared for those significant environmental factors as a result of having a Clinically Integrated Network. Next slide.

Sarah Dixon (40:31):

So just a little bit about Iowa Health Plus, just to give you a sense of the scale compared to the other two networks where we are smaller, but it's a voluntary business venture, so a limited liability company, and we have 11 of our 14 health centers that are involved with Iowa Health Plus, and those health centers serve over 170,000 patients, and then we've had over 58,000 patients in attributed Medicaid lives in 2018. So, we initially actually started off pursuing a Medicare ACO and that's something that is on our roadmap. Again, we weren't successful due to the small number of Medicare patients we had back in 2011, but we were able to use the Iowa Health Plus infrastructure to pursue that ACO under Medicaid expansion with our Medicaid agency and then has been successful in demonstrating clinical and financial integration with the bills that came into our state in 2016. Next slide.

Sarah Dixon (41:40):

So one of the things that we point to frequently when we talk about why we formed this Clinically Integrated Network and we've had our members really revisit is the value of Iowa Health Plus. And one of the things I think that has consistently been an issue for us is really safeguarding our mission and ensuring that we're not subsumed by larger health systems. We have a very aggressive health system here in the State of Iowa that did indicate that they were just going to take over our health centers one by one. And by having the Clinically Integrated Network in place we really were able to allow our health centers to work with the variety of health systems that they need to do at the local level. They don't just have one health system that they're working with.

Sarah Dixon (42:32):

I think that idea of sharing an investment in risks has been front and center for us and we've seen that our health centers have really stepped up in terms of making investments into our network when they needed to and they continue to value investments into the network and we are just getting to the place where we're able to be able to make some payouts to the health centers. So they've really been heavily invested in the network for the long haul and we're just starting to see those wins financially. We just got news yesterday that we were the highest performer in the... one of the Amerigroup programs and are going to be receiving the highest payout in the state, which is huge news for us.

Sarah Dixon (43:16):

And then the other thing I think I'll feature on this slide is just the ease of negotiating that one stop shop related to influence, negotiating power, and administrative ease that has made us a lot easier to work with in terms of the plans and they've appreciated that communication that we've been able to provide, and then we've made a lot of investments in practice information that the health centers don't individually have to make because we're doing that collectively through that network with them. The next slide.

Sarah Dixon (43:53):

So our approach to contracting, I'll just touch on this a little bit and I'm getting close to the end of my slides. I can't underscore enough the idea that you have to... everything is based on relationships. That has come into play time and time again for us as we've had these managed care companies kind of in and out of our network. And I think it's also important to know your value. And so Missouri and California demonstrated that with the data analytic solutions that they have invested in, and we have done the same. We have the Arcadia system and the Enlist system, which is a population health tool

that we've invested in and that was a big decision for our network to get all 11 health centers invested in that infrastructure.

Sarah Dixon (44:45):

The other thing I think I'll feature on this side is don't be afraid to walk from a bad deal. You likely have more power than you realize and we did walk from an MCO that was really not being supportive in the way that they wanted to contract with us, and they ultimately came back to the table when they realized that they would lose access for the patients that they needed to have care provided to. Hire a lawyer. I think this is right. There are so many intricacies to the work that goes into these contracts and the way in which you operationalize them. You know, we're learning every day. I think about these concepts that health insurance companies have known for years and it's critical to invest in that way so that you are as savvy at that table as those long saving health plans have been. Next slide.

Sarah Dixon (45:47):

So what's next? We'll continue to optimize our data systems. We have really good activity and growth in our use of the PRAPARE tool across our network and MRI will help us roadmap the capture of social determinants of health with a common tool and then using that data to inform care and to consider risk is front and center in our work over the next year, and then we are also very close to having claims coming into our Arcadia system. We should actually have that live this month, which is exciting for us as well. Like California and Missouri mentioned, we see a lot of opportunities within Medicare and Medicare advantage and commercial insurance that we are starting to really think about and that much more closely over in 2019, and then we've got lots of work on our quality and performance improvement, brand awareness, and I love that both of the States also talked about leadership development and change management. That is something that our members are very interested in thinking about I think in a more contemporary way and we hope to help them along with that process in 2020.

Sarah Dixon (47:06):

And then, I think this next slide is my last one. And it's just key takeaways. So can't underscore, understate these nuts, recognize and know your value and deploy the model that works for you. I think there starts to be a point where when you demonstrate with data how effective the health centers are at delivering care to vulnerable populations, you can start to define more of that payer agnostic care through the Clinically Integrated Network that you wouldn't be able to do individually. We're stronger together. We need each other. Time and time again, that has rang true for us in Iowa over the last six years that we've really been working closely on Iowa Health Plus, and managed care is a new world. So take the time to learn not only the motivation but the plans in the state have, but also thinking about how you articulate your value and your business case within that structure.

Sarah Dixon (48:14):

Build centralized systems and resources. So I pointed to the data analytics environment, and I think we have a lot of other examples where we're building infrastructure that is valuable to our health centers. And then don't forget about leadership development and change management. We just had a really interesting meeting with our all members, so the CEOs of all the health centers about this very topic and we talked about both structural or adaptive changes, the technical changes and they really are game, I think to think about those types of issues. So where you have a lack of consistency with the way in which providers might approach care, that's been maybe an issue for a long time for the health center and in

this new environment, I think there's just a lot more resilience within the health center leadership to be thinking about what does that mean for you in a value based world. And then relationships matters always is the way that will end. And I've got one slide that just has my contact information as well if you do want to reach out and learn more, but thanks so much for the opportunity and I'll turn it back to the NACHC team.

Jennifer Nolty (49:29):

Thank you Sarah. That was great. Again, if you have any questions, please feel free to put them in the chat. I just wanted to again thank everybody and we do have a few more minutes if anybody does have some questions and just to reiterate that next week, just to let everybody know that we do have additional time with today's speakers. We have what's called our office hours and we are going to be joined by the speakers. This will be your opportunity and anybody from your organization to actually have some time to have discussion, have Q&A and really, if there was something that you really wanted to dive into if you want to digest the slides, the information that you heard today, there is a registration link and it will be very informal, but we really welcome the time, the ability to have their brain trust to really understand what it is.

Jennifer Nolty (50:44):

I think there's a couple of common themes that we heard, and one thing I would like to reiterate to everybody out there, if you have not started, I know that all three organizations have been doing this for five or six years. If you haven't started as an organization, don't fret. I think that any time that you start looking at these types of organizations that you start bringing this to your health centers or looking at it at your health center, there's never a bad time to just start looking at information and looking at what the opportunities are out there. If you are a health center, raise us to your Primary Care Association and networks at your state level and see what they're doing or see what they're thinking about.

Jennifer Nolty (51:43):

We've heard a couple of really great pieces where I think all three of them, all three organizations are starting to now feel the fruits of their labor and are seeing where their organizations have, coming together that they're able to identify and become the leaders now, not just in the health centers, in their state with the payers, but the real leaders in the measures, in the quality outcomes and which is also turning into incentive payments. So I think that those are some really great things to talk about. We have a question.

Julie Balter (52:29):

We do. So this is for our friends from Missouri. Joe and Heidi, can you briefly describe how you are trying to reach out to the 60% of the Medicaid enrollees where no contact information is available?

Joe Pearly (52:45):

So it really starts at the state level. We met with the state Medicaid agency, the director yesterday and they are trying to identify a new broker to make sure that they're getting good contact information right away. So that's the biggest challenge right now. The state is not obtaining good contact information when someone becomes eligible for Medicaid, which is hard to believe but then they pass down expectations to the payers and then those expectations get passed down to the FQHC. But we have just hired a consultant for the purpose of identifying strategies that we can implement for patient engagement, for finding those 60% that we're having a hard time finding. At the same time, we also just

got some money through our state legislature, which will provide about five and a half million dollars to focus on this exact issue, helping the health centers build the infrastructure that they need to thrive in a value based environment but specifically, this money, most of it will be used for patient engagement and care coordination functions. So stay tuned, we'll be able to share more about strategies, I think within the next two to four weeks.

Jennifer Nolty (54:12):

Wow.

Julie Balter (54:14):

Thank you so much.

Jennifer Nolty (54:15):

Great. Any other questions in the chat room?

Julie Balter (54:19):

Not yet.

Jennifer Nolty (54:20):

Okay.

Julie Balter (54:23):

They're saving them all to the office hours.

Jennifer Nolty (54:25):

Yes, they are. Great. Well, I just wanted to, again, thank everybody for joining us, especially, I wanted to thank all of our presenters, Henry, Sparkle, Heidi, Joe and Sarah. Again, the information that you brought forward today, your sharing of information as well as next week, having you on the phone to also entertain questions and facilitate discussion is going to be great. So just a reminder that the office hours are next Wednesday from 12 to 1:00 PM Eastern. Also, you will see that we have two more ACO Academy webinars. Another one is going to be in two weeks on Thursday, May 30th, the same time, legal considerations and risks. What does that mean and what should you be really looking at? And that's going to be Adam Falcon from Feldesman Tucker Liefer Fidell, and then our third one is accountable care staff engagement and achieving the quadruple aim.

Jennifer Nolty (55:35):

So we are looking at a couple of health centers that have actually really put this to the test and have really done this with a couple of key quality measures. And we're very excited and then also looking at patients that are medical home and how drives us as well. So more to come on that, but that's Thursday, June 13th from 12:00 until 1:00. And actually I just noticed that the office hours are incorrect for the third one. That should actually be Tuesday, June 25th from 12:00 until 1:00. So we'll get that information out to everybody.

Jennifer Nolty (56:16):

But again, thank you. At the end of this webinar, there will be a evaluation that will pop up. It's a very short one, I think it's like eight questions, so we really, really appreciate it if you could take the time to complete it. If for some reason you don't have the time today, we will send out another link to that evaluation with the slide deck if you did not receive it and, again, the link for the office hours for next Wednesday. Have a great rest of your day and again, thank you everyone.