VALUE-BASED CARE LEARNING COLLABORATIVE:

IMPROVE QUALITY, OUTCOMES, AND VALUE IN HEALTH CARE

INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

PRESENTED BY:
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June 20, 2024
12:00 pm – 1:00 pm ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the U.S. Department of Health and Human Services (HHS). A total of $4,598,756, or 74 percent, of the project is financed with federal funds, and 1,639,167, or 26 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, HHS or the U.S. Government.

DHCF Department of Health Care Finance

HMA

WHAT IS INTEGRATED CARE DC?

INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

- Integrated Care DC enhances Medicaid providers' capacity to deliver whole-person care for the physical, behavioral health, substance use disorder, and social needs of beneficiaries.
- The technical assistance program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH).

To improve care and outcomes, the program focuses on three practice transformation core competencies:

1. Deliver **patient-centered care** across the care continuum
2. Use **population health analytics** to address complex needs
3. Engage **leadership** to support person-centered, value-based care

WHY PARTICIPATE IN INTEGRATED CARE DC?

INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

- Integrated Care DC will help ensure you have the infrastructure, knowledge, and tools you need to deliver high-value care.
- Our coaching team includes primary care, psychiatric, addiction medicine, and behavioral health clinicians with deep expertise in integrated care models.
- Educational credit (CE/CME) is offered at no cost to attendees for live webinars.
- All DC Medicaid providers are eligible.

All content was created and delivered by HMA.

INTEGRATED CARE DC UPDATES

INTEGRATED CARE DC
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» Are you receiving our Integrated Care DC Newsletters?

Check your inbox on the 1st Tuesday for the Monthly Newsletter.

» Got ideas?

Take this short survey to share suggestions and requests for trainings.
www.integratedcaredc.com/survey

PRESENTERS

INTEGRATED CARE DC
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Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A	N/A	N/A

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CONTINUING EDUCATION CREDITS

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- Health Management Associates (HMA), #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. HMA maintains responsibility for this course. ACE provider approval period: 09/22/2022–09/22/2025. Social workers completing this course receive 1.0 continuing education credits.
  - *To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.*
- The American Academy of Family Physicians (AAFP) has reviewed the Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 02/21/2024 to 02/22/2025. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1.0 Online Only, Live AAFP Prescribed credits.
- **If you would like to receive CE/CME credit, the online evaluation will need to be completed.**

  You will receive a link to the evaluation shortly after this webinar.
- Certificates of completion will be emailed within 10–12 business days of course completion.

AGENDA

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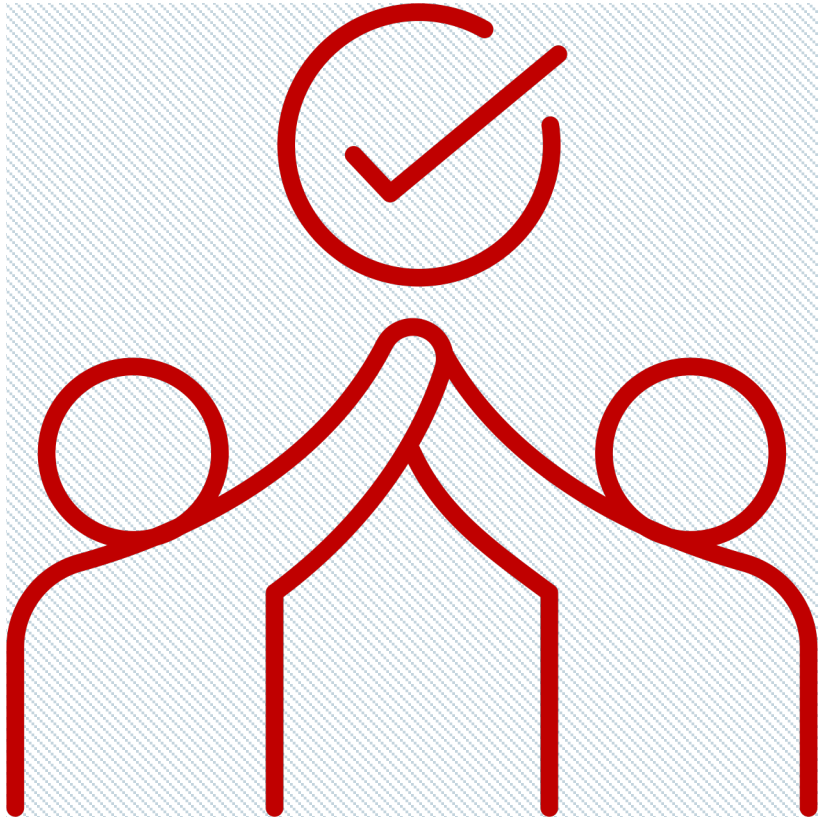

- Welcome and Program Announcements
- Overview of Value-Based Care (VBC)
- Value-Based Care in DC Medicaid
- Integrated Care DC Value-Based Care Learning Collaborative
- Next Steps
- Closing Remarks/Q&A

LEARNING OBJECTIVES

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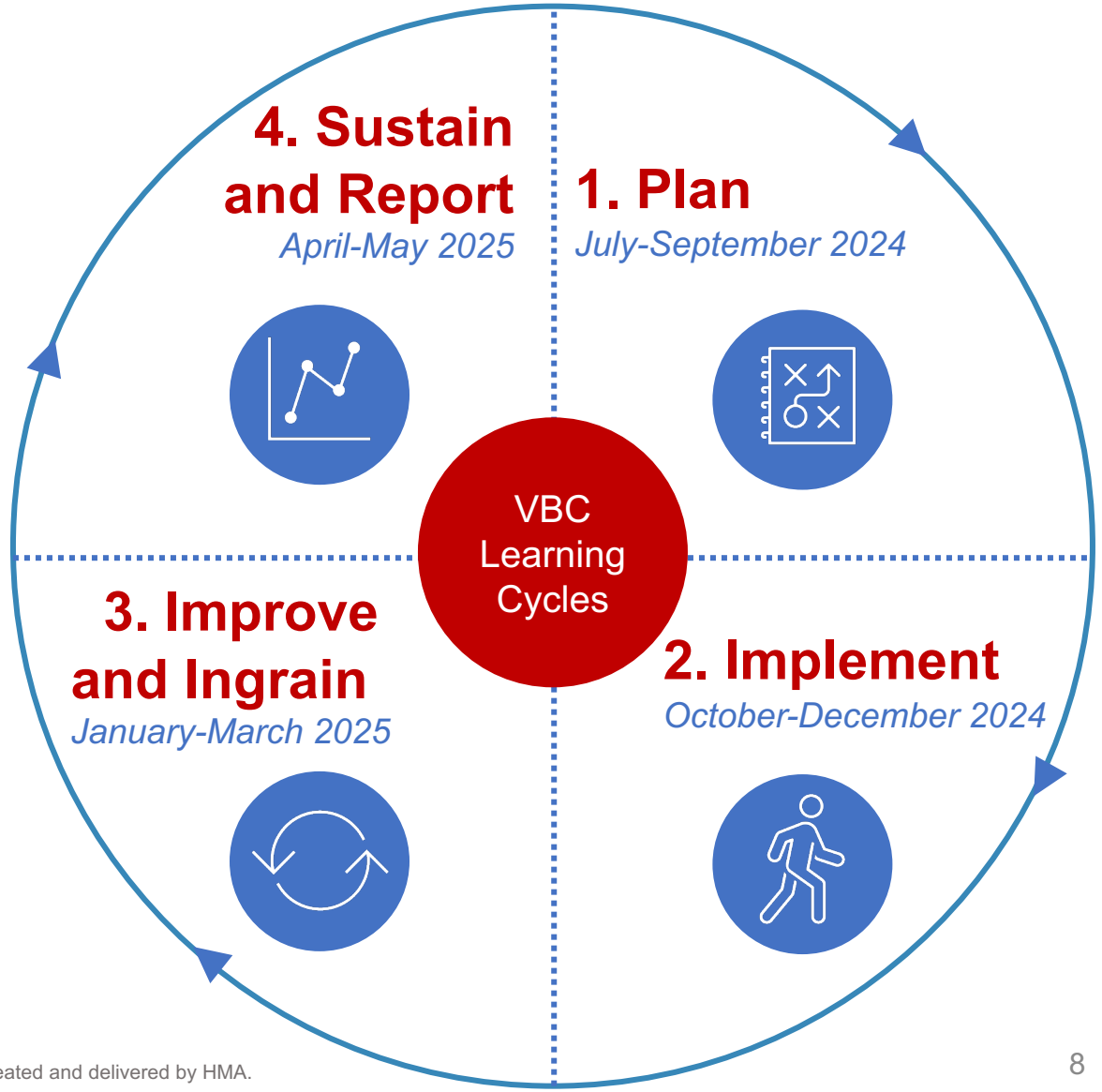
1. Describe Medicaid value-based care (VBC) in the District of Columbia, including different Medicaid Managed Care Plans' VBC programs
2. Demonstrate how to assess their provider practice's current value-based arrangements
3. Explain the offerings and requirements of the Value-Based Care Learning Collaborative



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OVERVIEW OF VALUE-BASED CARE

DEFINING VALUE-BASED CARE AND ALTERNATIVE PAYMENT METHODOLOGIES

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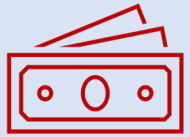
Value-Based Care (VBC)

Under VBC arrangements, providers are **reimbursed based on their ability to improve quality of care** in a cost-effective manner, or to lower costs while maintaining standards of care, **rather than the volume** of care they provide.[1]



Alternative Payment Models (APMs)

APMs refer to **payment approaches that incentivize providers for delivering high-quality, cost-efficient care**, such as bonuses for achieving specified quality and cost benchmarks, or shared savings for delivering services at a lower cost.[1,2]

- APMs can apply to a provider type, clinical condition, care episode, or population.
- APMs vary by complexity and risk.[1,2]

[1] Centers for Medicare & Medicaid Services. Fact Sheet. Value-based Care State Medicaid Directors Letter. (September 15, 2020). https://www.cms.gov/newsroom/fact-sheets/value-based-care-state-medicaid-directors-letter.
[2] Health Care Payment Learning & Action Network (HCPLAN or LAN). APM Framework. (Released July 11, 2017). https://hcp-lan.org/apm-framework.

VBC SPREAD IN MEDICAID

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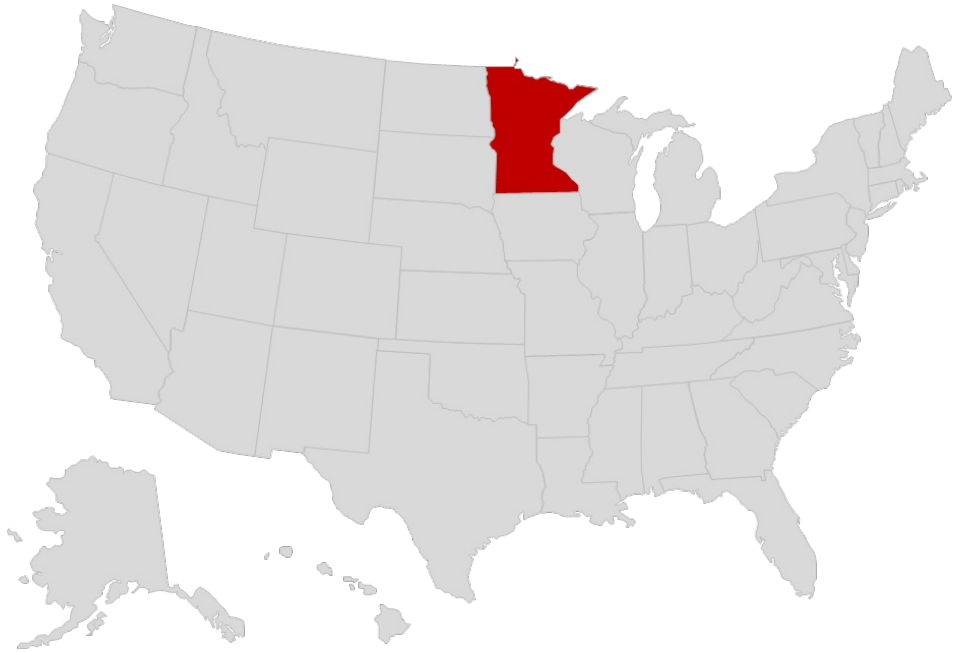
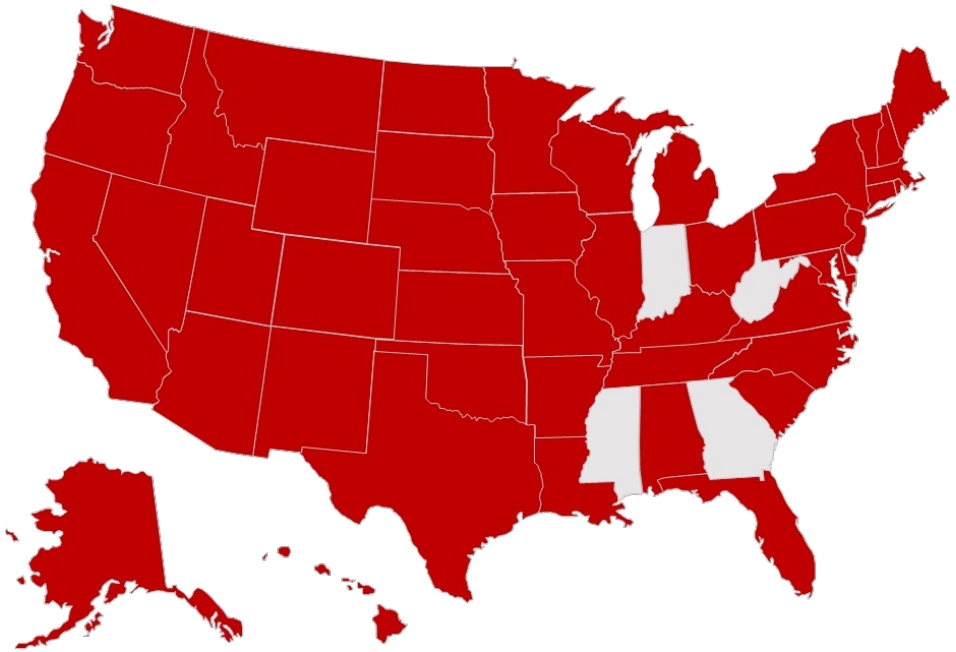
2008



2019



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PROGRESSION OF VALUE-BASED CARE

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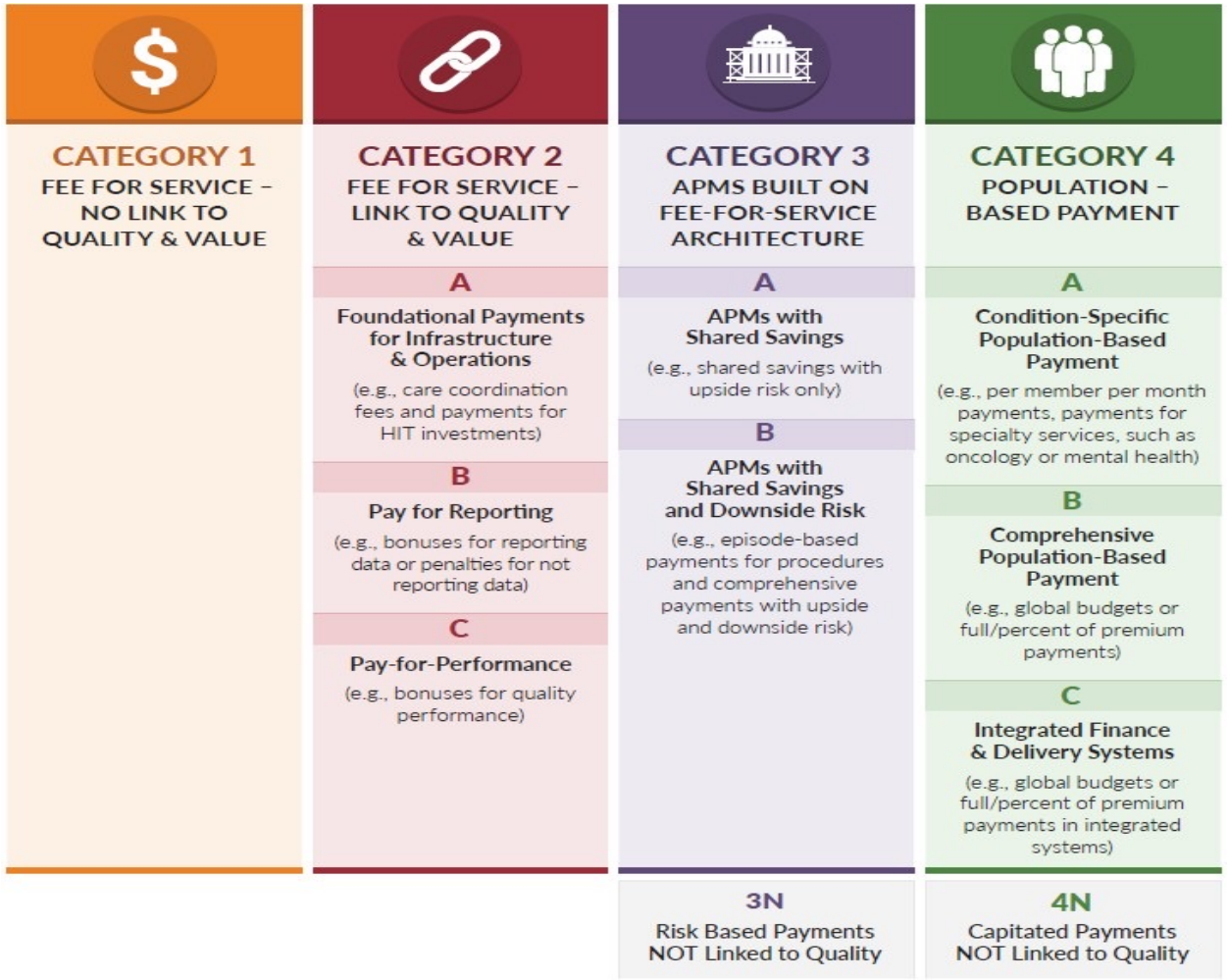

Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group. (January 12, 2016) *Alternative payment model (APM) framework*. Health Care Payment Learning & Action Network. https://hcp-lan.org/workproducts/apm-whitepaper.pdf

PROGRESSION OF VALUE-BASED CARE

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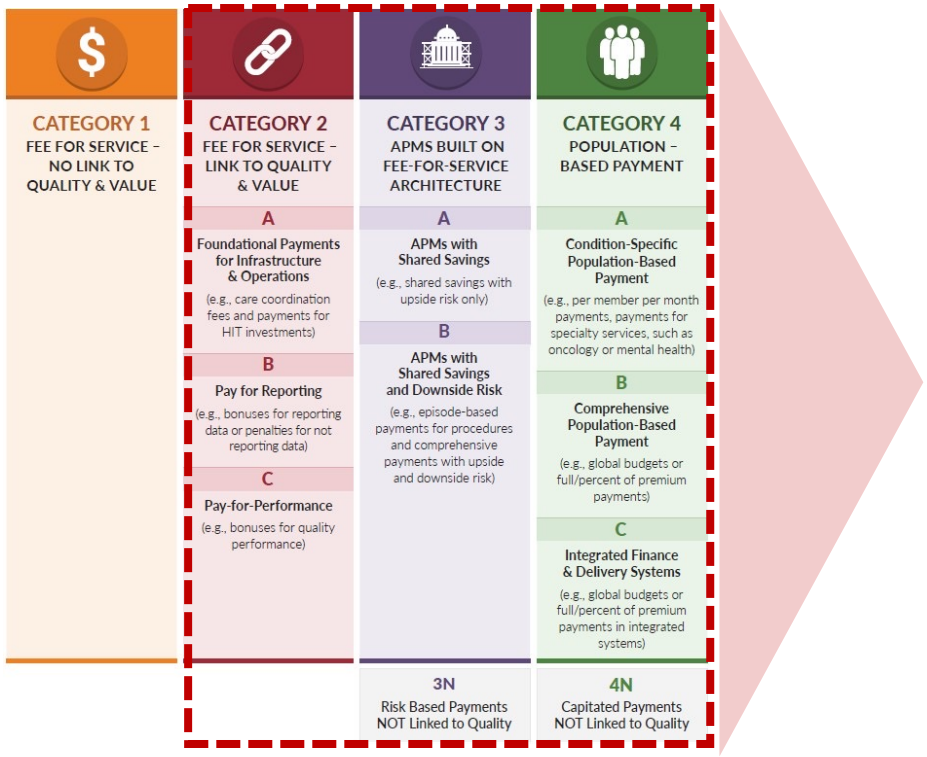

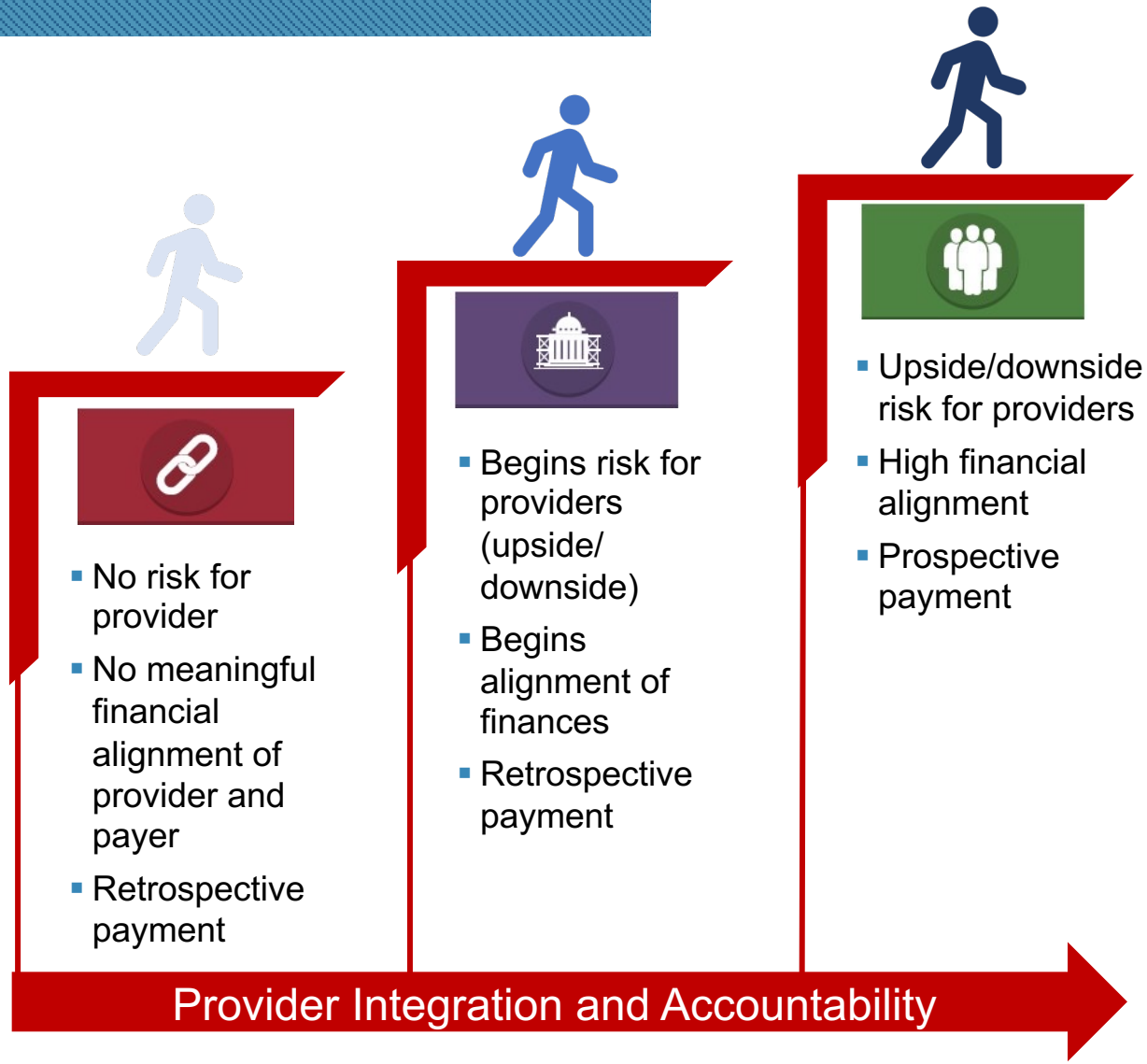

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ADDITIONAL ELEMENTS OF VBC DESIGN

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Provider Type:

Any provider type can be included in VBC

Different VBC programs are often available for different provider types (e.g., PCP, BH, Perinatal, hospital systems)

Structure:

Can be proprietary; can vary based on specific provider

Attribution (volume of patients/ services delivered) and level of sophistication and experience can influence payment arrangement offered

Measures:

Vary; generally align with:

- Metrics for which MCPs have financial accountability

- Areas considered most critical to patient overall health

- Areas where performance is low

VBC can look like:

- Measures that do not necessarily represent most of the care that a particular provider type provides
- Measures for which a particular provider type has only partial influence
- Opportunities where different provider types can work together to impact care

VALUE-BASED CARE IN DC MEDICAID

MEDICAID MANAGED CARE QUALITY AND VALUE-BASED PAYMENT IN THE DISTRICT

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The District's Department of Health Care Finance (DHCF) sets a multi-year Managed Care Quality Strategy to guide quality improvement in the District and align with the Centers for Medicare & Medicaid Services (CMS) National Quality Strategy.

The Quality Trickle-Down:

1. **Reporting**
2. **Performance Improvement**
3. **Value-Based Care**

CMS

Regulates State Medicaid Programs

1. District/states must **report** Adult and Child Core Set metrics

2. District/states must require their MCPs to **report** measures and conduct **performance improvement** projects

DHCF

Oversees DC Medicaid and MCPs

1. Sets Quality Strategy and required measures for MCP **reporting,** and performance benchmarks

2. Oversees measures, **performance improvement** projects

3. Determines **alternate payment options**, requires MCPs have VBC programs with providers, increasing over time

Medicaid MCPs

Contract with Medicaid Providers

1. Required to **report** on quality (Core Set measures)

2. Conduct **performance improvement** projects

3. Get **paid based on performance** on non-emergent ER use, potentially preventable hospitalizations and readmissions

Medicaid Providers

Accountability for Medicaid Population

1. Contribute/provide data for **reporting** (claims, clinical data)

2. MCPs involve providers in **performance improvement**

3. MCPs **pay providers in value-based care programs**

INCREASING VBC REQUIREMENTS IN DC MEDICAID

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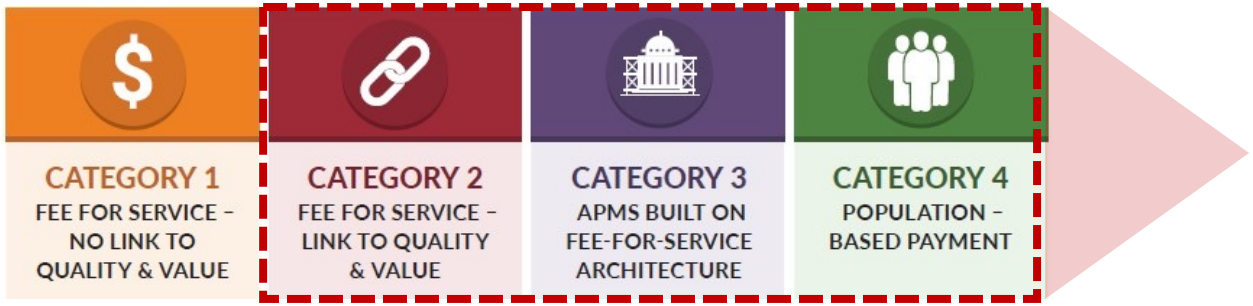

Over time, more Medicaid expenditures must be allocated toward more advanced levels of VBC:

CALENDAR YEAR	CATEGORY 2–4	CATEGORY 3–4
2024	30%	--
2025	40%	--
2026	50%	25%
2027	60%	30%
2028	70%	35%

Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group. (January 12, 2016) *Alternative payment model (APM) framework*. Health Care Payment Learning & Action Network. https://hcp-lan.org/workproducts/apm-whitepaper.pdf

DC MEDICAID VBC BY LEARNING & ACTION NETWORK (LAN) CATEGORY: CURRENT AND NEAR FUTURE STATE

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	Amerigroup District of Columbia	AmeriHealth Caritas District of Columbia	THE HSC HEALTH CARE SYSTEM Health Services for Children with Special Needs, Inc.	MedStar Family Choice
Primary Care	☑ (2C, 3A)	☑ (3A)	☑ (2C, 3A)	☑ (2C)
Maternal	☑ (2C)	☑ (2C)		**Future program, 2024*
Behavioral Health		☑ (3A)		**Future program, 2025*
Dental		☑ (2C)		
SDoH	☑ (2C)	(included in other incentive programs)		
Specialty			☑ (2C)	

Program eligibility varies based on size of member panel.

CROSS-CUTTING MEASURES IN KEY CONTENT AREAS

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	Amerigroup District of Columbia	AmeriHealth Caritas District of Columbia	THE HSC HEALTH CARE SYSTEM Health Services for Children with Special Needs, Inc.	MedStar Family Choice
CARE OF ACUTE AND CHRONIC CONDITIONS Potentially Avoidable Hospitalizations		✓ PCPs, BH		✓ PCPs
MATERNAL HEALTH Timeliness of Prenatal and Postpartum Care	✓ Maternal Health Providers	✓ Maternal Health Providers		
PEDIATRIC CARE Well-Child Visits (first 30 months of life, child and adolescent)	✓ PCPs	✓ PCPs (child and adolescent)	✓ PCPs	✓ PCPs

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THE IMPORTANCE OF VBC QUALITY IMPROVEMENT

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Value-based care is:

- A critical opportunity to support patient care and align patient outcomes with financial performance.
- An increasing proportion of health care finance; VBC performance will increasingly impact financial stability for DC Medicaid providers.

Understanding cross-cutting measures and VBC alignment across payers positions providers for success.

Practice transformation is needed: Focused improvement efforts on measures that matter is critical to provider success.

Support is available!

VALUE-BASED CARE LEARNING COLLABORATIVE:

Improve Quality, Outcomes, and Value in Health Care

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Improve Quality, Outcomes, and Value in Health Care

- Supports your practice's efforts related to value-based care:
  - Improve care for your population
  - Improve your practice's financial stability
- Access to quality improvement and clinical expertise; peer sharing
- Participation is free
- Commit to working in one of three tracks:

1

CARE OF ACUTE AND CHRONIC CONDITIONS

Successful management of conditions in the primary care setting to prevent costly hospital admissions.

2

MATERNAL HEALTH

Early access to care in pregnancy and postpartum to improve outcomes for pregnant individuals and children.

3

PEDIATRIC CARE

Access to well care to promote overall development and optimal health across the lifespan.

VBC COLLABORATIVE LEARNING CYCLES

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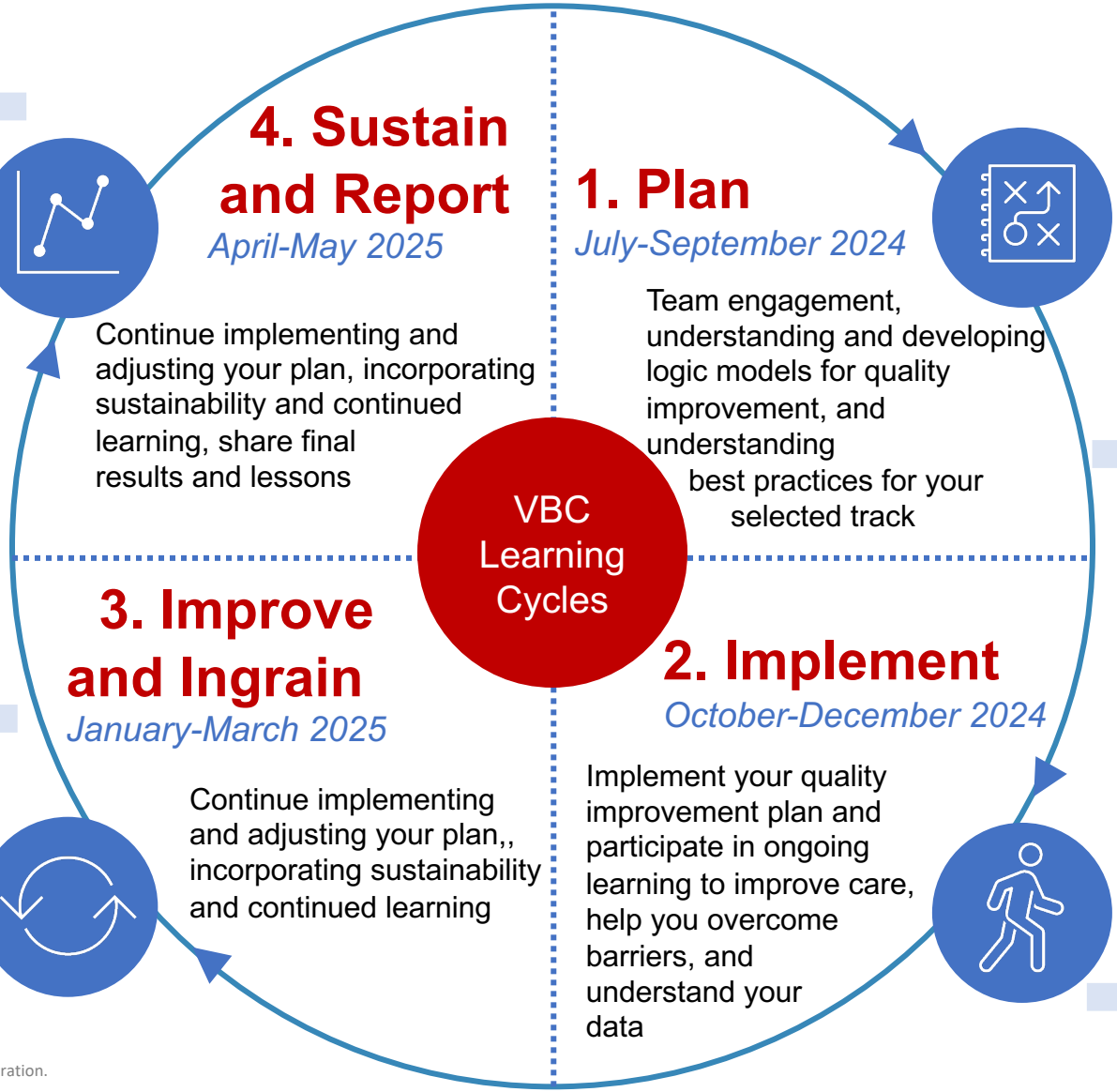

In-person event: October 2024

- *Share* your logic model and get feedback from peers
- *Learn* how to keep the momentum going through continued team engagement and overcoming barriers
- *Work* to develop a plan for mitigating potential barriers

In-person event: January 2025

- *Share* your progress and get feedback from peers
- *Learn* how to develop a plan for sustainability and spread
- *Work* to develop a plan for sustainability of quality improvement, and spread to other VBC metrics

Virtual event: April 2025

- *Share* your progress and get feedback from peers

In-person event: June 2025

- *Share* final lessons and get feedback from peers
- *Learn* the aggregated results and lessons learned
- *Celebrate* your and your peers' successes

CARE OF ACUTE AND CHRONIC CONDITIONS

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Acute and chronic conditions effectively managed in primary care and other non-acute settings can lead to a decrease in costly hospital admissions, which is better for the individual and the health care system.

POTENTIALLY AVOIDABLE HOSPITALIZATIONS

Initial hospitalizations for ambulatory care-sensitive conditions (ACSCs) for children and adults. Conditions include, for example, diabetes, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, gastroenteritis, or urinary tract infection.

Photo by CDC on Unsplash.

CARE OF ACUTE AND CHRONIC CONDITIONS

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» **The challenges:**

- Lack of condition-specific education
- Social drivers of health
- Minimal access to care

» **Best practices:** to address inefficient care delivery, lack of care coordination, patient education, provider follow-up, and medication reconciliation

» **What we'll do:** help you with chronic disease management, care coordination, increase provider productivity and optimization, improved patient outcomes and satisfaction

Photo by CDC on Unsplash.

MATERNAL HEALTH

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Positive maternal health outcomes depend on early detection of physical and behavioral health conditions.

TIMELINESS OF PRENATAL AND POSTPARTUM CARE

Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester.

Postpartum Care: Percentage of deliveries that had a postpartum visit 7 to 84 days after delivery.

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MATERNAL HEALTH

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- **The challenges:**
  - Social drivers of health
  - Timely and quality data
  - Standardized screening
  - Same-day access
  - Care coordination
  - Systemic bias

- **Best practices:** connect with patients early in their pregnancies and postpartum periods and evidence-based interventions that affect patient outcomes

- **What we'll do:** help you build connections with other providers, identify and track process measures, optimize workflows, and share screening tools and best practices

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PEDIATRIC CARE

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Well-child visits are important for health promotion and prevention, and provide opportunities to assess a child's physical, emotional, and social development.

WELL CHILD VISITS

- Six or more well-child visits before turning 15 months old.
- Two or more well-child visits between 15 and 30 months of age.
- At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner for individuals 3 to 21 years of age.

Photo by Jeffrey Riley on Unsplash

PEDIATRIC CARE

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- **The challenges:**
  - Parent/caregiver availability
  - Scheduling challenges (e.g., frequent visits, wait times)
  - Transportation
  - Health literacy
  - Perceived need
  - Fear/mistrust

- **Best practices:** for application at the provider/practice level to create better connections for patients and families to well-child/well-care visits

- **What we'll do:** help you explore and implement ways to better engage patients and families in care, improve workflows and processes, track measures, promote data-informed decisions, and plan for sustainability

Photo by Jeffrey Riley on Unsplash

WHAT LEARNING COLLABORATIVE PARTICIPATION LOOKS LIKE

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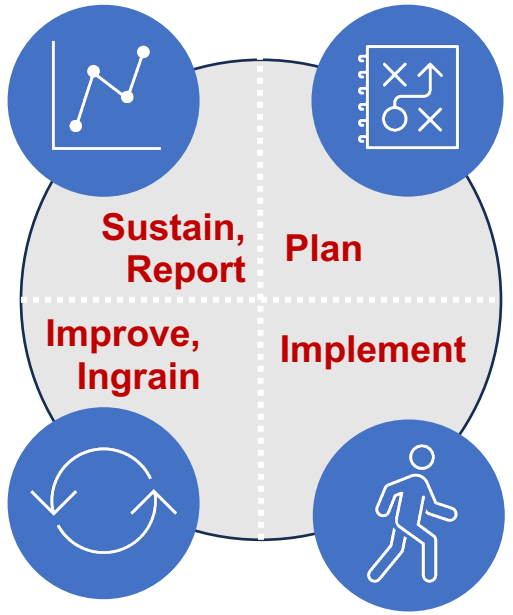
You'll Receive: Support, Technical Assistance, and Learning

- Learn best practices for improving care in VBC measures from experts
- QI approach for spreading these learnings across VBC measures
- Receive tailored group and individualized assistance opportunities
- Opportunities to share learnings across peers
- Opportunities to share your perspective and learnings with MCPs and the District

VBC Learning Cycle



WHAT LEARNING COLLABORATIVE PARTICIPATION LOOKS LIKE

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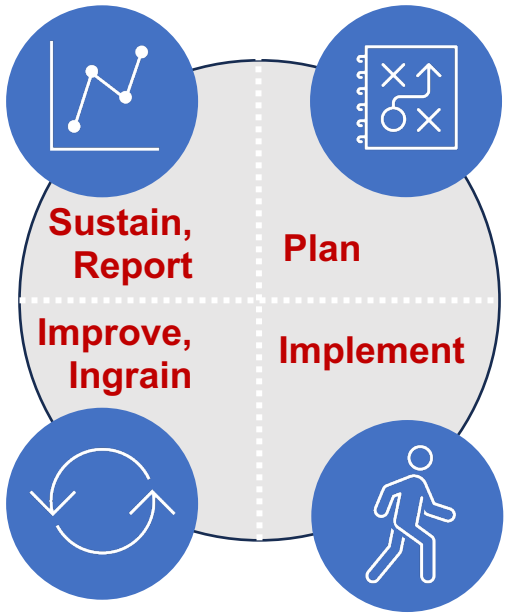
VBC Learning Cycle



What You'll Do: Commit, Work as a Team, Share the Results

- Commit to participation: Attend and actively participate in virtual and in-person sessions
- Work as a **team** in your organization (e.g., executive, quality, clinical, data/informatics) to complete assignments:
  - Assessment of VBC contracts
  - Logic model for improvement
  - Plan-Do-Study-Act (PDSA) cycles
  - Plan for mitigating barriers
  - Plan for sustaining and spreading the work
  - Collecting and reporting data
- **Become a value-based care leader**

NEXT STEPS

NEXT STEPS

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Join us in improving quality, outcomes and value!

» **Complete the Value-Based Care Application by July 15, 2024, to commit to participate and select your desired track.**

1

- Apply Now! Click the link in the chat box or scan the QR code to complete the assessment (takes less than 5 minutes). It will be also distributed to attendees after this call and will be available on our website.
- Office hours to assist with Application completion and to answer questions are available:
  - **June 24**, 4 pm – 5 pm ET; **June 25**, 11 am – 12 pm ET; **June 26**, 12 pm – 1 pm ET
- Individualized technical assistance is also available—just ask! Email support@integratedcaredc.com

» **Kick off work in your desired track: Once we've received your application, we'll communicate to you and send participants registration links for the initial track-specific webinar.**

2

- Care of Acute and Chronic Conditions: 7/30, 2 pm – 3 pm ET
- Maternal Health: 7/30, 12 pm – 1 pm ET
- Pediatric Care: 7/30, 1 pm – 2 pm ET

Q&A

WRAP UP AND NEXT STEPS

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- Please complete the online evaluation!
  - **If you would like to receive CE or CME credit, the evaluation will need to be completed.** You may use the link in the chat box or scan the QR code to access the evaluation.
- The webinar recording will be available within a few days at: www.integratedcaredc.com/learning
- For more information about Integrated Care DC, please visit: www.integratedcaredc.com

REFERENCE LIST

INTEGRATED CARE DC
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