PHM INITIATIVE

Aligning Strategic and Business Planning with Managed Care Plan Priorities

Including Case Studies from Community Health Centers

About This Presentation

This presentation walks through why Managed Care Plan (MCP) data matters with CHC business planning and how to utilize that data for quality improvement and strategic efforts.

There are two case studies from Venice Family Clinic and Northeast Valley Health Corporation that give successful examples of aligning strategic business planning with Managed Care Plan priorities. Each case walks through how they aligned with MCP data, how it impacted their overall strategic goals, and what successes and challenges they faced going through this process.

Why MCP Data Matters

Data Quality & Reporting

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PHMI Quality Measure Reporting is Aligned

1. With APM 2.0 measures
2. With DHCS MCAS measures
3. With DHCS' Comprehensive Quality Strategy Bold Goals
4. With MCP P4P measures

Importance of Alignment

- Most Medi-Cal patients are in MCPs
- MCPs are held accountable by DHCS for quality outcomes
- MCP performance expectations trickle down to CHCs

PHMI quality measure reporting will support the identification of opportunities and progress made in population health and will better position health centers for success in MCP P4P.

Supporting Foundational Competencies & Key Activities

Using HEDIS data for improvement can support the performance of these **foundational competencies**:

- Analyze core quality measures to identify inequities and improvement opportunities
- Assess current HIT capabilities and develop a plan for ongoing improvement in data utilization, care team workflows, and efficiency

Using HEDIS data for improvement can inform these **key activities**:

- Use a systematic approach to address inequities within the Population of Focus
- Use care gap reports to identify all patients eligible and due for care
- Coordinate care

Quality Measurements for PHMI

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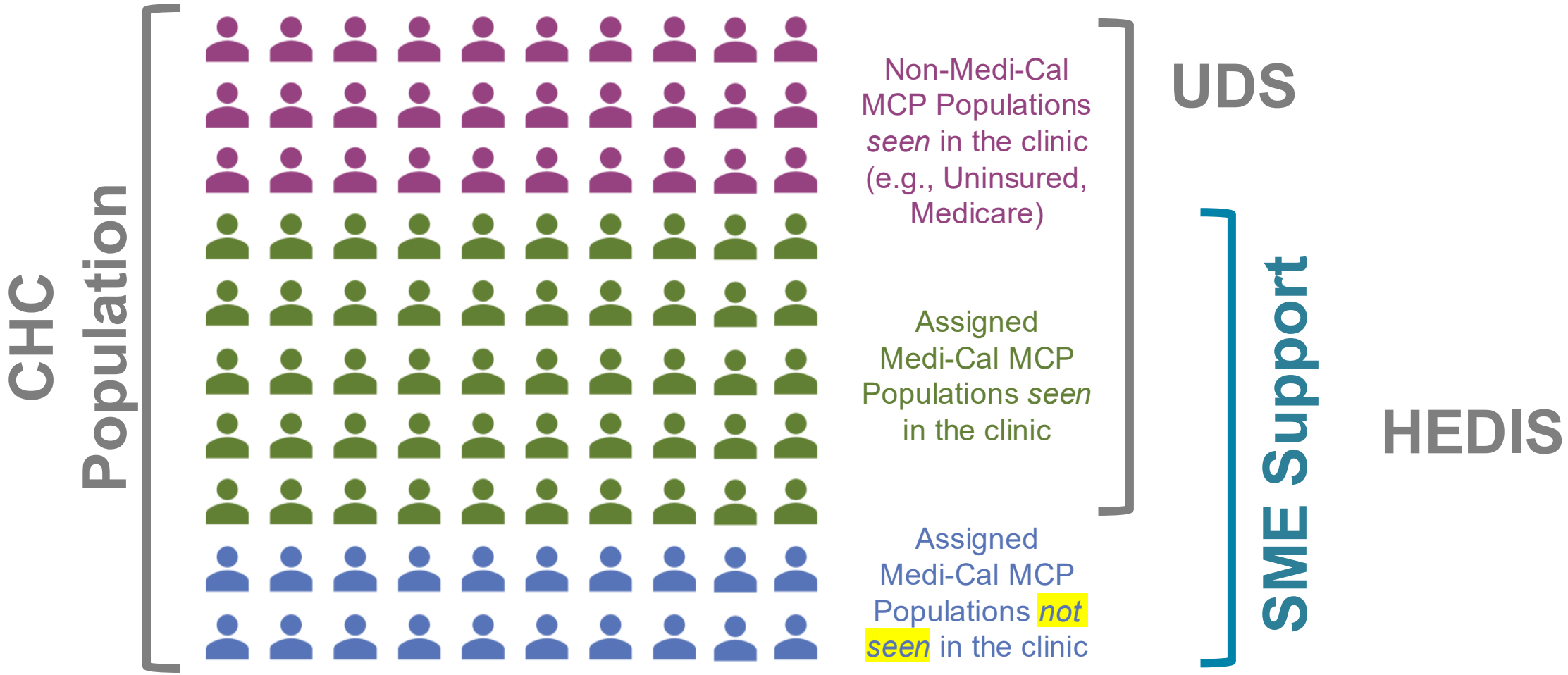
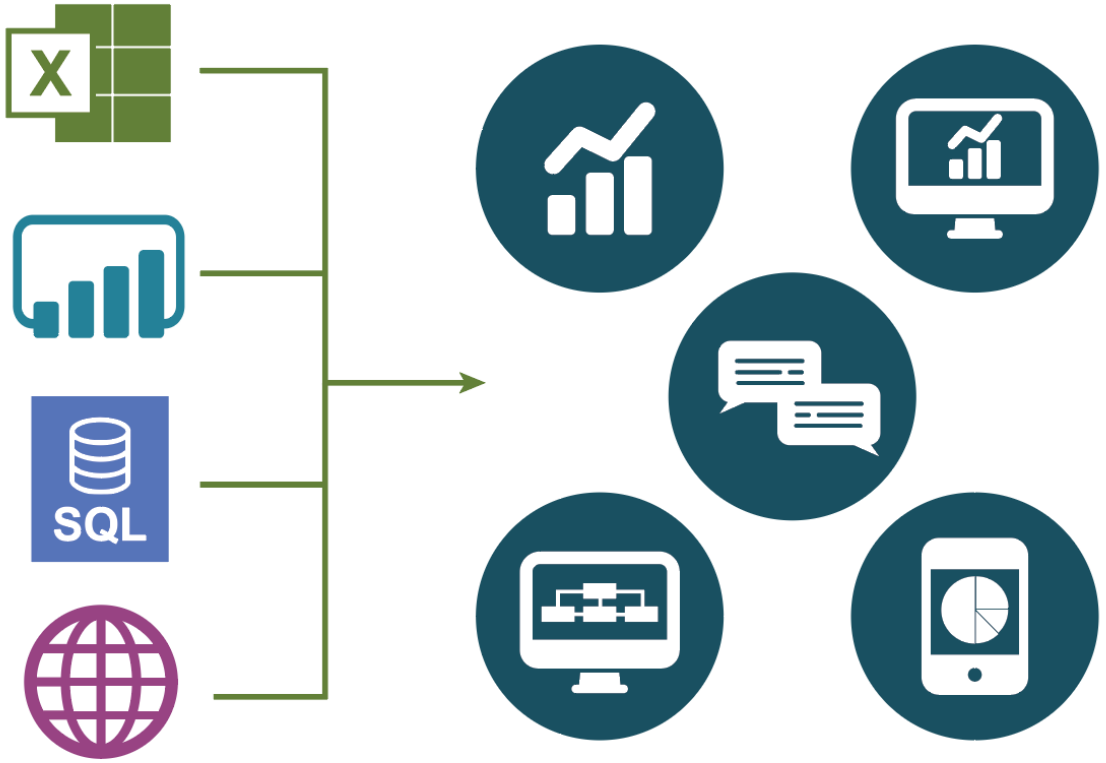


"Assigned MCP Medi-Cal Population" based on MCP plan assignment for the last month of the reporting period for MCP-attributed population eligible populations

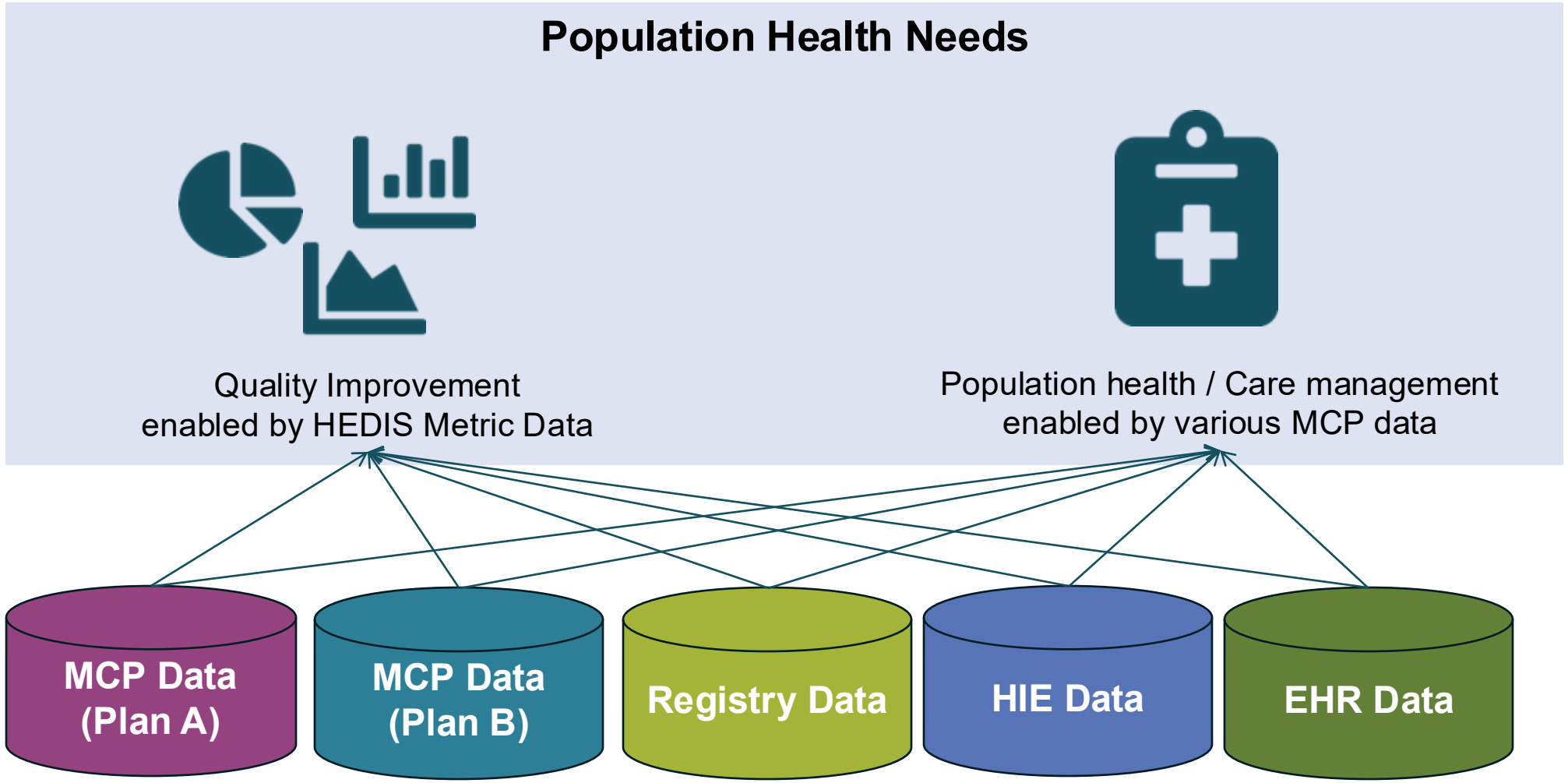
Assess Your HIT Environment to Identify the Best Tool for the Job

- **EHR:**
  Lots of data, limited reporting/analysis
- **PHM:**
  Population reporting, varying analysis
- **BI:**
  Interactive in-depth analysis
- **Excel:**
  Gap fill reporting, agile simple analysis



Two Main Use Cases for MCP Data & PHM

CHCs need Managed Care Plan data to meet two main needs: quality improvement and population health management



How CHCs benefit by Sharing Data

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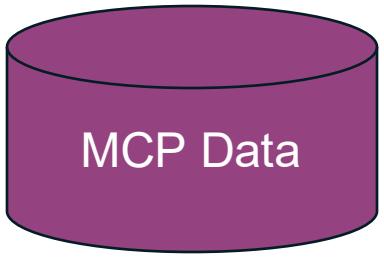
MCP data sharing with CHCs can enable a more holistic view of patient experience, proactive outreach, and actionable point of care decisioning.

Input



(e.g., raw claims data or data from other tools that have been invested in to share data with CHCs – e.g., Cozeva)

- **Harmonized, enabling views**: Integrating data (examples below) from disparate sources helps to better enable providers and care management teams.
  1. Claims data with EHR, Registry, etc..
  2. Across all CHC populations, including aggregate Medicaid MCP attributed populations
  3. Across various time periods, including rolling years
- **Proactive outreach**: Utilize analytics to more effectively target and manage populations rather than just reacting to illness
- **Point of Care actionability:** Leverage insights at the point of care to better enable individual care.*

** PHMI is providing active support to improve the use of data that is being made available to CHCs*

How MCPs can benefit by Sharing Data with CHCs for Pop Health

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MCP data sharing with CHCs will enable them to improve performance on key quality measures and succeed in MCP P4Ps, better identify and manage key assigned populations to improve specific outcomes and partner with MCPs on high risk/cost populations, and position CHCs for success in value-based contracting.

Performance Expectations: MCPs are held accountable by DHCS for quality outcomes & MCP performance expectations trickle down: CHC improvements in quality measures positively impact MCP's

Social Care Needs: Improve CHC ability to respond to social care needs with goal of impacting medical utilization and cost

Targeting Populations: Enable CHC to more effectively target high risk/high-cost populations through access to more detailed information from other settings

Insights: Combining MCP claims/encounter data with the wealth of detailed clinical data from CHC provides more accurate and detailed information to both CHCs and MCPs

Value-Based Care: Support efforts to encourage CHC's to advance in value-based care arrangements through visibility into care delivery outside CHC

Transitions in Care: Support efforts to manage transitions in care

Data Needs for PHM Platform

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Data Type	Description and Provider Use	DxF Crosswalk	Recommended Lookback	Frequency of Data Updates
Enrollment/ Eligibility	**Demographic data for members eligible for medical, pharmacy, and BH benefits.** Provides information on empanelment, identification of assigned but not seen patients, and supports practice/site analytics.	2023 Interoperability Standards Advisory (healthit.gov) Pg 240	At minimum 2 years	Monthly
Medical Claims	**Service-level remittance with clinical diagnosis codes and medical procedure codes.** No cost data to be included. Provides information about care provided outside practice.	Data Elements to Be Exchanged (OPP-8) DSA Data Elements to be Exchanged PP (ca.gov)		
Pharmacy Claims	**Service-level remittance with drug-dispensing, pharmacy and prescribing physician**, including references to the NCPDP Uniform Healthcare Payer Data Standard. Provide information about medications that have been filled/dispensed.	Data Elements to Be Exchanged (OPP-8) Medi-Cal Rx Pharmacy data: APL 22-012.		
Behavioral Health Claims	**Service-level remittance with BH diagnosis codes, procedures**. No cost data to be included. Provides information about BH services provided outside the practice.	Data Elements to Be Exchanged (OPP-8)		
Member Assessments & Care Plans performed by MCP/other providers (if available)	**Assessment and Care Plan data represents information about a patient's medical observations** including the result (i.e. assessment) and other relevant data as represented in an HL7 ORU Message. Provides information on patient's new and ongoing conditions.	Data Elements to Be Exchanged (OPP-8)		
Admit Discharge Transfer (ADT)	**Hospital ED and inpatient discharge including date(s) of service, diagnosis, facility**. Provides real-time information on when and where patients have been admitted, transferred, and discharged.	Technical Requirements for Exchange (OPP-9) CalHHS Technical Requirements for Exchange PP	N/A	N/A

Data in Action

CHC Capacity Building for HEDIS Measures

People

- Training on measure definitions
- Training on EHR and PHM documentation and coding

Process

- Reporting on attributed populations in MCO, EHR and PHM platforms
- Strengthening data quality for measure accuracy and validity
- Reporting segmentation by site, race/ethnicity and product line

Technology

- Optimizing EHR and PHM documentation and workflows

Using HEDIS to Identify and Address Disparities

Strengthen Data Quality:

- Collect high-quality, comprehensive data including REAL (Race, Ethnicity, and Language) and SOGI (Sexual Orientation and Gender Identity).
- Use this data to understand and address disparities in access, continuity and health outcomes.

Look Beyond Aggregated Data: Identify subpopulations with lower care rates and different support needs.

Recognize Disparities: Even with high HEDIS scores, significant racial and sociodemographic disparities may persist.

Tailor Care Delivery: Address specific needs of subpopulations and structural barriers to health.

Utilize Imperfect Data: Even incomplete data on race, ethnicity, sexual orientation, gender identity, and social needs can guide care improvements.

Population of Focus Measures for Quality Improvement

Assess Measure Change – EXAMPLE 1

Change in CHC rates over time

There may be small differences due to rounding between the listed percentage point difference and what you would get if you were to subtract the two rates.

			Oct 1 2022 to Sep 30 2023	CY 2023	Percentage point difference
Prevention: adults	Colorectal cancer screening	PHMI-HEDIS	28.0%	42.5%	14.6
		UDS	37.8%	35.3%	-2.5

Measure improved. Or did it?

Change in CHC denominators over time

			Oct 1 2022 to Sep 30 2023	CY 2023	% difference
Prevention: adults	Colorectal cancer screening	PHMI-HEDIS	2,336	1,068	-54.3%
		UDS	2,099	2,124	1.2%

Assess data quality – validate denominator total.

Population of Focus Measures for Quality Improvement

Assess Measure Change – EXAMPLE 2

Change in CHC rates over time

			10/1/22 to 9/30/23	CY 2023	7/1/23 to 6/30/24	Percentage point difference CY 2023	Percentage point difference 7/1/23 to 6/30/24
Prevention: adults	Colorectal cancer screening	PHMI-HEDIS	28.0%	42.5%	33.2%	14.6	-9.3
		UDS	37.8%	35.3%	39.3%	-2.5	4.0

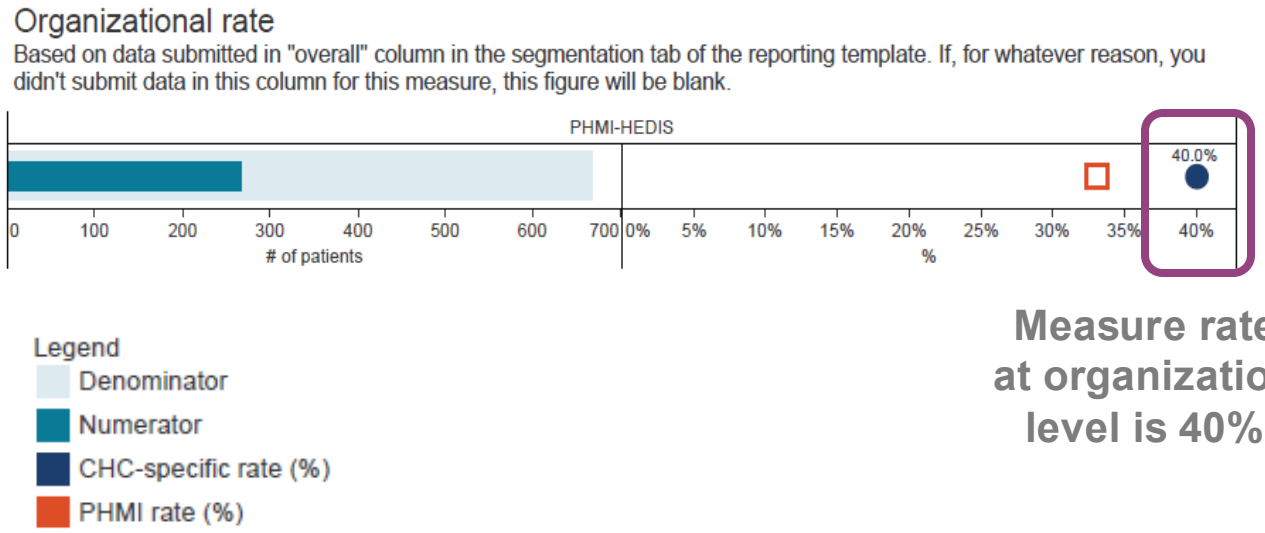
Measure declined. Or did it?

Change in CHC denominators over time

			10/1/22 to 9/30/23	CY 2023	7/1/23 to 6/30/24	% difference CY 2023	% difference 7/1/23 to 6/30/24
Prevention: adults	Colorectal cancer screening	PHMI-HEDIS	2,336	1,068	1,406	-54.3%	31.6%
		UDS	2,099	2,124	1,515	1.2%	-28.7%

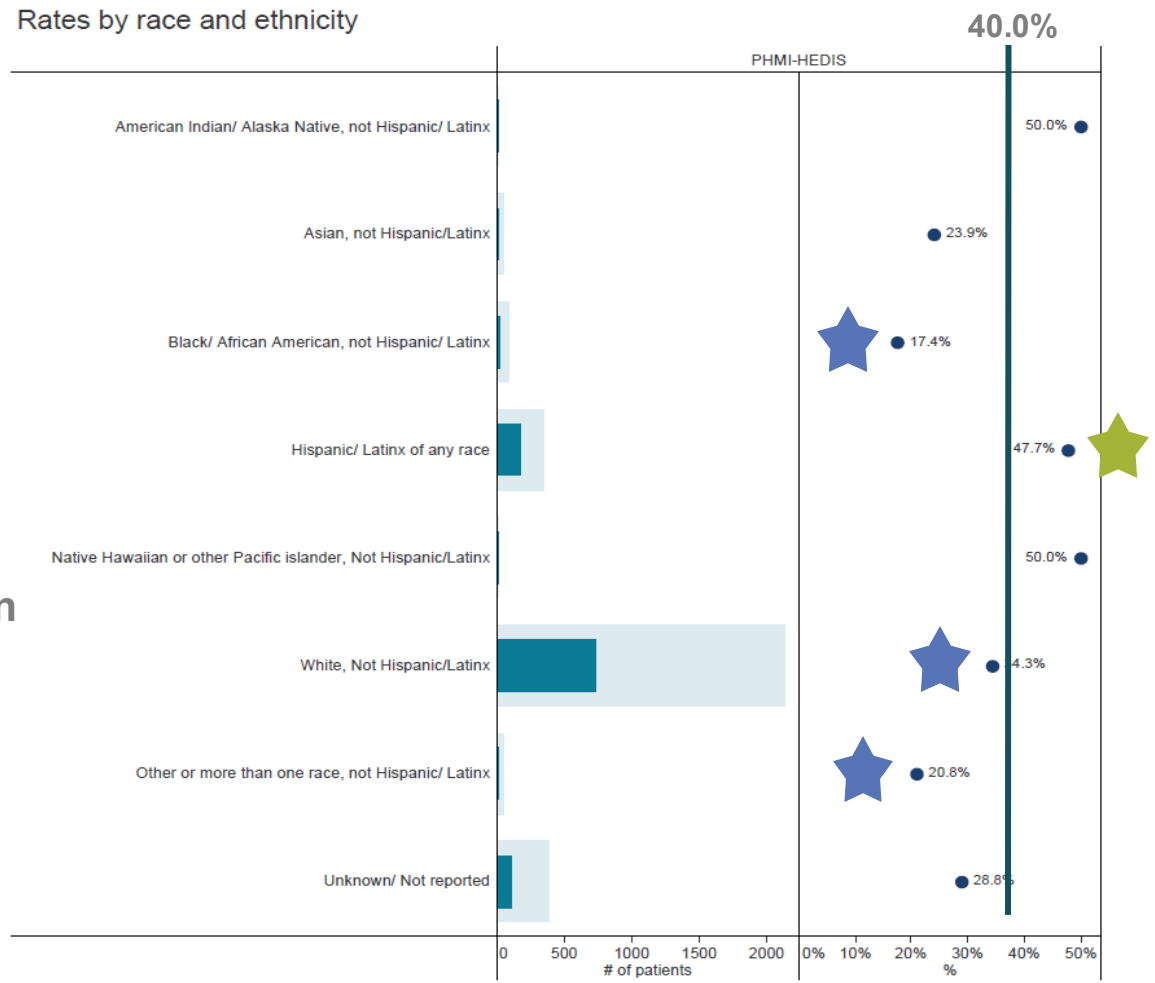
Improved data quality by capturing more patients that were assigned by MCO

Race/Ethnicity Segmentation: Assessing Equitable Care



Measure rate at organization level is 40%

Are any race/ethnicity segments different from the organization total?



Statistical techniques sift out meaningful differences

IHQC Quality Improvement Summit

Integrating Managed Care Plan Data for Quality Improvement and Population Health Management

September 17, 2025

Fred Dolgin
Chief Operations Officer

Venice Family Clinic

About Venice Family Clinic

Our legacy

Founded in 1970 by volunteers as a free clinic. Federally Qualified Health Center (FQHC) since 2012.

Merged with South Bay Family Health Care in 2021. Now the largest provider of health care to people on Medi-Cal serving communities from the Santa Monica through the South Bay.

Our model

Comprehensive, whole-person health care that addresses the physical, social and environmental factors that impact health

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Comprehensive, integrated health care

- MEDICAL CARE
- DENTAL CARE
- BEHAVIORAL HEALTH
- VISION CARE
- EARLY HEAD START
- HOMELESS SERVICES & STREET MEDICINE
- REPRODUCTIVE HEALTH
- SUBSTANCE USE TREATMENT
- HEALTH & WELLNESS EDUCATION
- DOMESTIC VIOLENCE INTERVENTION
- INTEGRATIVE MEDICINE
- PHARMACY SERVICES
- HIV/AIDS CARE
- PRENATAL CARE
- SUPPORT GROUPS

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Expansive reach and impact

- A network of clinical sites, Early Head Start locations and mobile clinics plus an expansive street medicine program to reach people experiencing homelessness
- Programs and services that reach people from the Santa Monica Mountains through the South Bay

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Our Systems

nextgen healthcare → OCHIN

Applied Research Works, Inc. COZEVA®

azara healthcare

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Category	Cozeva (MCP Data)	EHR / Azara (Internal Data)
About the platform	❖ Web-based population health platform (via Healthcare LA IPA) ❖ Provides gaps-in-care reports for all MCPs ❖ Shows assigned members and compliance by measure ❖ Supports supplemental data submission	❖ OHCIN Epic = clinical system of record ❖ Azara DRVS = population health tool ❖ Detailed documentation of services provided in clinic ❖ Structured fields: labs, vitals, screenings, immunizations ❖ Contains reports received and entered into chart (e.g., mammograms)
Expected to show	❖ Administrative Data = Services billed via claims ❖ Well-child visits ❖ Mammograms (billed by imaging center) ❖ Labs processed through Quest and billed to MCP	❖ Detailed screenings ❖ Depression Screening ❖ Developmental Screening ❖ Point-of-care test results ❖ Outside reports received and documented in chart
Might be missing	❖ Data without CPT-2 codes (e.g., blood pressure control) ❖ Historical services before Medi-Cal enrollment ❖ Point-of-care results not coded on claim	❖ Services not documented or reports not received by VFC (e.g., Colonoscopy report not forwarded by specialist) ❖ Vaccines given elsewhere ❖ Well-child visits prior to establishing care

Objectives for this Work

Ensure MCP data reflects the care provided

- Get credit for our work
- Build trust in data

Maintain up-to-date, comprehensive medical records

- Provide care teams with the information they need to care of the patients

Run an effective population health program that improves outcomes

- Make the most of limited access and resources
- Accurately identify true gaps in care

Leverage pay-for-performance opportunities

- Additional support for clinic programs that otherwise would not be reimbursed

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Data Reconciliation Process
Example: Breast Cancer Screening

Cozeva (MCP Data)	EHR / Azara (Internal Data)	Action
✅ Compliant	✅ Compliant	No action needed
✅ Compliant	❌ Non-compliant	Potential chart update (track down report, update Epic)
❌ Non-compliant	✅ Compliant	Potential supplemental data submission (to MCP via Cozeva)
❌ Non-compliant	❌ Non-compliant	Target for outreach to schedule breast cancer screening

- Start with Cozeva list of members eligible for the measure
- Compare compliance in Cozeva vs. Azara (Epic data)
- Next steps depend on which system shows compliance

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Standard vs Non-Standard Supplemental Data

Standard

- Exported from the EHR in required format (via MedPoint)
- Includes codes and values to assess compliance
- Example: blood pressure readings submitted when CPT-2 codes are not included on claims

Non-Standard

- Manual uploads into Cozeva
- Reports or documents not captured as structured data
- Example: mammogram report uploaded to Cozeva so compliance is credited

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Successes

- Expanded supplemental data submissions (standard and non-standard)
- Educated staff on importance of MCP metrics
- YTD HEDIS performance reviewed at least Monthly (more frequently by QI Team)
- Implemented system upgrades:
    - Increased Cozeva utilization
    - Automated coding in OCHIN Epic (CPT II codes for BP, for example)
    - Exploring integration of payer data into Azara DRVS

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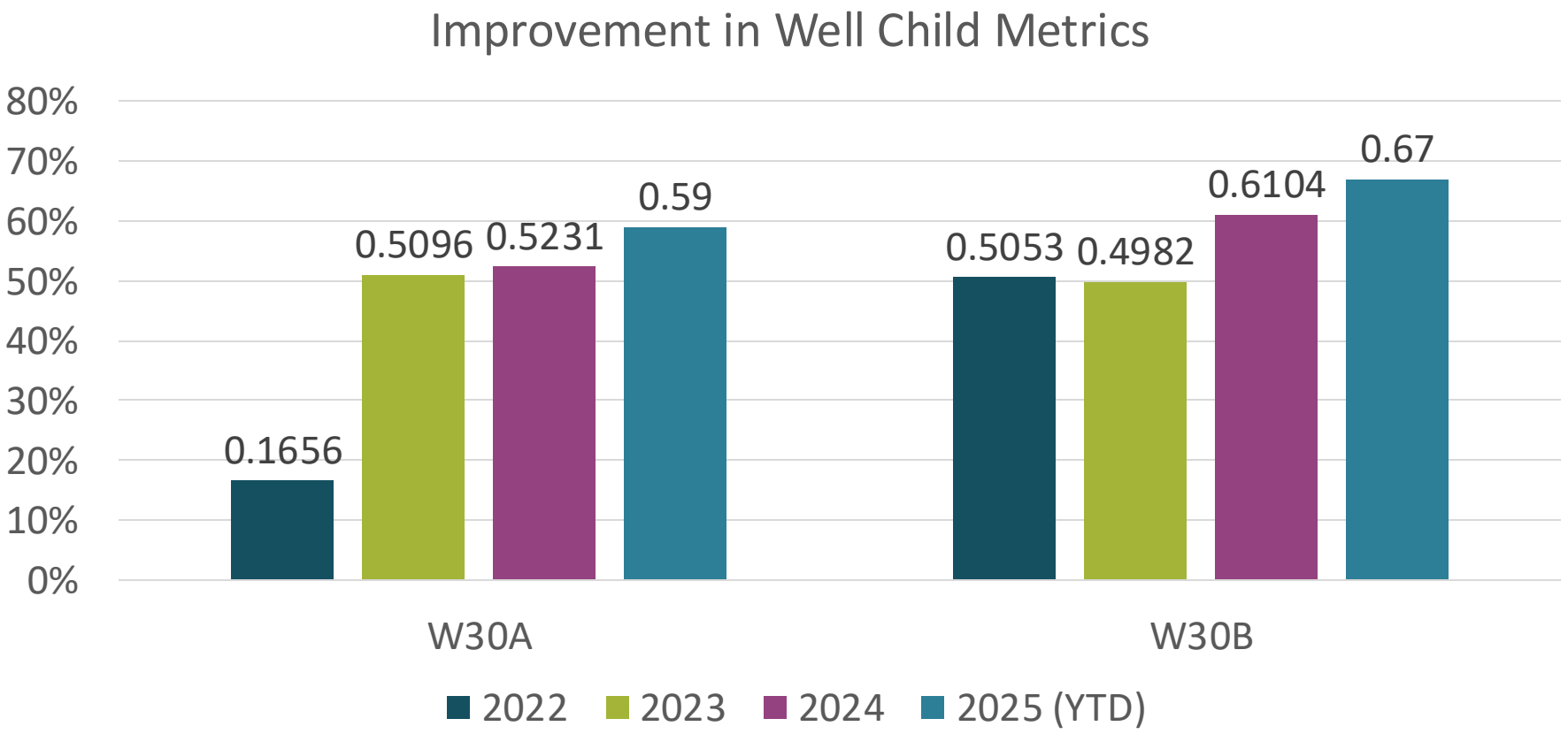
Improvement in HEDIS Metrics – Well Child Exams



2025 results reflect year-to-date performance through September. Even with an incomplete year, we are already exceeding 2024 results and expect continued improvement by year-end.

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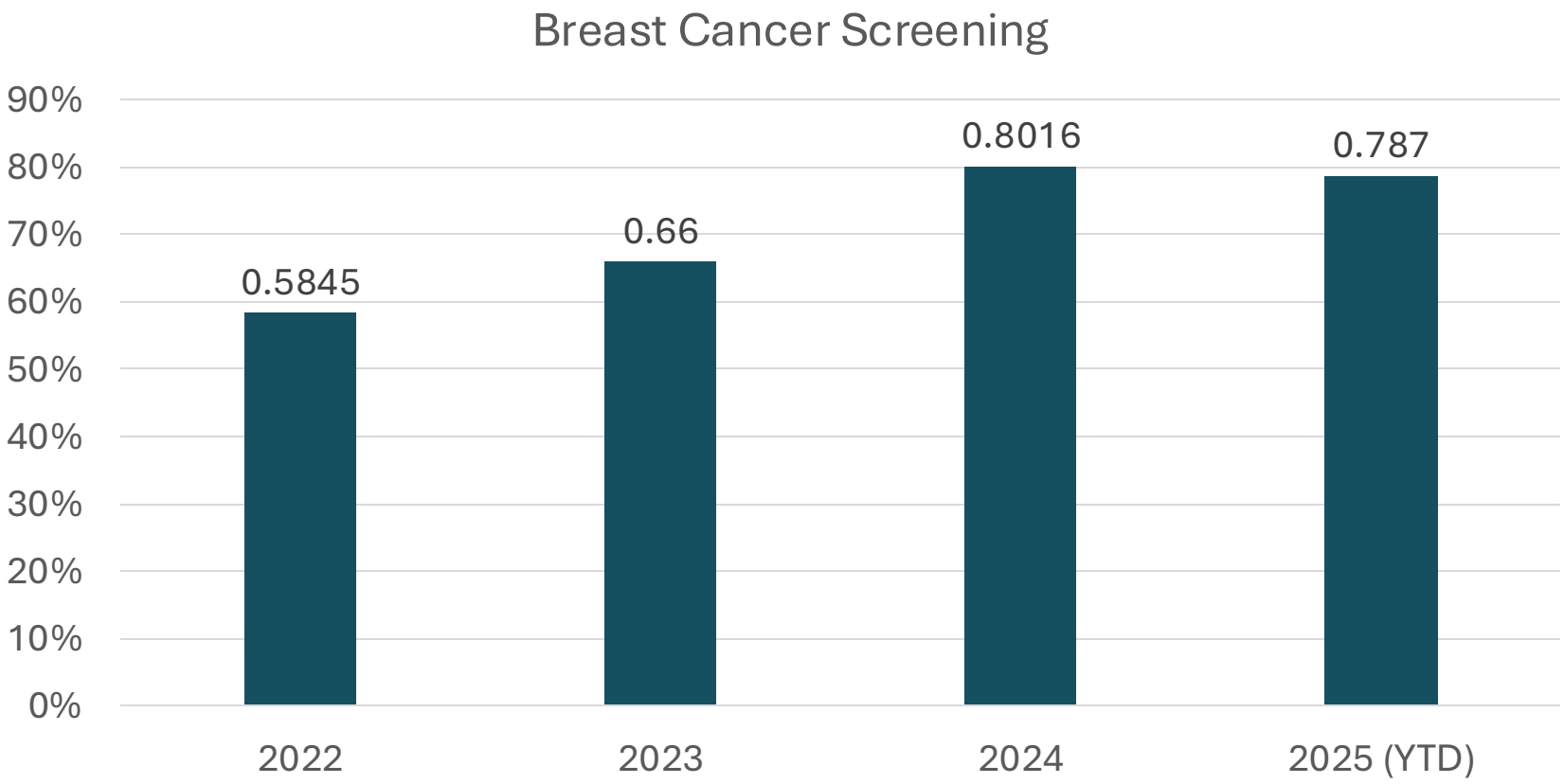
Improvement in UDS Metrics – Breast Cancer Screening



Best Practices

- Understand what to expect in each system (not complete on its own)
- Focus outreach on true care gaps
- Start reconciliation and outreach early in the year
    - Use DOB/quarterly lists to spread workload
- Track performance throughout the year vs. prior years

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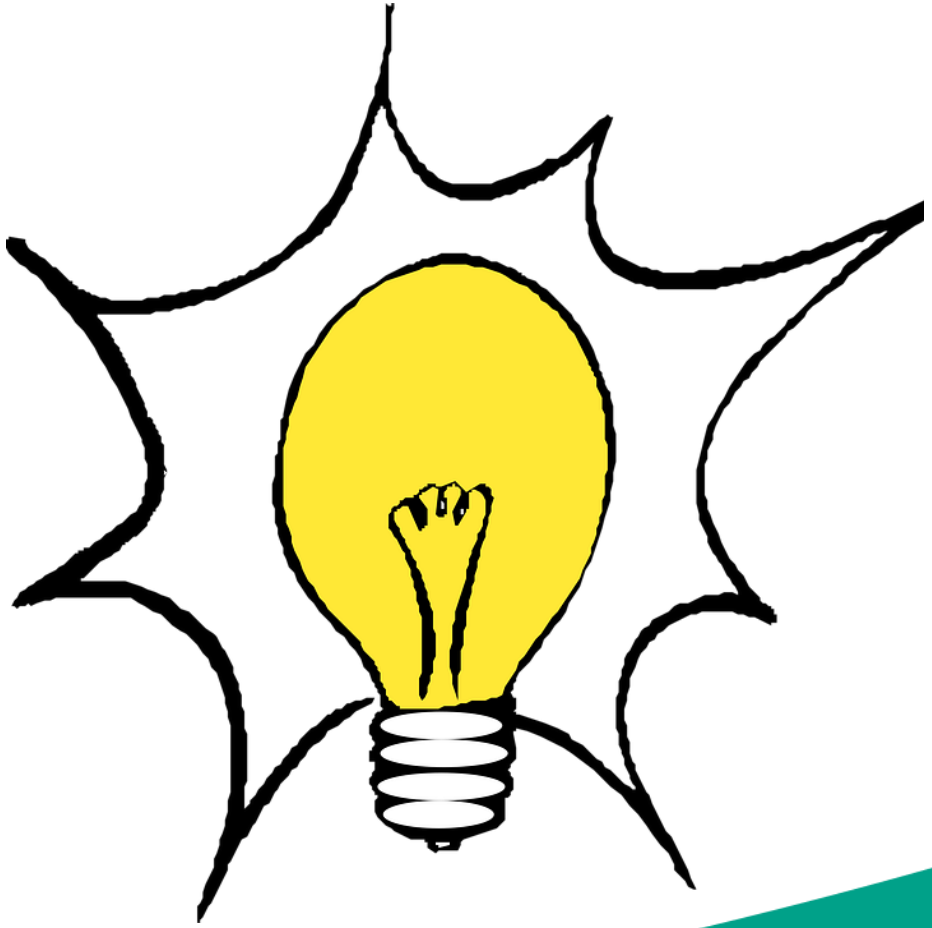
Lessons Learned

- No system is fully accurate; each has gaps
- Do not assume MCP data is comprehensive (example: vaccines)
- Performance gains often rely on supplemental data
- After reconciliation, the harder work is engaging assigned-but-not-seen patients
- Create systematic strategies (example: automate CPT-2 codes)



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Challenges

- Manual reconciliation and report tracking across systems
- Lack of ongoing MCP data feed into reporting software
- Limited appointment access requires careful, strategic outreach
- Reaching assigned-but-not-seen patients is the biggest challenge

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Value Proposition

Ensure MCP data reflects the care provided

- Get credit for our work
- Build trust in data

Maintain up-to-date, comprehensive medical records

- Provide care teams with the information they need to care of the patients

Run an effective population health program that improves outcomes

- Make the most of limited access and resources
- Accurately identify true gaps in care

Leverage pay-for-performance opportunities

- Additional support for clinic programs that otherwise would not be reimbursed

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Thank You!

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Northeast Valley Health Corporation
a california health+ center

IHQC Summit

September 17th, 2025

Integrating Managed Care Plan Data for Quality Improvement and Population Health Management

Presented by:

Debra Rosen, RN, MPH

Director, Special Projects

Northeast Valley Health Corporation (NEVHC)

- PCMH & Joint Commission Accredited FQHC
- Los Angeles County (SPA 2)
- 18 licensed clinic sites
- 99,830+ patients
  - 315K+ visits in 2024
- 90.5% <200% of FPL
- Patient Ages:
  - 34% ages 0-17;
  - 66% 18 & up

Why we need integrated data

- NEVHC User data
  - Electronic Health Record - NG
  - Population Management Tool i2i Tracks
    - Identify Care Gaps within the EHR
    - Outreach to users with Care Gaps

- NEVHC Member data
  - Medpoint COZEVA (provides data from all five MCPS)
  - PHMI Platform
    - Identify Care Gaps within EHR, and through 3rd party data
    - Outreach to users and members with Care Gaps

Successes

- NEVHC: PHMI Data Quality & Reporting
  - Accessed data from Cozeva
    - Denominator and Numerator (compliance with HEDIS metrics)
  - Matched data to existing users in our EHR
    - Added compliance from our EHR to the numerator
  - Future expectation is for NEVHC to report data on both users and assigned members using the PHMI Platform
- Accessing 3rd party data on users as well as assigned members
  - Results in a larger more accurate denominator for HEDIS/MCAS rates
  - Improved HEDIS/MCAS rates reflecting EHR and 3rd party data (better capture of numerator)

COZEVA Data "Member Data"

MCAS Measures 2025												
2024	Abbrev.	Measure	50th Percentile 2025	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025	July 2025	August 2025	# of Patients to the 50th percentile
63.39%	BCS	Breast Cancer Screening	52.60%	49.37%	51.02%	52.42%	53.58%	54.47%	55.59%	56.22%	53.90%	544 to 75th
66.18%	LSC	**Lead Screening in Children**	63.84%	50.50%	60.48%	62.14%	64.08%	65.24%	66.38%	66.81%	68.07%	43 to 75th
53.79%	CCS	**Cervical Cancer Screening**	57.18%	40.71%	42.14%	43.79%	45.81%	46.46%	47.68%	48.37%	50.04%	2092
29.78%	CIS-10	**Childhood Immunizations**	27.49%	11.65%	13.78%	18.73%	23.84%	26.16%	27.90%	28.15%	30.23%	64 to th 75th
71.00%	GSD2	Glycemic Status Assessment for Patients with Diabetes (Glycemic Status <=9.0%)	66.67%	9.73%	23.71%	38.88%	51.04%	54.79%	59.07%	60.63%	64.95%	112
66.00%	CBP	Controlling Blood Pressure	64.48%	8.04%	15.59%	14.84%	14.18%	45.93%	50.20%	52.68%	56.59%	458
45.15%	IMA-2	Adolescent Immunizations	34.30%	30.82%	32.25%	35.34%	38.16%	40.88%	43.18%	44.07%	47.32%	29 to 90th
88.93%	PPC-PRE	PPC - Prenatal Care	84.55%	89.45%	91.04%	90.89%	89.11%	88.80%	89.64%	89.71%	89.11%	26 to 90th
89.74%	PPC-PST	PPC - Postpartum Care	80.23%	79.75%	84.10%	85.19%	86.93%	87.46%	88.79%	89.44%	89.34%	100 to 100th
67.56%	W30A	**Well Child Exams 0-15**	60.38%	12.77%	23.66%	29.33%	37.34%	43.90%	48.83%	51.11%	62.02%	23 to 75th
68.84%	W30B	**Well Child Exams 15-30**	69.43%	49.97%	56.06%	59.68%	63.01%	64.17%	67.05%	68.75%	70.20%	42 to 75th
45.98%	WCV	**Well Child and Adolescent visits**	51.81%	1.28%	4.43%	8.23%	12.52%	14.53%	19.12%	20.89%	28.81%	9238
37.28%	COL	Colorectal Cancer Screening	38.07%	13.21%	13.71%	14.50%	15.32%	16.75%	17.77%	21.30%	22.00%	2807
30.59%	DSF-E	Depression Screening	1.03%	0.01%	0.02%	0.05%	0.11%	0.16%	0.18%	0.21%	3.87%	
77.58%	CHL	Chlamydia Screening	56.0%	37.16%	43.91%	52.74%	62.16%	64.79%	67.74%	69.54%	72.35%	784 to 100%
62.33%	DEV	Developmental Screening in the first 3 years	34.70%	34.55%	39.58%	44.62%	49.56%	51.58%	55.57%	56.36%	61.04%	593 to 90th
60.63	AMR	Asthma Medication Ratio	65.61%		75.00%	80.95%	70.78%	71.23%	69.75%	69.64%	70.38%	6 to 75th
	TFL-CH	Topical Fluoride for Children	50.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7411
19.17%	FUM	Behavioral Health FUM follow up within 30 days	53.82%	0%	21.74%	14.95%	18.13%	19.23%	20.86%	21.30%	18.83%	168
19.18%	FUA	Behavioral Health FUA follow up within 30 days	36.18%			20.69%	16.33%	16.10%	18.42%	18.44%	20.00%	41

Managing Data Discrepancies Best practices

- **Automated Supplemental Data**
  - Submitted monthly to MedPoint Management
    - BP Values, Fit Kit labs, HbA1c Labs, Depression Screening (LOINC Codes)

- **Manual Supplemental Data**
  - Submit directly into COZEVA
    - W30A (0-15mo)
    - Newborn Visits are billed to the mother's insurance. NEVHC submits nursery visits and 2-week WCE as supplemental Data

JM

← Quality Gap Details

Breast Cancer Screening

2025 2024

Status	Closed on	Source
CLOSED	03/01/2024	BH Anthem Blue Cross

More information

https://www.ncqa.org/hedis/measures/breast-cancer-screening/

Source: National Committee for Quality Assurance

EVIDENCE

Claims/EHR | Manual entry

Tomosynthesis, mammo - - G0279

Service date:	02/29/2024
Servicing provider:	KECK MEDICAL CENTER OF USC
Facility:	KECK MEDICAL CENTER OF USC
Contact:	3238653868, 3234422844
Source:	Claims

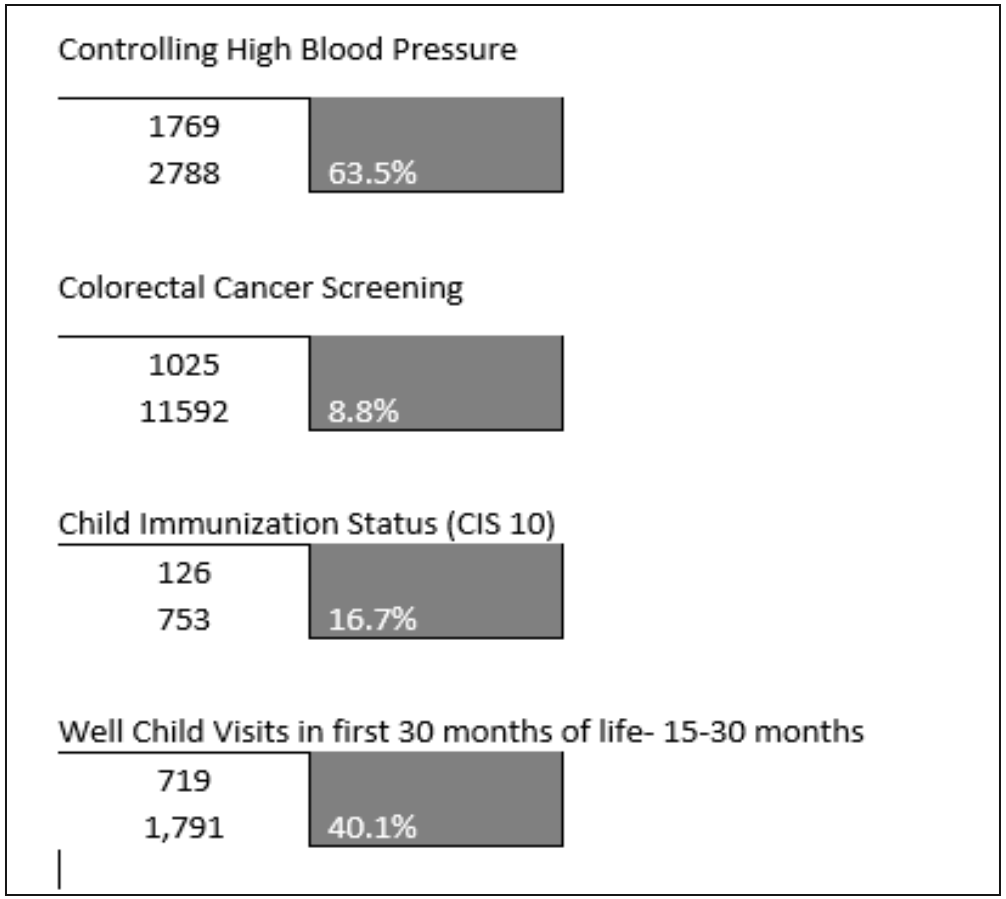
Challenges

- COZEVA is NOT currently a bi-directional system.
- COZEVA does not provide access to the actual clinical report (eg, mammogram or colonoscopy results).
  - NEVHC requires a copy of the clinical report to document compliance within the EHR.
- We are not actively conducting outreach to members based on COZEVA data, as this data still needs to be validated within Nextgen.
- Current outreach is being conducted using i2i Tracks and Care Message for users.

NEVHC Clinic: “Attributed But Not Seen”

	Health Center
1	Canoga Park Health Center
2	Pacoima Health Center
3	San Fernando Health Center
4	Transition to Wellness North Hollywood Health Center
5	Transition to Wellness Van Nuys Health Center
6	Van Nuys Adult Health Center
7	Van Nuys Pediatric Health Center
8	Newhall Health Center
9	Santa Clarita Health Center
10	Valencia Health Center
11	Maclay Health Center
12	Sun Valley Health Center
13	School Based Clinic
14	Mission College Student Health Center
15	Santa Clarita Dental and Wellness Center
16	Homeless Mobile Clinic
17	**Attributed Not Seen**

Attributed but not seen



Attributed Not Seen

# of Unique Patients

Outreach to Attributed Not Seen

- Enrollment Manager: Weekly text outreach for designated age categories to establish care.
- Text results
  - 2% - Appt. Scheduled per Message Received
  - 14% - Appt. Kept per Scheduled Appt.
- Additional outreach via live calls to Attributed Not Seen who are due for a clinical metric
- Also working to clean up member assignment

Value Proposition – Opportunities with PHMI Platform

PHMI Platform Opportunities		Value Add (tied back to slide 19)
Close True Care Gaps	• Identify patients with care gaps and assign to care coordinator for outreach. • Triage/stratify patient lists based on set criteria.	• **Targeted outreach:** Utilize data to more effectively target and manage populations.
Close Coding Gaps	• Close coding gaps using EHR, HIE, and MCP data through point of care EMR overlay (InNote) and integrated patient record (P360). • Allows the provider to address the disease, make referrals, & close the care and coding gaps.	• **Point of Care actionability:** Leverage insights at the point of care to better enable individual care.
Integrated Patient Data	• Access detailed information including dates of service and provider for specialty visits, ER/inpatient encounters, and specific services such as mammograms.	• **Harmonized, enabling views:** Integrating data from disparate sources helps to better enable providers and care management teams.
Expanded Outreach	• Expand outreach from current users to assigned members with integrated attributed member data. • Documentation & tracking on successful/unsuccessful outreaches.	• **Proactive outreach:** Utilize data to more effectively manage assigned but not yet seen patients and track outreach.

**Currently requesting enhancements to allow direct access to clinical reports and E.H.R writeback, reducing the need to navigate multiple portals and double entry.*