Enhanced Medical Home For Medi-Cal's SPD Population

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Introduction

The California Department of Health Care Services (DHCS) seeks to improve the quality and efficiency of care provided to approximately 360,000 fee-for-service Medi-Cal beneficiaries with disabilities and chronic illnesses by creating a new statewide infrastructure of *Enhanced Medical Homes* (EMH). In this context, the Enhanced Medical Home model is a system of care that provides access to a primary care provider, as well as targeted care management support for beneficiaries at high risk of using acute medical services. With support from the California HealthCare Foundation, the Center for Health Care Strategies, Inc. (CHCS), a national non-profit with expertise in this arena, prepared this policy options paper for the consideration of the Executive and Legislative branches of California government. The paper is based on input from stakeholders across the state, Medicaid officials from best practice states, as well as internal deliberations among state officials. It also benefits from a round of intensive interviews with selected California stakeholders conducted by CHCS in June and July 2009 (see Appendix 1).

The Context

DHCS will be submitting a concept paper to the Centers for Medicare and Medicaid Services (CMS) in September 2009 as the preliminary step in informing CMS of the state's plans for the renewal of the current 1115 Waiver that expires on August 31, 2010. The waiver mechanism provides the state with a flexible vehicle for transforming key elements of the Medi-Cal delivery system, such as the current delivery of care for seniors and persons with disabilities (SPD). The waiver mechanism is critical because it gives the state the overall financial ability to make front-end investments in system redesign and care management infrastructures that would not otherwise be possible in today's current fiscal situation. These investments could generate out-year savings through reduced emergency department (ED) use and hospital readmissions. These savings will allow the state to be rewarded with federal funding for health care costs that would not otherwise be claimable under the state's Medicaid state plan. While the waiver renewal would provide the state with some financial flexibility, DHCS will still be challenged to identify funding sources and develop a reimbursement methodology to support the EMH and increase accountability for improved quality and cost outcomes through this effort to transform care for seniors and beneficiaries with disabilities.

By design, Medi-Cal has used a pilot project approach over the past few years to test ways to better manage the care and cost of its fee-for-service (FFS) SPD beneficiaries. Initially, Medi-Cal implemented two disease management pilot projects for this population. In the first pilot, DHCS contracted with an outside vendor, McKesson Health Solutions, to provide disease management services for beneficiaries with one or more chronic diseases residing in Alameda or Los Angeles counties. For the second pilot, DHCS contracted with the AIDS Healthcare Foundation/Positive Healthcare Partners to run a statewide disease management pilot to serve beneficiaries with HIV/AIDS. Both pilots are testing disease management concepts and offer participating beneficiaries a variety of services (e.g., outreach and assessment; linkage to a medical home; and access to a 24-hour nurse advice telephone line). As part of the evaluation of the two-county disease management pilot, a first-year consumer survey indicated that beneficiaries are highly satisfied with the disease management services.

California, like many other states, recognized that its highest-risk populations have multiple needs. Hence, it further modified the traditional single-disease model used in the past. With a more holistic person-centered approach to care, DHCS is now working with APS Healthcare to develop two Coordinated Care Management (CCM) pilots. One pilot will focus on people with multiple chronic conditions; the other pilot will focus on individuals with severe mental illness. These two projects use the types of care management concepts likely to be part of the EMH model. As such, DHCS has a unique opportunity to learn from them as it develops its new statewide program.

These disease management and care management pilots complement Medi-Cal's long-standing Medical Case Management (MCM) program, which was designed for the state's most complex FFS SPD beneficiaries, and could be another possible building block for the EMH model. Through this program, state-employed nurse case managers are responsible for managing utilization patterns; assuring safe medical facility discharge and continuity of medical care; and coordinating and facilitating the approval of medically necessary services for approximately 2,000 patient cases per month. Additionally, the state is in a position to learn from its Coverage Initiative program for uninsured adults—many of whom have similar comorbidities to the non-elderly SPD population—and, in its more rural areas, from the County Medical Services Program (CMSP). Finally, and certainly highly relevant, is the Frequent Users of Health Services Initiative (FUHSI), a privately-funded, six-year demonstration project that sought to decrease unnecessary ED use and avoidable hospital stays.[1] Much like Medi-Cal's current efforts to target high-need FFS beneficiaries, this initiative aims to meet beneficiaries' multiple medical and psychosocial needs through innovative practices (e.g., multidisciplinary care teams, data sharing) as well as tailored care interventions.

This policy options paper also provides insights from a recent multi-state analysis of alternatives for introducing care management/coordinated care in the FFS system for the SPD population.[2] A number of states have made notable strides in implementing non-capitated models that more successfully address some of the known limitations of prior disease and care management programs. These options include: thorough and continuous risk assessment; patient-centeredness; and structured and accountable connections to primary care and other providers. One critical factor in making the medical home work for beneficiaries with chronic illnesses and disabilities is to provide various forms of external support to physician practices. These supports should include: risk stratification through predictive modeling and targeting of the intensity of the intervention (i.e., high- or low-touch); current information about their patients' conditions, care needs, and service use; resources for care management and care coordination that are often not available in physician offices; and performance measurement and incentives for medical homes that improve care for beneficiaries. Each of the contracting options to be considered by the state must have the capacity to organize and/or directly deliver these supports.

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[1] For more details on the Frequent Users of Health Services Initiative, visit **http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=20142**. This initiative was jointly funded by The California Endowment and the California HealthCare Foundation.

[2] Verdier, J., et al., *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*. Center for Health Care Strategies. Resource paper to be published August 2009. **http://www.chcs.org/publications3960/publications_show.htm?doc_id=1013920**.

The Core Concept

The state recognizes that the current FFS system needs to be reformed to address the needs of the SPD population and to be more efficient with scarce state funding. The states' goals are to: promote better organization of care and provide enrollees with a medical home, as well as targeted care management support. The EMH program for the SPD population would have seven core elements, including the ability to:

1. Provide a medical home for each of the approximate 360,000 FFS SPD, i.e., establish a mandatory relationship with a patient-centered provider of primary care services;
2. Identify, assess, and stratify the needs of the target population;
3. Tailor care interventions to meet the needs of subsets of the target population, including those experiencing disparities in care associated with race, ethnicity, language, and literacy;
4. Address the psychosocial, preventive care, and social support needs of high-risk beneficiaries through effective care coordination and management interventions, and linkages to appropriate community-based services;
5. Use innovative HIT solutions to share data with providers on their panel of patients, practice performance, and their compliance with evidence-based guidelines;
6. Measure performance to promote accountability and quality improvement; and
7. Structure financing to support the EMH program's ability to perform the above functions.

Ultimately, through a competitive bid process an RFP and contract(s) would address each of these core elements. The DHCS would benefit from consulting with other states and national experts on the value-based purchasing strategies and contracting specifications most likely to meet the state's goals for improved quality and cost effectiveness. The state could also seek guidance on how best to structure its 1115 Waiver request and program design such that necessary front-end development costs can be covered by future savings. For estimates of future savings to be plausible, however, the EMH must be designed to have a reasonably quick and predictable impact on avoidable hospital and ED use. In the absence of sizable impacts on these costly services, it would be difficult for the EMH program to pay for itself over the five-year period used to calculate budget neutrality in most 1115 Waivers.

The Contracting Options: Stakeholders' Views

Before describing the reactions to the specific contracting options delineated by the state, it bears noting that the stakeholders generally concurred on the following points:

1. They repeatedly expressed their appreciation for the opportunity afforded by DHCS and CHCF to provide early feedback during the planning stages of the EHM program.
2. They *uniformly agreed with the state's goals and expressed no opposition to the proposition that enhancing FFS is a necessary next step for Medi-Cal's SPD population*. Although one interviewee did not accept the underlying premise that Medi-Cal is overspending on the SPD population, others agreed that, with its current unmanaged system, the state is spending excessive dollars on poor quality, fragmented care.

Beyond the two critical points of agreement, consensus became harder to come by. As described below, however, there was near consensus that a "one-size-fits-all" approach would not work in California. It seemed that the most obvious way to segment the state was: (1) *managed care* counties (excluding County Organized Health Systems [COHS]); and (2) *non-managed care* counties. Even so, it is certainly conceivable to have one statewide vendor (e.g., an Administrative Services Organization or ASO) that has subcontracting relationships with regional partners. Whether the state chooses to issue one contract or to operate under a multi-option scenario, there was widespread agreement that the care and care management of all SPD beneficiaries should be governed by the same core elements and statewide performance standards. A comprehensive stakeholder process conducted in 2005 resulted in a set of consensus-based performance standards and monitoring practices; stakeholders would like the EMH program to build off of that work.[3]

I. State-Operated Care Management Program

Stakeholder View: *This option is viewed with nearly universal skepticism*. The principal reason for this is California's current fiscal situation and its impact on state staffing. There was an understandable unwillingness on the part of stakeholders to suspend their disbelief regarding the viability of this model. Few people interviewed were familiar with the Medical Case Management (MCM) program. This is unfortunate, because in the state's 35 non-managed care counties, MCMP nurses may provide the closest approximation available to an EMH infrastructure with care management capabilities for the SPD population (particularly in the area of hospital transitions).

Preliminary Recommendation: A pure state option does not appear to be viable at this time. However, in the future, the state may wish to consider developing a new option that has worked well in Pennsylvania's rural counties: a combination of state care managers working with a disease management or other administrative services organization (DMO/ASO).

II. National, Multi-State or Statewide Vendor

Stakeholder View: *There was very limited support for this option among this select group of regionally-oriented stakeholders*. The principal reasons in order of prevalence: (a) disbelief in a statewide solution given California's size and variability; (b) a fairly deep mistrust of for-profit entities; and (c) skepticism about the SPD-related capabilities or accomplishments to date of any entity capable of statewideness (e.g., health plan, DMO, etc.).

A number of stakeholders acknowledged that a single statewide vendor approach would probably be preferred by DHCS in terms of ease and cost of administration; that sentiment, however, appeared to be more or less an obligatory gesture expressed with little enthusiasm.

The major concerns about all of these potential statewide, for-profit entities revolved around the observations that none of them have: (a) a feel for the dramatic regional/local variation

[3] *Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions*. Prepared for the California HealthCare Foundation by the Center for Disability Issues and the Health Professions, the Center for Health Care Strategies, and The Lewin Group, November 2005, **http://www.chcf.org/documents/policy/Medi-CalPerfStandardsRecommendatns112205Moved.pdf**.

across the state; or (b) established relationships with the principal providers of care for the SPD population. It bears noting that all of the state's current EMH-like pilots, including the more "medical home-like" AIDS CCM project, suffer because enrollment is on a voluntary basis, a problem that the state intends to address with the new EMH program.

Given that most of the stakeholders in this set of interviews took a dim view of this option, CHCS did not seek extensive feedback on appropriate contractual mechanisms for ensuring accountability, including placing fees at risk against clear performance measures (e.g., ED visits, hospital readmissions, etc.). With rare exceptions (such as the managed care plans currently providing care for SPD), stakeholders complained about DHCS' proclivity for risk-based contracting. They expressed frustration that many local or regional entities were unable to contract at risk despite being otherwise well-qualified to serve the SPD population.

Preliminary Recommendation: While it may seem obvious, the stakeholders were emphatic that a one-size-fits-all approach would be widely opposed. However, some form of a DMO/ASO-like arrangement may still be the most viable option for non-managed care rural counties and a blended state vendor/regional contractor model may be appropriate for the more urban counties.

III. Regional Public/Private Infrastructures

Stakeholder View: *This is the option that received the most support and the most attention from advocates and potential contractors alik*e. The rationale for segmenting the state into managed care counties vs. non-managed care counties became clear from the outset of the interview process: the general existence of infrastructure (and entities interested in the business) vs. the relative absence of infrastructure.

A. Non-Managed Care Counties: To deal with the easier half of the equation first, the stakeholders were unable to identify any infrastructure in the 35 non-managed care counties that they would consider viable for serving this special needs population. The more urban-based interviewees admitted to not focusing on strategies for the rural counties due to their having only 15 percent of all Medi-Cal beneficiaries. They questioned the relevance of the Healthy Families infrastructure administered by Blue Cross in all 58 counties. They argued that a CHIP network would have little overlap with a network for SPD beneficiaries and that the company had scant interest or expertise in serving this population.

The stakeholders generally had little insight into the County Medical Services Program, which works with 32 rural county Departments of Health to organize care for the uninsured. Although no one affirmed that the CMSP had the wherewithal to manage care for the SPD population, there was speculation that managing the care of the portion of the uninsured with complex problems (e.g., frequent users) could equip the CMSP to do the same for SPD to some degree.

Preliminary Recommendation for Non-Managed Care Counties: The state should embrace one set of governing principles and performance objectives for all EMH

contractor(s), but it will probably need a separate RFP (or sub-RFP) for one vendor to be responsible for creating the EMH infrastructure for the non-managed care counties. This approach would not necessarily preclude that vendor from also competing with other statewide vendors and regional entities under a separate RFP for the managed care counties (see below).

B. ***Managed Care Counties***: The situation (and the stakeholders' views about it) is much more complex in the urban counties serving the bulk of the SPD population. Although the COHS are not slated to be part of the EMH program, they were interviewed because of their experience with care management for SPD and other proposed features of the EMH program. These interviews provided useful feedback about the model, the needs of the SPD population, and the COHS' efforts to support PCPs. Stakeholders offered comments about San Mateo's role in the Coverage Initiative, and held a generally positive regard for CalOptima.

In terms of managed care entities considered to have relevant experience and the wherewithal to provide the underlying EMH infrastructure, several of the Local Initiative Health Plans (LIHPs) were viewed positively, most notably Inland Empire Health Plan (IEHP) with its 16,000 voluntarily enrolled SPD and its concerted efforts to be disability-sensitive and to expand its provider network.

With their proven capacity to take risk and their inherent incentives to invest in community-based preventive services in order to avoid unnecessary utilization of more expensive hospital services, committed LIHPs may be one of the more suitable contracting or sub-contracting options available to DHCS. Yet, there is no guarantee that the LIHPs will respond. Those, like IEHP, with experience serving the SPD population may have some skepticism about the financial viability of an EMH program, particularly one that does not provide adequate per member per month (PMPM) payments. To quote one stakeholder, "$300 per year won't get us there." One of the most challenging issues for them would be obtaining the participation of specialists. (See also Provider Supports.) A capitated plan can pay providers more than Medi-Cal rates, an option not as readily available to a non-risk EMH contractor unless the overall PMPM is high enough to subsidize specialty provider reimbursement. Theoretically, a non-risk contract could allow for flexible spending, e.g., using any cost savings to increase access to needed services, including those of a specialist.

The health plan interviewees revealed two other conundrums for those involved in designing the on-the-ground features of the EMH:

1. If an EMH health care team is supposed to have a primary care physician (PCP) as the quarterback, few private physicians are able to step up to the role; and
2. Except for that very rare physician and the most sophisticated federally qualified health centers (FQHCs), no PCPs can be single-handedly responsible for the care of the most complex 15-20 percent of SPD who have cross-system (mental health, criminal justice, transportation, housing, etc.) needs beyond the scope of PCPs. Care coordination provided by an organization with the requisite expertise would be a welcome support to most provider practices.

These observations, which will be addressed in more detail in the sections devoted to Provider Supports and Payments, were reiterated—from different vantage points—throughout the interview process. Before closing out the discussion of the potential of regional contractors, we should note that a case can be made for allowing the regional affiliates of the commercial plans to compete for regionally-based contracts or sub-contracts. Not all will, but they do share many essential advantages with the LIHPs: the ability to assume risk; existing provider networks; and data mining and care management infrastructure.

The other set of regional players with a very real stake in the EMH program are the public hospital systems and community health center networks. The respective representatives of these two constituencies made it very clear that they believe they are already delivering the elements of an EMH to the SPD population. They each demonstrated their understanding of the population, including the needs of frequent users, and also reported an established track record in coordinating care needs with other public social services. They both argued strongly for the preeminent value of connectedness to the regional/local provider network and largely dismissed concerns about conflicting incentives. We heard from several interviewees, for example, that seismic retrofitting requirements set for 2014 will result in the elimination of hospital beds and will reduce the incentive to hospitalize patients unnecessarily. The issue of their inability to take risk for their fees was left largely unanswered.

There was general recognition that the current care provided to FFS SPD beneficiaries throughout the states, including in these settings, is insufficiently coordinated and managed. While the representatives of these provider organizations asserted their capabilities "on the ground" and their expectation that they would have a continuing role in the care of this population, they did not suggest that they were in a position to deliver the kinds of population–based care management and data mining infrastructure that larger, statewide organizations could bring to an EMH program.

Within a number of public hospital system in non-COHS counties, a new infrastructure is being built to implement the Coverage Initiatives. The Coverage Initiatives are very explicitly trying to build medical homes for uninsured (and otherwise publicly uninsurable) adults, many of whom, like the SPD population, have chronic physical and behavioral health conditions and are frequent users of emergency departments and inpatient services. However, these are relatively nascent pilot programs, which may or may not continue to exist depending upon the shape of federal reform and state decisions about design of the 1115 waiver renewal. CHCF funded an evaluation and draft interim reports are currently under review by DHCS staff. Based on CHCS discussions with the evaluators, the Coverage Initiative projects may yield useful lessons for the EMH programs, the most compelling of which may be that: (a) each county has implemented very different programs; (b) each Coverage Initiative project has been able to bear the costs of creating the underlying infrastructure for the program while the state continues to negotiate with federal officials about how to reimburse county-level administrative expenses; and (c) some have used that flexibility to pay primary care physicians at Medicare levels in order to build their networks. Even though the

Coverage Initiatives are just pilot projects, the experience to date suggests that some county health departments may be able to provide the infrastructure for an EMH program.

Preliminary Recommendations for Managed Care Counties: The stakeholders interviewed uniformly advocated for a strong regional role where strong regional players exist. Given the size of some of these counties, especially, of course, Los Angeles, it is difficult to see how a statewide vendor without pre-existing connections to the delivery system would be able to engage a PCP network capable of providing EMHs to the SPD population. As such, the state essentially has three options that could accommodate the strong regional preferences among stakeholders from these urban counties:

1. Issue a separate RFP for the managed care counties, opening up competition to the array of potential regional bidders or to a subset thereof (e.g., those willing to take on risk);
2. Issue one statewide RFP for all counties, but require that the vendor subcontract with regional entities that meet certain standards; or
3. Issue staged RFPs that allow local providers such as public hospitals the first option to serve as the regional EMH for their own enrollees, with subsequent procurement to meet the needs of the remaining population.

These scenarios, however, raise the specter of complex and costly administration for DHCS or a statewide vendor. Even if the RFP(s) set high bars for experience and performance, the variability among the regional players is vast. A further problem would be the political fall-out from a selection process that, by definition, could not reward all bidders.

Lessons from Other States

States that have chosen non-capitated arrangements for managing the care of the SPD population have implemented a wide variety of programs (see Appendix 2). Despite the vast differences in implementing a program in less populous, demographically homogenous states vs. California, some lessons are still applicable as California considers its contracting option.

State-operated programs*:*

- *Internal resources/capacity.* For a state to operate a PCCM or EMH program, state staff must be able to take on some aspects of the enhancements needed to support providers and enrollees. In Washington, the state has taken over the predictive modeling and high-risk enrollee identification information system. In Oklahoma, a large team of state-employed nurses offers disease and high-risk care management.
- *Local/regional partners.* States can take advantage of partnerships with local/regional entities to deliver some aspects of the enhanced services (a "hybrid" approach), but the time it takes to build that model varies with the availability of local resources. Partnerships in other states may rely on FQHCs or Area Agencies on Aging, e.g., because of their statewide presence and familiarity with matching needs of people

with disabilities to local resources. However, if new organizations need to be created, the infrastructure will develop slowly. Indiana is an example of using community health centers to support the PCCM program.

- *Provider payment rates.* State-operated PCCM programs build on existing networks of well-reimbursed (i.e., at or near 100% of Medicare rates) providers. Additional PCCM payments allow providers to supplement services and care management supports for Medicaid clients, and are not as necessary to entice them into doing business with the state. Both North Carolina and Oklahoma pay rates that are approximately equal to Medicare. States with lower reimbursement levels (such as Illinois) required their contractors to develop the necessary incentives to build a robust provider network.
- *Time horizon for ROI.* State-operated programs take time to begin to show cost-effectiveness. North Carolina is showing cost-savings now, but this was not demanded of its program in early years.

Contracted models:

- *Financial risk.* States that contract out PCCM programs frequently take advantage of the contractor's ability to take risk. This may include putting fees at risk for improving outcomes and utilization and/or reducing the cost trend.
- *Local vs. central control.* National vendors, while providing an existing infrastructure and ability to absorb start-up costs, may use a uniform approach across many states or lines of business that is less adaptable to an individual state's needs.
- *Data systems*. States can reach out to vendors that have readily accessible data systems for many of the necessary PCCM supports, such as provider profiling and triaging of members based on utilization and diagnosis.
- *Flexible staffing models.* National contractors may have nurses located in parts of the country where a nursing shortage is not an issue. The nurses would already be familiar with the contractor's assessment and care management tools. The state can require licensure in California.

General lessons from other models:

- Researchers at Mathematica found that almost all PCCM enhancements improved the quality of care for SPD at relatively low cost, e.g., provider profiling and reporting of quality measurement. However, they also found that it is difficult for physicians alone to meet the complex needs of low income beneficiaries with multiple chronic illnesses and disabilities; they need the support of care management/ coordination services, which is challenging to finance out of savings.[4]
- Innovative solutions are needed when carve-outs create the potential for conflicting incentives. For example, Pennsylvania is piloting a novel approach in which behavioral health and physical managed care organizations will share equally in a pool of funds if their quality improvement efforts result in improved outcomes.
- Whether operated by the state or by a contractor, most states do not design a system in which non-capitated PCCM contractors compete in the same geographical region

[4] Verdier, J. "Assessing the Effectiveness of Enhanced Primary Care Case Management Programs." Presentation for the 17th Annual Medicaid Managed Care Congress, Baltimore, MD, June 10, 2009.

with capitated managed care plans for the same population. Capitated managed care plans have some competitive advantages, for example, being able to offer differential payments for select specialty providers.

Potential insights for the dual eligible population (Medicaid-Medicare):

- Because seniors are included as part of the eligible population for EMH, stakeholders have asked whether dual eligibles would be included. States have approached this issue in new ways recently. For example, the PCCM program in North Carolina, North Carolina Community Care Networks (NCCCN), is pursuing a gain-sharing demonstration, authorized under the Medicare Modernization Act (MMA), designed to better serve dual eligibles and address the financial misalignments between Medicare and Medicaid. Under this demonstration, NCCCN will expand current care coordination efforts for the Medicaid population to include the dual eligible and, eventually, the Medicare-only population as well. Networks will receive a PMPM fee for benefits, including on-the-ground case management, care transitions, and co-location of mental health. Any Medicare savings beyond a set threshold (using comparison counties) will be shared with NCCCN and reinvested.
- Other states with PCCM programs are interested in building on their established PCCM infrastructure to assume responsibility for integrating the Medicare and Medicaid benefits and receiving payment directly from Medicare to do so.

Enrollee and Provider Supports and Requirements

The standards for the EMH extend naturally to providers. In almost every interview, stakeholders addressed whether to limit assignment to providers who could meet the needs of SPD (the "Centers of Excellence" model) or whether to allow all providers to participate. In this latter, "any willing provider" approach, providers would need to gradually improve their capacity to serve the population.

1. Centers of Excellence: In this model, only providers who meet specified EMH standards could participate. Advocates have already worked with health plans to ensure that their networks include providers who meet performance standards for SPD. Advocates use site visit and survey tools to identify providers who have the interest, skills, and physical accessibility for the population. Physical accessibility includes exam tables, weight scales, mammography equipment, etc. that can be used by a person with limited mobility. A workable solution is that providers who do not have the necessary equipment can arrange to meet their patients where such equipment exists. Advocates recommend that these Centers of Excellence be included in the network of the EMH.

2. Any Willing Provider: In this model, all providers could participate initially, but would be required to meet EMH standards within a specified period of time. Advocates stated a preference for a balanced approach in which beneficiaries could maintain continuity of care with current providers, even when those providers do not initially meet high standards for EMH. Thus, this more flexible approach would address beneficiary concerns regarding their choice of provider being limited and potential disruptions in long-standing provider relationships. Some felt that the choice of provider as the

primary source of care needed to include medical and behavioral health specialists, and as such could be called a "Health Home" rather than a "Medical Home." (A minority viewpoint was that an "opt-out" provision be allowed as a safeguard to guarantee continuity of care.)

With that balance in mind, stakeholders proposed the following requirements for participation as an EMH provider for SPD (note that these elements had wide support among interviewees):

1. Care Coordination: SPD have multiple specialists and ancillary providers involved in their care. The EMH Primary Care Provider should be able to communicate with all the members of the health care team (the "quarterback" role), and ideally, the communication should be supported by technology, such as a web-based electronic medical record that is accessible by the patient and all providers. The use of technology could also support the requirement of mandatory referral from the PCP to specialist providers, which was not objected to by advocates as long as continuity of specialist relationships was not disrupted. San Francisco, for example, has a model web-based specialty referral system that has opened up access to providers. It was suggested that specialists are more willing to see Medi-Cal patients when they know they are in an equitable rotation with other willing specialists.

2. Linkage to Community Resources: Since almost all SPDs have needs that extend beyond the medical system, it is vital that the PCP be able to link to community resources. These include the mental health system, long-term supports and services, housing, etc. FUHSI projects have found that without housing resources in the mix, ED use actually increases when beneficiaries become part of a care coordination effort. In rural communities, awareness of transportation resources and development of telemedicine access are important supports. Many advocates suggested that the role of navigating these multiple systems be a reimbursable role in the EMH.

3. Care Management: There was universal agreement that a significant subgroup of the SPD population would benefit from intensive care management. A few stakeholders offered specific ways of triaging the population based on utilization or a health status assessment. Care management supports mentioned included: access to a 24/7 nurse advice line; home visits; hospital discharge and transitional care planning; outreach and education. Group visits for education were also mentioned as an alternative that might be cost-effective. Stakeholders made the distinction between <u>clinical</u> care management, ideally provided at or closely tied to the provider's office setting, and <u>social</u> case management, which could be provided by a separate entity. There was widespread skepticism as to whether care management as an intervention would be cost-neutral, let alone cost-saving, and a minority view that held that ED use would not decrease in response to any intervention.

4. Interdisciplinary Team: High-risk SPD need a full complement of providers, including mental health and substance abuse providers, specialty medical providers, nutritionists, and physical and occupational therapists. Two suggestions emerged for improving access to the limited number of specialists:

   a. Create an expert panel of specialists to consult with the PCP/EMH team on the care plan and specific recommendations for treatment. This could be a statewide or locally-based panel.
   b. Use care management to prepare the patient for specialty visits by ensuring that all tests are complete, results are delivered, pre-surgical instructions are followed, and reminders are provided to make sure that the patient shows up for scheduled visits.

5. After-Hours Access: Evening and weekend clinic hours can also be shared within a community if EMH providers are willing to discuss and distribute the responsibility equitably.

Many stakeholders volunteered to continue the dialogue with DHCS to assist with standard-setting and review of EMH proposals. It was suggested that involving beneficiaries in the design would result in a better product.

Provider Accountability and Reimbursement

Advocates and other stakeholders emphasized that any discussion of provider reimbursement in California must start with the acknowledgement that medical services are underfunded by Medi-Cal. For example, stakeholders specifically referred to the low proportion that outpatient medical services represent within the overall Medi-Cal budget, the low FFS reimbursement for typical visits, and/or the poor comparison to commercial and Medicare payment for the same services.

Interviewees suggested a variety of options for enhancing payment for providers willing to serve the SPD population.

1. Enhanced Provider Reimbursement/Supports: For small/rural practices, a PMPM for the few EMH enrollees would not make much difference. Enhancing reimbursement fees and adding supports for high-risk patients (e.g., care management and coordination) would potentially be more attractive.
2. Enhanced Community Clinic Reimbursement: Community clinics already have many of the needed supports for SPD, but additional reimbursement for improving systems of care would allow them to extend hours, add navigators, and pay for consulting specialists, etc. (Note that FQHCs' unique method of cost-based reimbursement needs to be taken into account.)
3. Alternative Reimbursement Strategies: Small changes in methods of reimbursement might make a big difference, such as allowing mental health and physical health providers to bill for services on the same day, or allowing mental health providers to bill at a PCP office site.
4. Pay for Performance: Pay for performance (P4P) and other reimbursement methods were supported by stakeholders, as long as provider input is part of the design. At least one interviewee suggested that the reimbursement not be done in such a piecemeal fashion that it becomes administratively burdensome to providers. Methods that were acceptable to stakeholders include:

a. PMPM reimbursement for taking assignment/coordinating care for SPD;
b. Enhanced PMPM based on severity level of enrollees;
c. Pay for EMH elements to be available, such as nurse hotline, HIT, and telemedicine, or tele-consultation;
d. Incentive payment for appropriate referrals to mental health or other specialists;
e. Pay for improved outcomes using standardized measures such as HEDIS;
f. Pay for improved processes such as decreased waiting times for appointments;
g. Gain-sharing with the EMH contractor or providers for decreased ED visits and hospital admissions.

Taken all together, the move to greater acceptance of a P4P system, including shared information such as provider profiling, was somewhat surprising given previous interviews on the subject in California. Even one interviewee who said providers are not motivated by more money agreed that P4P might help improve outcomes overall.

Other Considerations

Finally, the interviewees were generous with advice that might help DHCS avoid the "third rail" with stakeholders. Here are some selected comments from individuals that might inform the decision-making and design of the EMH model:

1. **Be clear about goals**: At the outset, determine your goals for the project and be able to articulate them consistently. What outcomes do you want to improve? Once goals are established, hold each model against those goals and determine whether it is a good fit. The performance standards required in the contract should be in line with those goals.
2. **Focus on quality**: "We know this is a costly population but don't beat us over the head with this." Advocates are requesting that DHCS focus on improving access and care, not on cost-savings.
3. **Consider non-risk-based contracts:** Some of the best local or regional partners available to serve the SPD population are unable to bear risk in contracts with the state.
4. **Build the case:** Get good evidence from other states that this has the potential to improve care in a cost-effective manner, and then use that evidence to sell the program to stakeholders and legislators.
5. **Include an evaluation in design:** Make sure that you have a strong evaluation design so the program will be sustainable if it works.
6. **Market the program:** In marketing the new model it will help to have some "cache" – for example, university-based subspecialists who are leaders in the field as part of the network of available providers. It will also help to reinforce the message "this is not the same as capitated managed care."
7. **Look for avoidable expenses:** The state can use examples from health plans' efforts to realign spending, e.g. with utilization management, evidence-based medicine, and increased use of generic prescription drugs.
8. **Develop local-state partnerships:** Local advisory boards will help ensure success, but it would be important to have one designated person at the state level who can help problem-solve when conflicts arise.

9. **Seize the opportunity:** The fewer carve-outs, the less shifting of risk and cost. The 1115 waiver is a good opportunity to start staging long-term reform, including integrating services across physical health, behavioral health, and long-term supports and services.

Conclusion: Key Options for California

A central lesson for California from states that have implemented enhanced PCCM programs is that they "may be as good for ABD/SSI beneficiaries (and taxpayers) as good capitated MCOs, but only if they do most of the things that good MCOs do (e.g., care coordination, preventive services, utilization management)."[5] Whatever model California chooses, the state should take advantage of existing resources, including the MCM staff, the good will and interest of advocates and providers, and the willingness of health plans to adapt to DHCS needs. Putting aside models that do not seem viable for California, the options outlined in Appendix 3 are important considerations for addressing the key elements of an EMH program.

[5] Verdier, J., ibid.

Appendix 1: Medical Home Stakeholder Interviews - Participant List

Advocacy

Beth Capell
Lobbyist/Policy Advocate
Health Access

Marilyn Holle
Senior Attorney
Disability Rights California

June Isaacson Kailes
Disability Policy Consultant/Associate Director
Center for Disability Issues and Health Professions
Western University of Health Sciences

Mandy Johnson
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Integrated Behavioral Health Project

Elizabeth A. Landsberg
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Western Center on Law & Poverty

Kim Lewis
Staff Attorney
Western Center on Law and Poverty

Harriet Markell
Association Director
CA Council of Community
Mental Health Agencies

Brenda Premo
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Sharon Rapport
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Corporation for Supportive Housing

Barbara Siegal
Managing Attorney
Neighborhood Legal Services of Los Angeles

Mary Rainwater
Project Director
Integrated Behavioral Health Project

Hospital / Associations

Erica Murray
Vice President
California Association of Public Hospitals & Health Systems

Sarah Brooks
Policy Analyst
California Association of Public Hospitals & Health Systems

Clinic / Provider

Allison Homewood
Policy Analyst, Health Center Operations
California Primary Care Association

California Medical Association

David Ford
Associate Director, Medical and Regulatory Policy
California Medical Association

Health Plan / Association

Terry Bayer, JD
Chief Operating Officer
CA Molina Healthcare, Inc.

William Henning, MD
Chief Executive Officer
Inland Empire Health Plan

Lisa Rubino
Chief Executive Officer
CA Molina Healthcare, Inc.

Richard Sanchez, MD
Chief Medical Officer
CA Molina Healthcare, Inc.

Chris R. Cammisa, MD
Medical Director
Partnership HealthPlan of California

Cyndi Ardans
Quality Monitoring and Improvement Manager
Partnership HealthPlan of California

Mary Giammona, MD
Medical Director
Health Plan of San Mateo

Other Stakeholders and Subject Matter Experts

Kathy Ochoa
Director, Strategic Initiatives
Service Employees International Union

Dylan H. Roby, PhD
Research Scientist
UCLA Center for Health Policy Research

Nadereh Pourat, PhD
Director of Research Planning
UCLA Center of Health Policy Research

Len Finocchio, PhD
Senior Program Officer
Innovations for the Underserved
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Jalynne Callori
Assistant Chief
Safety Net Financing Division
Department of Health Care Services

Lee D. Kemper
Administrative Officer
County Medical Services Program
Governing Board

Jonathan E. Freedman
Chief Deputy Director
Los Angeles Department of Public Health

Appendix 2: Examples of Primary Care Case Management (PCCM) and Medical Home Programs Used for Interviews

	Oklahoma ***Sooner Care Choice***	**North Carolina** ***Community Care of North Carolina***	**Illinois** ***YourHealthPlus***	**Washington** ***Chronic Care Management***
Program Description	Oklahoma's PCCM program is operated by the state. State staff are responsible for enrollment, training, technical assistance, and care management. State staff develop and monitor the provider network.	PCCM/medical home program developed as a public/private partnership. Fourteen contracted entities (local physician-led networks of physicians, hospitals, and local health and social services departments) serve as the locus of administrative activities for the statewide PCCM program.	PCCM/medical home program is provided by a vendor and available for all fee-for-service beneficiaries on a statewide basis. If the beneficiary also has a chronic illness(es), he/she can receive DM services.	Care management program provided by two vendors: a local care management program that provides medical home and care management services in one county; and a statewide vendor responsible for predictive modeling tool used to identify high-risk enrollees.
Target Population	Both TANF and ABD populations have been mandatorily enrolled since 1995 (current enrollment approximately half a million).	Approximately 2/3 of all Medicaid beneficiaries enroll in PCCM program (all non-dual eligible). Now 900,000 enrollees, including people with disabilities as a mandatory population.	PCCM: All fee-for-service beneficiaries must enroll in program. DM: DM is component of PCCM program. Adults with disabilities; children with asthma; and frequent emergency department users qualify for DM program.	High-risk adults (excluding HCBS waiver, hospice) in fee-for-service.
Care Management Strategy	Care management is provided by state staff. 5,000 high-risk clients are enrolled in care management program.	Local physician-led networks responsible for delivering care management interventions. Staff includes clinical coordinators, care managers, and pharmacists.	PCCM: Vendor responsible for ensuring connection to a medical home. DM: Vendor staff conducts DM for five diseases (coronary artery disease, congestive heart failure, asthma, COPD, and diabetes) through telephonic and in-person visits. Staff also placed at high-volume sites (hospitals and clinics).	Statewide: Vendor (health plan) provides care management on statewide basis. Local providers: King County Health Partners serve as medical home (health assessments, care plans, patient self-management).

Appendix 2 continued

	Oklahoma ***Sooner Care Choice***	**North Carolina** ***Community Care of North Carolina***	**Illinois** ***YourHealthPlus***	**Washington** ***Chronic Care Management***
Physician Supports	Practice supports are provided by state staff. Provider profiles are available for performance comparisons.	Local entities responsible for performance measurement and feedback, quality improvement, and technical assistance to providers.	DM: Physician-level pay-for-performance component. Physicians are also provided with patient profiles.	Statewide: Vendor provides physicians with patient profiles.
Payment & Risk Arrangements	Medical home model includes payments for primary care office visits made on a FFS basis. Includes additional monthly care coordination payment and performance-based payments for a variety of measures (health outcomes and utilization).	Providers receive $2.50 – 5 PMPM for each enrollee. Local networks receive $3 – 5 PMPM for each enrollee. No risk delegated from state.	PCCM: Primary care physician receives the following for care management: $2-3 PMPM per child/parent; $4 PMPM per disabled adult. Minimal financial risk based on clinical performance. DM: State pays vendor on a PMPM basis. Vendor at financial risk: 80% for meeting net savings target and 20% for clinical target.	Care management: $126 PMPM paid to local providers for each participant in care management program. Medical home: $8.70 PMPM paid to local contractor, includes $2.50 PMPM to PCP/clinics.

Appendix 3: Key Elements and Options

Key Element	Considerations	Options
Assignment of beneficiaries to a primary care provider or clinic	Centralize for accurate and equitable distribution, smooth exchange of information. Best if connected to claims payment system.	1. Contract out enrollment/payment function to MMIS provider/enrollment broker. 2. Contract out to a single statewide ASO (or other entity).
Provider network development, education, monitoring	Set standards for access, but network development, contracting, etc. can be delegated.	1. Contract network development to ASO. 2. Multiple contracts: One with a single entity that manages all rural counties, and individual contracts with one or more local entities in urban counties.
Identification, assessment, stratification of population	Centralize identification and base-level stratification function for consistency and cost-effectiveness. Assessment and additional stratification could be done by state/local entity, but ideally minimum standards should be in place.	1. Contract out to MMIS provider. 2. Contract out to a single statewide ASO/CMO. 3. Perform in-house.
Care management interventions tailored according to need	Address critical requirements for high-risk population, including the capacity to do in-person visits; connection to PCP; access to information on hospital/ED visits; medical management; health education; patient engagement; etc.	1. Contract out to a single statewide ASO/CMO. 2. Contract out to regional or statewide ASO and local providers. 3. Contract with regional or statewide ASO and require subcontracts with local providers. 4. MCM staff to support hospital/transition function and coordinate other care management with contracted entities.
Care coordination across multiple psychosocial systems	Design approach to provide services closest to the site of care with care coordinators who know local systems of care. Could be performed telephonically.	1. Contract with regional or statewide ASO/CMO and require subcontracts with local providers. 2. Require/reimburse local EMH providers (PCP/clinics) to provide care coordination.
HIT to support data/information sharing and quality measurement	Address critical features, including ability to: (1) communicate evidence-based standards of care; (2) monitor performance against standards; (3) produce provider profiles; and (4) share patient information among providers; etc. Desired additional feature: shared care planning (web-based).	1. Contract with a single statewide ASO (linked to other provider functions above). 2. Contract with regional or statewide ASO to support rural counties and require in contracts with multiple urban contractors. 3. Contract with quality improvement organization to operate statewide.
Financing system that supports EMH functions	Determine how much downside risk to require; multiple potential bidders open to upside risk-sharing.	1. Partially capitated (PCP and related outpatient only). 2. FFS with P4P to providers, risk-sharing with contractor. 3. FFS with only upside-risk shared with providers.
Incentives tied to performance/ accountability	Link incentives to provider performance and financing systems (above).	1. Contract with one centralized ASO (part of payment system). 2. Build P4P requirements into multiple contracts with local entities.