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Creation of Safety-Net-Based Provider Networks Under The California Health Care Coverage Initiative: Interim Findings

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Organized provider networks have been developed as a method of achieving efficiencies in the delivery of health care, and to reduce problems such as limited access to specialty and tertiary care, fragmentation and duplication of services, low-quality care and poor patient outcomes. Provider networks are based on collaborative agreements between an array of providers offering a comprehensive range of services, bolstered with extensive administrative, structural and financial supports.[1, 2] Standard components of networks include private practice and clinic-based physicians, hospitals, and ancillary service providers such as laboratory and diagnostic services. Service providers are organized and supported by an organization that administers important aspects of the network, including provider reimbursement, utilization management, quality assurance and health information technology (HIT).[3, 4]

Organized provider networks have been used by commercial insurers as part of managed care, and are being adopted increasingly by Medicaid and Medicare as an important aspect of an effective health care delivery system.[5] Research indicates that collaborative care delivery networks can enhance the capacity of local primary care and safety-net systems, improve access to care, and lead to efficiencies in care delivery, thereby leading to improved health outcomes.[5-9] However, public programs continue to face important barriers in developing organized provider networks. This policy brief examines the experience of ten California counties participating in the Health Care Coverage Initiative (HCCI) demonstration project in overcoming these barriers and creating provider networks based on existing safety-net systems. These interim findings should provide valuable information for future efforts to develop effective networks based on safety-net providers.

Inherent Challenges in the Safety Net

In contrast to the private sector, networks based on safety-net systems are less common for a number of reasons. Safety-net providers typically consist of local government health care facilities, Federally-Qualified Health Centers (FQHCs), and other private entities, including clinics and providers willing to provide free or reduced-cost care to low-income uninsured and Medicaid-insured individuals.[10-12] When safety-net care is reimbursed, it is ultimately financed through tax revenues redistributed to providers in various forms, including budget allocations and other arrangements. Limited patient payments for care as well as service delivery and infrastructure building grants may supplement these revenues.[9, 13] Over time, the

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number of uninsured individuals has increased while government budgets that support care delivery to the uninsured have decreased, and private donations and resources have declined.[14, 15] Moreover, facilities grapple with regional health care workforce shortages, rising costs of care, limited access to information technology and limited infrastructure resources and support.[7, 16]

The limited development and implementation of provider networks within the safety net are due to numerous challenges.[7] Safety-net systems vary considerably in size, scope and organization.[7, 11] Most systems provide fragmented and episodic care and are burdened with compromised quality and high costs.[7, 17] Specific barriers include limited access to primary care services; emergency room overcrowding; lack of access to specialty care, mental health care, and dental care; and financial pressures on patients and providers.[7] Barriers to timely access to specialty care are of particular concern, with many primary care clinics unable to provide specialty services onsite or to refer patients to specialty providers and coordinate such care.[7, 17-19] These problems are exacerbated by a limited supply of specialists in some regions, many of whom are not willing to accept uninsured or Medicaid patients.[7] In addition, the reliance on emergency room services by uninsured individuals is a major problem, especially for patients with primary care-sensitive conditions such as diabetes, congestive heart failure and asthma. These individuals represent a significant proportion of preventable and potentially expensive hospitalizations.[7, 20]

Safety-net providers generally lack the capacity to provide a full range of services to their patients.[10] They rely heavily on private physicians and hospitals to accept their specialty care referrals and to provide advanced diagnostic services. Often these services are provided with little or no payment. Moreover, many private physicians are reluctant to accept uninsured patients without reimbursement contracts in place.[14, 16, 21]

Safety-net providers rely on limited and inconsistent financial support from federal, state and local sources, as well as on charity care provided by physicians and facilities.[12, 14, 21] The fractured nature of funding contributes to an absence of organized safety-net systems and little coordination between providers.[12] Existing subsidies, including community health center grants and disproportionate share hospital (DSH) payments, are often assigned retrospectively based on uninsured and Medicaid patient caseload, uncompensated care, and need.[7, 11, 22, 23] Beyond negotiated inpatient Medi-Cal rates and the prospective cost-based rates received by FQHCs, development of prospective reimbursement agreements within safety-net systems has been limited.[7, 11, 16, 24]

Evidence indicates that participation in an organized care delivery network can mitigate many of the challenges faced by safety-net health care providers.[8] Despite this evidence, instances of such coordinated networks in the United States are infrequent.[7, 25] Nevertheless, it is feasible to create a comprehensive and coordinated safety-net network with administrative, financial and technological supports that can enhance access to a full range of provider types and services.[8, 21, 26]

Existing Examples of Safety-Net Provider Networks

Several examples of organized safety-net provider networks exist.[10] Prior to the 2006 implementation of health care reform in Massachusetts, the state funded safety-net care through its uncompensated care pool to assist hospitals that provided a disproportionate share of unreimbursed services and to remove disincentives to caring for uninsured patients.[25, 27] As early as 1995, two Massachusetts hospital systems with large "free care" burdens, Boston Medical Center and the Cambridge Health Alliance, were granted permission to establish managed care programs for the uninsured, funded through the uncompensated care pool.[26] Each medical center created a "health plan" that issued membership cards to eligible individuals and assigned them a primary care provider.[28]

Boston Medical Center's network included community health centers and clinic-based providers. The coordinated safety-net network provided comprehensive benefits, access to specialty care, and included selection of or assignment to a primary provider for each patient. The networks were effective in encouraging appropriate use of primary care services and reducing unnecessary expenditures through reductions in emergency room use and preventable hospitalizations.[25] Other states, including Michigan, Maine, Georgia, New York, New Jersey and Wisconsin have implemented similar health care coverage systems based on uncompensated care pools.[25, 27] These systems are models of effective, coordinated networks operating within the safety net, and have enhanced access and improved outcomes while reducing costs.[25, 27]

Some states have implemented organized networks through Medicaid-managed care or other state-funded programs. In California, 23 counties enroll some or all of their Medicaid enrollees in managed care plans, while the remaining counties continue to deliver fee-for-service (FFS) care to this population.[29] Increasingly, FQHCs and other safety-net providers are incorporated in such networks, as states and the federal government acknowledge the critical role of these providers.[7, 10, 29] FQHCs have demonstrated success in providing primary and preventive care and reducing health care disparities.[30-32] In California, Medi-Cal contracts now require that health plans meet federal requirements for access to FQHC services, and that "local initiative" plans offer subcontracts to FQHCs.[33]

Elements of Effective Provider Networks Within the Safety Net

Effective provider networks require attention to specific aspects such as network design, formalized relationships among a broad array of providers, enhanced access to specialty care and referrals, development and dissemination of health information technology, and expanding and enhancing care coordination and delivery.[7]

Managed Care Approach in Network Design

Modeling safety-net networks on managed care networks has been examined in several communities as an innovative way to improve health status and control costs.[26, 34-36] This method was adopted in response to changes in the local health care markets, including diminished resources and budgets, hospital mergers and deregulation of hospital rates, among others. Although implementation models have varied between communities, use of the managed care approach within the safety net has been credited with reductions in emergency room use and hospital days. Managed care organizations are expected to improve access to a usual source of care, encourage the use of primary and preventive care, increase appropriate service use, and eventually save costs.[26] However, the extent to which these models improve clinical outcomes is as yet unknown.[26, 37]

Pharmacy benefit management (PBM) and medication reconciliation are critical utilization review and management tools used by managed care systems. These services can result in a range of patient care and administrative improvements, including changes in network formulary utilization and prescribing patterns, reduction in potential complications due to medication interactions, increased use of generic medications, and a reduction in per-member cost.[38, 39]

Specialty Care Redesign

Access barriers to specialty care within the safety net are significant.[19] Formal agreements with specialty care providers have been suggested as a way to remedy this problem.[10] Affiliation between an FQHC and a teaching hospital has demonstrated improved access to specialty medical services. In addition, an agreement to provide onsite clinical mental health services has led to greater access for the FQHC patients to specialty mental health care.[21] Provision of onsite specialty care, as well as other innovations—such as training primary care providers to expand their scope of practice and use of telemedicine—can improve access to specialty care services.

Supportive activities such as utilization and dissemination of clinical care guidelines and disease registries can also enhance specialty care capacity and quality.[18, 40] These methods are advocated to encourage appropriate referrals and ensure that adequate clinical information is available to specialists upon referral receipt.[17, 18, 40]

Enhancement and enforcement of referral methods is another area of specialty care redesign within the safety net. Use of Web-based applications for referral and followup care can facilitate specialty care referrals across the network.[17, 18] Moreover, development of a formal referral network and use of clear referral policies and procedures improve referral management and can lead to improvements in access and outcomes.[7] Implementation of such features is challenging since they require consistent entry of patient information and scheduling, physician participation in data entry and staff training.[41] These challenges are particularly relevant within the fragmented safety-net system where providers, clinics and hospitals often lack capabilities or resources to develop such systems.[18, 21]

Health Information Technology (HIT)

Implementation of information systems enables network providers to follow patients between sites of care, and is advocated as a vehicle for improving access, quality of care, patient outcomes and systemwide efficiencies.[5, 7, 42, 43] HIT includes electronic medical records, electronic specialty referral, disease registries and electronic prescribing. Such tools facilitate diagnosis, establish communication channels between primary and specialty providers, increase appropriate specialty referrals, increase efficiency in specialty care, and reduce duplication of services.[40] In addition, electronic prescribing can potentially reduce the rate of medical errors during dispensing, and is effective in tracking patient co-payments, and promoting medication adherence.[44] Ideally, HIT resources and tools are centralized and available to all providers across a network.

Web-based enrollment systems can improve patient follow-up and retention capabilities.[45] Research indicates that such systems can limit complications and delay in eligibility and registration processes, give providers access to up-to-date patient information, and improve continuous eligibility for patients.[45] Despite these advantages, public programs are slow to adopt electronic enrollment and eligibility systems, in part due to the costs.[10, 46]

Expanding and Enhancing Care Coordination and Delivery

The creation of formalized provider networks coupled with expanded scope of services within the safety-net system necessitates improving care coordination. Methods for improving care coordination include physician training through targeted continuing medical education (CME) to expand provider skills, "mini-fellowships" to provide training and mentorship for primary care physicians, and enforcement of referral policies and clinical care guidelines to streamline the specialty referral process.[17, 47] Additional methods of care coordination such as the use of disease and case managers, care coordinators, panel management, disease registries, phone triage and referral coordination have been shown to improve efficiency, reduce demand on overburdened systems, and improve patient outcomes.[17, 48]

California's Health Care Coverage Initiative

Counties are the organizing element of California's health care safety-net system and have a statutory obligation to meet the health care needs of low-income uninsured residents without other sources of care.[49, 50] County programs for low-income uninsured individuals vary in structure and scope, due to autonomy in meeting statutory requirements and varying resources and policies.

The California Health Care Coverage Initiative (HCCI) demonstration project was approved in August 2005 under California's Section 1115 waiver (No. 11-W-00193/9). The Centers for Medicare and Medicaid Services

(CMS) approved the five-year demonstration with $180 million in federal funds during years three, four and five of the waiver (September 1, 2007 to August 31, 2010) in 10 California counties. HCCI extends health care coverage to eligible low-income uninsured adults who are otherwise ineligible for Medi-Cal and other public programs. A major goal of the HCCI program is to expand and strengthen the safety-net system as the main vehicle for increasing access to high-quality care. Participating counties are required to establish provider networks using their existing safety-net providers, expand these networks, and provide infrastructure support such as medical record systems, utilization review and quality monitoring.

Each participating HCCI county adopted a unique approach to network design and implementation. At the start of the HCCI program, counties differed in multiple aspects, including existence of Medi-Cal-managed care provider networks, scope of health information technology, quality monitoring and assurance activities, availability of specialty care and the extent of formalized relationships with safety-net providers.

Key Components of Safety-Net Provider Networks

Exhibit 1 displays a framework for describing the elements of safety-net provider networks under the HCCI program. This framework summarizes the key components of such networks as well as how each county has addressed each of these components while developing its network.

Network Structure

Under the HCCI program, most counties have built upon an existing network of the local county hospital system, except for two counties that lacked a county hospital system and formed new relationships with private and district facilities. Of the eight that built upon an existing network, only one has developed a network composed solely of county-owned and operated facilities, while the others have used a combination of public/private partnerships that are sometimes structured around existing managed-care networks.

These networks may be comprised of providers from the county's public system, or from private non-profit clinics, hospitals and physicians. Partnerships with providers new to the safety-net system have had the additional benefit of services and infrastructure not available through prior safety-net providers. Two counties incorporated their HCCI programs into their Medi-Cal-managed care network and three others utilized the local health plan as a third-party administrator to capitalize on their existing administrative structures (data not shown).

Network Services and Reimbursement

A broad range of services are delivered by a variety of providers in different settings. Reimbursement methods include the spectrum of payment options, depending on the type of service, such as salary (fixed compensation to providers); capitation (fixed monthly payment per enrollee); bundled fee-for-service rates (a single fee that encompasses all services delivered as part of a patient visit); fee-for-service rates (a specific fee for each test, procedure or service provided); bundled per diem rates (a single fee that encompasses all services delivered per day in the inpatient setting); and per diem rates (a single fee for each type of service delivered during a single day of inpatient treatment). The form of reimbursement to each provider type is identified in the following sections.

Primary Care

Primary care providers (PCPs) in HCCI counties practice in a variety of settings including private community clinics (nine counties), county-owned clinics or hospitals (eight counties) and private practice (two counties). Most counties reimburse PCPs at a bundled fee-for-service rate (five) or a traditional fee-for-service rate (four). Many of these counties also utilize salaried PCPs working at county or community clinics.

Exhibit 1 **Elements of the Safety-Net-Based Provider Networks in HCCI Counties: Interim Findings**

	County 1	County 2	County 3	County 4	County 5	County 6	County 7	County 8	County 9	County 10
HCCI Network Structure										
County hospital system (CH), public/private network (PPN)	CH PPN	CH PPN	CH PPN	CH PPN	PPN	PPN	CH	CH PPN	CH PPN	CH PPN
Network Services and Reimbursement										
Primary Care										
Setting: county hospital (CH), county clinic (CC), private clinic (PC), private physician (PP)	CH CC PC	CH CC PC	CH CC PC	CH CC PC	PC PP	PC	CH CC	CH CC PC	CH CC PC PP	CC PC
Reimbursement Method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	C BF	F	S BF	S BF	F	F	S	S BF	S F	S BF
Urgent Care										
Setting: county hospital (CH), county clinic (CC), private clinic (PC), retail clinic (RC), private physician (PP)	CH CC PC	CC PC PP	CH CC PC	CH CC PC	RC PC	PC	CH CC	CH CC PC	CH CC PC PP	CH CC PC
Reimbursement Method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	C BF	F	S BF	S BF	F	F	S	S BF	S F	S BF
Specialty Care										
Setting: county hospital (CH), county clinic (CC), private hospital (PH), district hospital (DH), private clinic (PC), private physician (PP)	CH CC PH PC PP	CH CC PH PC PP	CH CC	CH CC PC	PH PC PP	PH DH PC PP	CH CC	CH CC PH PC PP	CH CC PC PP	CH CC PC
Reimbursement Method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	C BF	F	S	S F	C F	F	S	S BF	S F	S
Inpatient Care										
Setting: county hospital (CH), private hospital (PH), district hospital (DH)	CH PH	CH PH	CH PH	CH	PH	PH DH	CH	CH PH	CH	CH
Reimbursement Method: capitation (C), salary (S), bundled per diem (BP), Per diem (PD), Other (O)	BP	BP PD	S PD	S	BP	PD	S	PD	C PD	S
Ancillary Services and Reimbursement										
Laboratory Services										
Setting: county clinic onsite (CS), county hospital onsite (CHS), private clinic onsite (PS), private hospital onsite (PHS), district hospital onsite (DHS), private/commercial offsite (PO)	CS CHS PS PHS PO	CS CHS PS PO	CS CHS PS PO	CS CHS PS	PHS PO DHS PO	PS PHS	CS CHS PS PHS PO	CS CHS PS	CS CHS	CHS
Reimbursement Method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	BF	BF F	S BF	S BF	C	F	S F	BF	C BF	S

Elements of the Safety-Net-Based Provider Networks in HCCI Counties: Interim Findings (continued)

Exhibit 1

	County 1	County 2	County 3	County 4	County 5	County 6	County 7	County 8	County 9	County 10
Imaging/Diagnostic Services										
Setting: county clinic onsite (CS), county hospital onsite (CHS), private clinic onsite (PS), private hospital onsite (PHS), district hospital onsite (DHS), private/commercial offsite (PO)	CS CHS PS PHS PO	CS CHS PO	CS CHS PS PO	CHS PS	PHS PO	PS PHS DHS PO	CHS	CHS PHS PO	CS CHS PS	CHS
Reimbursement Method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	BF	BF F	S BF	S BF	C F	F	S	BF F	C F	S BF
Pharmacy Services										
Setting: county clinic onsite (CS), county hospital onsite (CHS), private clinic onsite (PS), private hospital onsite (PHS), district hospital onsite (DHS), private/commercial offsite (PO)	CS CHS PS PHS PO	CHS PO	CS CHS PS PO	CS CHS PS PO	PHS PO	PS PHS DHS PO	CHS PO	CHS PO	CS CHS	CS CHS PO
Reimbursement Method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	BF	F	S BF	S BF	F	F	S F	F	C	S BF
Pharmacy Benefit Manager (PBM): all (A), some (S), none (N)	S	A	N	N	A	A	N	A	N	A
Medication Reconciliation Services Required by Contract: all (A), some (S) none (N)	S	S	N	N	N	N	A	S	N	N
Health Information Technology (HIT)										
Electronic Eligibility Check Available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I), program staff only (O)	PCP S ER I	PCP S ER I	PCP S ER I	O	PCP S ER I	O	PCP S ER I	PCP S ER I	PCP	O
Electronic Appointment Scheduling Available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I), program staff only (O)	O	PCP S ER I	PCP S	PCP S ER I	O	PCP ER	PCP S ER I	PCP S	PCP S	PCP S ER I
Electronic Patient Information System: EMR, LCR, electronic summary sheets, care records, or other (O)	O	O	EMR O	O	O	O	LCR	EMR LCR	EMR LCR	O
Electronic Patient Information Available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I)	PCP S	PCP S ER I	PCP S ER I	PCP S ER I	PCP ER	PCP S ER I	PCP S ER I	PCP S ER I	PCP S ER I	PCP S ER I
Electronic Specialty Referral/Tracking Available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I), none (N)	PCP S	N	PCP S	PCP S ER I	PCP ER	N	PCP S ER I	PCP S	PCP S ER I	N

Exhibit 1

Elements of the Safety-Net-Based Provider Networks in HCCI Counties: Interim Findings (continued)

	County 1	County 2	County 3	County 4	County 5	County 6	County 7	County 8	County 9	County 10
Health Information Technology (HIT) (cont.)										
Method of Specialty Referral Followup to PCP: Web-based (W), other electonic system (E), other followup (O)	W E O	E O	W E O	W E O	E O	E O	W E O	W E O	W E O	E O
Disease Registries Utilized: diabetes (1), heart disease (2), hypertension (3), hyperlipidemia (4), asthma (5), immunizations (6), other (7)	1	1 5 6	1 2 3 5 6	1 2 5	1 2 3 5 7	1 3 4	1 2 4 5	1 3 4 5 6	1	1 3 4 7
Disease Registries Available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I)	PCP S ER I	PCP S ER I	PCP	PCP S	PCP	PCP S ER I	PCP S ER I	PCP S ER I	PCP S I	PCP
Electronic Prescribing Available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I), none (N)	N	S ER I	PCP S	N	N	S ER I	PCP S ER I	PCP S	I	N
Incentives for HIT Use: contract requirement (CR), enhanced reimbursement (ER), bonuses (B), other (O), pay-for-performance (P4P), none (N)	N	N	N	CR	CR P4P	N	O	N	CR	N
System Design Innovations in Care Coordination and Delivery										
Onsite Specialty Care at Primary Care Practice Sites: all (A), some (S), none (N)	S	S	S	S	S	S	S	S	S	S
Alternative Sources of Specialty Care: volunteer specialists (V), telemedicine (T), none (N)	T	T	T	V	N	V T	N	T	N	T
Clinical Specialty Consultation Methods Available to PCPs: telephonic (T), electronic (E)	T E	T E	T E	N	N	T E	T E	T E	T E	T E
Expanding Training or Scope of Practice for PCPs: continuing medical education (CME), mini-fellowships (MF), specialty champions (SC), other training (O), none (N)	O	SC O	CME MF SC	N	N	O	O	CME	CME O	N
Existence of Referral Management Policies for: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I)	PCP S ER I	PCP S	PCP S ER I	PCP S	PCP S I	PCP	PCP S ER I	PCP S	PCP S ER I	PCP S
Clinical Care Guidelines for Appropriate Specialty Referral Available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I)	PCP S	PCP S I	PCP S	PCP S	PCP S	PCP S ER I	PCP S	PCP I	PCP S ER I	PCP S

Urgent Care

Urgent care is most often delivered at multiple sites including county facilities, private clinics and physician offices. However, one county relies solely on private clinics, one relies solely on county facilities, and one uses retail clinics located in retail stores or pharmacies and private clinics. Urgent care services are not distinguished from primary care services with respect to reimbursement rates, because many providers have extended hours and walk-in capabilities. The retail clinics that provide urgent care in one county are reimbursed at a fee-for-service rate.

Specialty Care

Specialty care is provided at hospitals and hospital-based clinics, as well as through community-based providers. Six counties further contract with private practice specialists. In seven HCCI programs, the county pays a fee-for-service rate or a bundled fee-for-service rate for contracted specialty services at private community clinics, offices or medical centers. Some counties only utilize salaried specialists or use capitation in addition to fee-for-service payment. Many counties negotiate reimbursement rates with specialty providers on a case-by-case basis or individual provider basis, some at pay rates equivalent to or above Medicare rates, particularly for specialties in high demand.

Inpatient Care

Five counties provide inpatient care at private and public hospitals, four solely use public hospitals, and one county only contracts with private hospitals. Some of the contracted hospitals are academic medical centers. Most HCCI counties pay a bundled per diem or per diem rate for county and/or contracted-facility inpatient care. In one of these counties and three others, inpatient services are part of the county budget and providers are salaried. In another county, capitation and per diem rates are used for payment to county facilities.

Ancillary Services and Reimbursement

Laboratory and Imaging/Diagnostic Testing Services

Hospitals and community clinics (public and private) provide onsite laboratory and imaging or other diagnostic services to enrollees. Six counties additionally contract with private offsite laboratory and imaging or diagnostic facilities to expand availability of these services. Laboratory services are reimbursed through salary at county facilities as part of the budget allocation in four counties. In some of these counties, and several others, private contractors are paid at some form of fee-for-service rate. Capitation is used in two counties for laboratory services. The reimbursement for imaging and diagnostic services in HCCI counties generally follows the same pattern as reimbursement for laboratory services with a few modifications.

Pharmacy Services

Onsite pharmacy services to members are provided at hospitals, county facilities and private community clinics. All counties but one also provide pharmacy services through contracts with private offsite commercial pharmacy chains. In two counties, HCCI patients must utilize the specific pharmacy associated with their assigned medical home which may be a county facility or a private commercial pharmacy (data not shown).

Reimbursement methods for pharmacy services vary by county. Pharmacy services are included in the budget allocations in the four counties with global budgets for hospital care. Pharmacy services for contracted providers are often reimbursed at a bundled or traditional fee-for-service rate. One county utilizes a capitated rate for county facilities.

Most if not all counties also utilize Patient Assistance Programs offered by pharmaceutical companies to obtain more expensive medically-necessary medications to address gaps in coverage of drugs in their respective formularies.

Six counties utilize a pharmacy benefit manager (PBM) to manage pharmacy networks, and provide drug utilization review, outcomes management and disease management for all or some of their network pharmacies. Medication reconciliation, or the review of patient prescriptions during a patient visit or upon hospital discharge, are routinely performed by all pharmacists. In four counties, these services are required by contract for at least some network pharmacies.

Health Information Technology (HIT)

Eligibility and Appointment Systems

HCCI counties have computerized or use Web-based electronic enrollment systems. However, not all of these systems are HCCI-specific, or are available to providers across the networks. Six counties have an electronic enrollment system that allows all provider types to check eligibility for a particular patient and in one county the system is only available to PCPs. Three counties have electronic enrollment systems available to program staff only, and member lists are forwarded to clinics and providers on a regular (weekly or monthly) basis.

Electronic appointment scheduling is available in all counties. In four counties appointment scheduling is available to all provider types and in four others the system is available to PCPs and specialists, or to PCPs and emergency rooms. However, availability is not systemwide in all cases. In two counties, only program staff has access to appointment scheduling systems. Some counties have a centralized call center or appointment scheduling unit, but allow established patients to schedule appointments directly with the clinic or assigned medical home. Across HCCI counties, contracted private community clinics and providers tend to have their own electronic scheduling systems and may not have access to the HCCI systems.

Electronic Patient Information

Currently all counties have access to some form of electronic patient information. Four counties have access to electronic medical records (EMRs) at some clinic and/or hospital sites and/or have access to the Lifetime Clinical Record (LCR). Other counties report utilizing other limited-content electronic documents, such as electronic summary sheets, to capture and share patient information. Eight counties report that electronic patient information is available to all provider types, including primary, specialty, emergency room and inpatient providers, although in some cases access may be limited to county-owned and operated facilities. In two counties, the system is available to a more limited number of providers.

Referrals and Referral Tracking Systems

Three counties do not have electronic specialty referral systems but use faxed referrals. The remainder have an electronic specialty referral or electronic referral system. Of these, three counties provide access to electronic referral to all provider types, and three counties provide access to PCPs and specialists.

Six counties have Web-based electronic referral systems that allow two-way communication between PCPs and specialists, though this access may be limited to some rather than all. In four other counties, other electronic systems and/or email communication are used. The followup includes feedback to the PCP after specialty care or use of other services, and can include direct communication as well as access to clinical notes or other information.

Disease Registries

Most counties utilize multiple registries, while two counties use only one disease registry for their HCCI population. In six counties, disease registries are available to all or nearly all provider types, and in other counties registries are available to PCPs alone or to PCPs and specialists. Specific disease registries, such as diabetes, hypertension or immunization registries are available systemwide in four counties. However, in most counties, registries are unique to specific clinics and practice sites, although they may use the same software (data not shown).

Electronic Prescribing Systems

Electronic prescribing is available to all provider types in one county, and to some providers in five other counties.

Incentives for Health Information Technology Use

In three counties, providers' use of health information technology (HIT) is required by contract. In one of these counties, explicit financial incentives for HIT use by providers are also offered. Another county has instituted a program where the clinic medical home may receive incentive payments for reaching targeted clinical improvements, achieved in part through increased use of disease registries for chronic conditions.

System Design Innovations in Care Coordination and Delivery

Enhanced Access to Specialty Care

Health Care Coverage Initiative counties have enhanced access to specialty care in a variety of ways, including some primary care practice sites. This care may be provided by a specialist and/or an advance-trained PCP. To expand availability of specialty care, two counties report utilizing volunteer specialists and six counties report utilizing telemedicine for specialty care services via grant funding for diabetic retinopathy screening.

Eight counties report that some PCPs have access to remote clinical consultation with specialists via telephone and email. At least two of these counties have conducted more intensive efforts in redesigning their delivery of specialty care that includes ongoing communication between PCPs and specialists in the form of telephone consultations to offer specific treatment or condition management without requiring a specialty referral. Two counties do not employ formal methods of clinical specialty consultation currently, but report that PCPs and specialists may communicate informally.

Expanding Scope of Practice of Primary Care Providers

Three counties report they provide specific continuing medical education (CME) courses to primary care providers. These courses focus on HCCI program objectives, such as increasing knowledge and practice of chronic care management or the medical home model. One of these counties has also implemented mini-fellowships or apprenticeships to provide intensive topical clinical training as well as mentoring and access to future consultations. This county and one other utilize specialty champions or "registrars." These are defined as PCPs who become familiar with specific evidence-based guidelines and/or basic specialty procedures, and are then available to provide internal training for and consultation to other primary care providers.

Five counties report other interventions, such as meetings between PCPs and medical directors and between PCPs and pharmacy directors, which may include training on effective team-based care for chronic conditions or appropriate medication management. Among those with no formal training at present, at least two counties have PCP scope-of-practice expansion activities planned for the next year.

Referral Management Policies and Clinical Guidelines for Referrals

All HCCI counties report that they have created referral policies and make them available to PCPs and specialists. Four counties include emergency rooms and five include hospitals among the list of providers with access to referral management policies.

Evidence-based clinical care guidelines for specific disease conditions outline requirements and appropriate protocols for specialty care referral. PCPs and specialists have access to these disease-specific guidelines nearly always. Hospitals (four counties) and emergency rooms (two counties) also have access to these guidelines.

HCCI Counties Plan to Further Enhance Provider Networks

Further developments are planned or are underway in most HCCI counties. These activities predominantly fall into the areas of infrastructure support tools and system design innovations, although some modifications in provider networks, reimbursement agreements and covered services are also planned. County efforts to enhance their provider networks include:

- Updating and enhancing HIT systems (all counties)
- Increasing access to electronic patient information systems for providers across the network (six counties)
- Establishing electronic referrals within the next year (two counties), or enhancing their existing systems (three counties)
- Developing disease management programs for HCCI enrollees (three counties)
- Increasing access by providers to disease registries (two counties)
- Augmenting provider networks to meet patient demand (three counties)
- Updating provider/service payment agreements to increase the probability of program sustainability (three counties)
- Implementing or enforcing cost sharing for enrollees for primary and specialty care visits and pharmacy and emergency room services (three counties)
- Increasing access to specialty care (two counties)
- Implementing a dedicated nurse advice line (one county)

Lessons Learned: Recommendations for Further Enhancements of Provider Networks in HCCI Counties

The provider networks organized by HCCI counties are diverse, ranging from those consisting exclusively of public health providers to various forms of public-private partnerships. The HCCI provider networks encompass a comprehensive array of providers to insure provision of services covered under each program. Provider reimbursement methods are primarily fee-for-service, designed to encourage provider participation in the program, though other forms of payment to better align reimbursement and incentives have been implemented more recently. Health information technology is available in all counties in a variety of forms and to varying degrees. A number of notable innovations in specialty care redesign and care coordination have been implemented. The formation and implementation of provider networks under the HCCI program reveal areas where further enhancements can be made as well as lessons for the creation of safety-net-based networks elsewhere. Based on the evaluation of the experience of the ten HCCI counties to date, we recommend the following for successful development and implementation of safety-net provider networks:

1. Develop networks that are strategically organized and sustainable. Specifically, build provider networks using existing safety-net providers and enhance access by expanding the networks to provide a comprehensive array of services.
2. Align provider reimbursements to increase systemwide efficiencies in care delivery and control expenditures. Fee-for-service reimbursement methods encourage provider participation but are less likely to contain costs. Identifying alternative reimbursement methods combined with utilization review can increase efficiencies in care delivery.
3. Develop uniform and centralized health information technologies, such as electronic medical records, electronic referral systems and disease registries, to reduce inefficiencies due to duplication of systems, and provide systemwide access for all providers.

4. Consider pay for performance (P4P) or other incentives to develop and improve use of health information technologies. These incentives may be necessary initially for development costs and to encourage full and accurate participation of individual providers. Ultimately, enhanced reimbursement rates for medical homes are intended to reimburse primary care providers for costs and to motivate participation. Similarly, enhanced reimbursement rates for specialists and other providers are intended to motivate use of such systems and ultimately enhance quality of care.
5. Explore training to increase the scope of practice of PCPs, thus reducing the need for specialty care referrals. Innovative methods such as specialty champions and mini-fellowships are promising examples of increasing the scope of practice of PCPs and reducing the inefficient use of specialists.
6. Enhance the ability of PCPs to consult with specialists prior to referral by implementing formal processes and increasing the available methods of communication between these providers.
7. Develop specialty care referral management policies and clinical care guidelines, and insure adherence to these guidelines.

Future of HCCI and Safety-Net Provider Networks

The existing federal 1115 waiver, which led to the implementation of the HCCI program, is set to expire on August 31, 2010. Negotiations for renewal of the waiver are in progress, though the structure and components of the renewed waiver will not be determined until August 2010.[51] The sustainability of the HCCI programs in the ten demonstration counties without ongoing supplemental funding is questionable, particularly because the majority of HCCI counties have increased population enrollment, scope of services and provider reimbursement levels. Some infrastructure and administrative innovations, such as HIT and administrative policies and procedures, are relatively permanent and sustainable even if the waiver were not renewed. However, many other advances indentified in this policy brief are not sustainable in the absence of additional funds. As a result, an enrollment freeze across HCCI programs is scheduled for March 1, 2010, and four HCCI programs have already halted new member enrollment.

The preliminary version of the new waiver would expand enrollment in existing HCCI counties as well as add more counties to significantly reduce the number of documented low-income uninsured Californians. Expansion of safety-net provider networks will prepare California for implementation of proposed national health care reform. Although comprehensive primary care centers are an essential component of the safety net nationally, the limitations these centers currently face in specialty referral, diagnostic and other hospital-based services result in compromised care for the uninsured, even those that have a primary care medical home. Nevertheless, California's HCCI safety-net-based networks demonstrate how existing infrastructure and community-based services can be incorporated into a comprehensive system of care to address such resource limitations.

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	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
HCCI NETWORK STRUCTURE										
County hospital system (CH), public/private network (PPN)	CH, PPN	CH, PPN	CH, PPN	CH, PPN	PPN	PPN	CH	CH, PPN	CH, PPN	CH, PPN
NETWORK SERVICES AND REIMBURSEMENT										
Primary Care										
Setting: county hospital (CH), county clinic (CC), private clinic (PC), private physician (PP)	CH, CC, PC	CH, CC, PC	CH, CC, PC	CH, CC, PC	PC, PP	PC	CH,CC	CH, CC, PC	CH, CC, PC, PP	CC, PC
Reimbursement method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	C, BF	F	S, BF	S, BF	F	F	S	S, BF	S, F	S, BF
Urgent Care										
Setting: county hospital (CH), county clinic (CC), private clinic (PC), retail clinic (RC), private physician (PP)	CH, CC, PC	CC, PC, PP	CH, CC, PC	CH, CC, PC	RC, PC	PC	CH, CC	CH, CC, PC	CH, CC, PC, PP	CH, CC, PC
Reimbursement method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	C, BF	F	S, BF	S, BF	F	F	S	S, BF	S, F	S, BF
Specialty Care										
Setting: county hospital (CH) county clinic (CC); private hospital (PH), district hospital (DH), private clinic (PC); private physician (PP)	CH, CC, PH, PC, PP	CH, CC, PH, PC, PP	CH, CC	CH, CC, PC	PH, PC, PP	PH, DH, PC, PP	CH, CC	CH, CC, PH, PC, PP	CH, CC, PC, PP	CH, CC, PC
Reimbursement method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	C, BF	F	S	S, F	C, F	F	S	S, BF	S, F	S
Inpatient Care										
Setting: county hospital (CH), private hospital (PH), district hospital (DH)	CH, PH	CH, PH	CH, PH	CH	PH	PH, DH	CH	CH, PH	CH	CH
Reimbursement method: capitation (C), salary (S), bundled per diem (BP), Per diem (PD), Other (O)	BP	BP, PD	S, PD	S	BP	PD	S	PD	C, PD	S
ANCILLARY SERVICES AND REIMBURSEMENT										
Laboratory Services										
Setting: county clinic on-site (CS), county hospital on-site (CHS), private clinic on-site (PS), private hospital on-site (PHS), district hospital on-site (DHS), private/commercial off-site (PO)	CS, CHS, PS, PHS, PO	CS, CHS, PS, PO	CS, CHS, PS, PO	CS, CHS, PS	PHS, PO	PS, PHS, DHS, PO	CS, CHS	CS, CHS, PS, PHS, PO	CS, CHS, PS	CHS
Reimbursement method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	BF	BF, F	S, BF	S, BF	C	F	S	BF, F	C	S, BF
Imaging/Diagnostic Services										
Setting: county clinic on-site (CS), county hospital on-site (CHS), private clinic on-site (PS), private hospital on-site (PHS), district hospital on-site (DHS), private/commercial off-site (PO)	CS, CHS, PS, PHS, PO	CS, CHS, PO	CS, CHS, PS, PO	CHS, PS	PHS, PO	PS, PHS, DHS, PO	CHS	CHS, PHS, PO	CS, CHS, PS	CHS

	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Reimbursement method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	BF	BF, F	S, BF	S, BF	C, F	F	S	BF, F	C, F	S, BF
Pharmacy Services										
Setting: county clinic on-site (CS), county hospital on-site (CHS), private clinic on-site (PS), private hospital on-site (PHS), district hospital on-site (DHS), private/commercial off-site (PO)	CS, CHS, PS, PHS, PO	CHS, PO	CS, CHS, PS, PO	CS, CHS, PS, PO	PHS, PO	PS, PHS, DHS, PO	CHS, PO	CHS, PO	CS, CHS	CS, CHS, PO
Reimbursement method: capitation (C), salary (S), bundled fee-for-service (BF), fee-for-service (F)	BF	F	S, BF	S, BF	F	F	S, F	F	C	S, BF
Pharmacy Benefit Manager (PBM): all (A), some (S), none (N)	S	A	N	N	A	A	N	A	N	A
Medication reconciliation services required by contract: all (A), some (S), none (N)	S	S	N	N	N	N	A	S	N	N
HEALTH INFORMATION TECHNOLOGY (HIT)										
Electronic eligibility check available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I), program staff only (O)	PCP, S, ER, I	PCP, S, ER, I	PCP, S, ER, I	O	PCP, S, ER, I	O	PCP, S, ER, I	PCP, S, ER, I	PCP	O
Electronic appointment scheduling available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I), program staff only (O)	O	PCP, S, ER, I	PCP, S	PCP, S, ER, I	O	PCP, ER	PCP, S, ER, I	PCP, S	PCP, S	PCP, S, ER, I
Electronic patient information system: EMR, LCR, electronic summary sheets, care records, or other (O)	O	O	EMR, O	O	O	O	LCR	EMR, LCR	EMR, LCR	O
Electronic patient information available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I)	PCP, S	PCP, S, ER, I	PCP, S, ER, I	PCP, S, ER, I	PCP, ER	PCP, S, ER, I	PCP, S, ER, I	PCP, S, ER, I	PCP, S, ER, I	PCP, S, ER, I
Electronic specialty referral/tracking available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I), none (N)	PCP, S	N	PCP, S	PCP, S, ER, I	PCP, ER	N	PCP, S, ER, I	PCP, S	PCP, S, ER, I	N
Method of specialty referral follow up to PCP: web-based (W), other electronic system (E), other follow-up (O)	W, E, O	E, O	W, E,O	W, E, O	E, O	E, O	W, E, O	W, E, O	W, E, O	E, O
Disease registries utilized: diabetes (1), heart disease (2), hypertension (3), hyperlipidemia (4), asthma (5), immunizations (6), other (7)	1	1, 5, 6	1, 2, 3, 5, 6	1, 2, 5	1, 2, 3, 5, 7	1, 3, 4	1, 2, 4, 5	1, 3, 4, 5, 6	1	1, 3, 4, 7
Disease registries available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I)	PCP, S, ER, I	PCP, S, I, ER	PCP	PCP, S	PCP	PCP, S, ER, I	PCP, S, ER, I	PCP, S, ER, I	PCP, S, I	PCP
Electronic prescribing available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I), none (N)	N	S, ER, I	PCP, S	N	N	S, ER, I	PCP, S, ER, I	PCP, S	I	N

	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Incentives for HIT use: contract requirement (CR); enhanced reimbursement (ER), bonuses (B), other (O), pay-for-performance (P4P), none (N)	N	N	N	CR	CR, P4P	N	O	N	CR	N
SYSTEM DESIGN INNOVATIONS IN CARE COORDINATION AND DELIVERY										
On-site specialty care at primary care practice sites: all (A), some (S), none (N)	S	S	S	S	S	S	S	S	S	S
Alternative sources of specialty care: volunteer specialists (V), telemedicine (T), none (N)	T	T	T	V	N	V, T	N	T	N	T
Clinical specialty consultation communication methods available to PCPs: telephonic (T), electronic (E)	T, E	T, E	T, E	N	N	T, E	T, E	T, E	T, E	T, E
Expanding training or scope of practice for PCPs: continuing medical education (CME), mini-fellowships (MF), specialty champions (SC), other training (O), none (N)	O	SC, O	CME, MF, SC	N	N	O	O	CME	CME, O	N
Existence of referral management policies for: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I)	PCP, S, ER, I	PCP, S	PCP, S, ER, I	PCP, S	PCP, S, I	PCP	PCP, S, ER, I	PCP, S	PCP, S, ER, I	PCP, S
Clinical care guidelines for appropriate specialty referral available to: PCPs (PCP), specialists (S), emergency room (ER), inpatient (I)	PCP, S	PCP, S, I	PCP, S	PCP, S	PCP, S	PCP, S, ER, I	PCP, S	PCP, I	PCP, S, ER, I	PCP, S

Alameda County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The Health Care Coverage Initiative (HCCI) Program in Alameda County is called Alameda County Excellence (ACE). Implemented by the Alameda Health Care Services Agency (HCSA), ACE focuses on improving the quality of care for low-income uninsured adults with diabetes, hypertension, asthma and congestive heart failure. The program uses the chronic care model in conjunction with panel management, a population-based, data-driven multidisciplinary approach to provide team-based primary care. As of May 31, 2009, Alameda County has enrolled 6,655 ACE members; 1,155 more than the proposed three-year program target.

Safety-Net System Prior to HCCI

Prior to HCCI, safety-net providers in Alameda County consisted of the Alameda County Medical Center (ACMC), with one onsite hospital-based clinic, three hospital-affiliated free-standing clinics dispersed throughout the community, and nine contracted-community clinic organizations with approximately 25 clinic sites. The county contracted with local community clinics to provide care to low-income indigent adults, and paid individually-negotiated bundled rates similar to the Federally Qualified Health Center (FQHC) rate. There were significant unmet need and access barriers among the medically-indigent population in the county. Limited referral and case management services existed, and provider training programs, collaborative meetings and other communications between the components of the network were neither formal nor frequent.

HCCI Network Structure

The Alameda County ACE network consists of the county hospital system and private providers. All providers in the ACE program network were previously the safety-net providers in Alameda.

Network Services and Reimbursement

The ACE network is built around ACMC, which is a county-affiliated public hospital with an independent governing board and a budget separate from the county. The HCCI network providers include the ACMC, one ACMC hospital-based clinic, three free-standing clinics with FQHC status, and nine contracted community clinic organizations with 25 clinic sites (including two dental clinic sites) for a total of 27 medical homes. Eight of these clinic organizations have FQHC status. The contract with one community provider called Bay Area Consortium for Quality Care ended in November 2008 and the county replaced this provider with a new provider called Healthy Communities, Inc., which began providing services in July, 2009. Although the physical network did not change in size it did change in scope under HCCI. Such changes include the addition of programs, including the heart-failure clinic, as well as formalization of the medical home model, implementation of panel management and team-based primary care, and quality improvement activities.

In the process of executing contracts with clinics for the ACE network, the county stipulated an enrollment target for each clinic. The reimbursement level for each clinic was then based on this initial target, which was an estimate of the number of eligible individuals previously seen as patients in each clinic. Clinics are reimbursed based on the number of patient visits in their contract target, regardless of utilization beyond

that level. Community clinics targets ranged from 80 to 500 enrollees but ACE enrollment currently ranges from 80 to 1,000 enrollees at clinics. The medical center and affiliated clinics had a target of 2,000 but currently have about 3,000 ACE enrollees. At the end of the first program year, the county redistributed funding according to actual enrollment at each clinic, as some clinics had not yet met their initial target, while others had exceeded it. Most clinics accept all assigned enrollees and have not capped ACE enrollment at their contracted target.

ACE utilizes primary care providers from ACMC and private community clinics. Primary care visits for ACE patients are reimbursed through an enhanced bundled fee-for-service payment of $206 which is paid in addition to each clinic's contracted base rate, and is inclusive of all ancillary services.

Urgent care services are available at many of the clinics within the network, which offer after-hours and urgent care appointments. Clinics are reimbursed for urgent care visits with the same enhanced fee they receive for primary care. ACE enrollees can also utilize urgent care at ACMC in the emergency room. The hospital is reimbursed a per life rate, which is a monthly installment based on achieving a required target number of lives as designated by their contract with the HCSA for urgent care. A bundled fee-for-service payment of $500, which is inclusive of all ancillary services, is paid on top of the per life rate for emergency room visits.

ACE enrollees typically receive specialty services at ACMC. The ACMC also has contractual agreements with private providers and hospitals in the county to provide access to specialty services not available in the county system. Some community clinics provide limited specialty services onsite, including podiatry and optometry. Reimbursement for specialty care is not differentiated from primary care at community clinics. ACMC is reimbursed for specialty care at the per-life rate described previously, in addition to the enhanced bundled fee-for-service payment of $500 for all ancillary services. ACE also pays ACMC the specialty-care fee for care provided by contracted specialists outside of the medical center; ACMC then negotiates payment with each private hospital directly.

Inpatient care is provided at ACMC and private hospitals if services are not available at ACMC. ACMC receives a per-life rate for inpatient care and an additional bundled per-diem payment of $1,000 per day above the base rate for all ancillary services. For inpatient days provided by private hospitals, ACMC receives inpatient care reimbursement from ACE and pays these hospitals at negotiated rates.

Ancillary Services and Reimbursement

Select clinics have limited laboratory, diagnostic and pharmacy services available onsite. Enrollees who receive care at ACMC-affiliated clinics or on the ACMC campus utilize the medical center's outpatient laboratory, diagnostic and pharmacy services. Those clinics that do not have access to onsite ancillary services contract with private offsite facilities to meet enrollee demand.

The enhanced fees paid by ACE for primary, specialty, emergency and inpatient care are inclusive of reimbursement for all ancillary services. This is true for all providers and facilities contracted to provide care within the ACE network. Individual clinics or clinic organizations develop their own contractual agreements to provide ancillary service to enrollees. The county ACE program does not monitor how clinics provide these services, although the county does have data on what services enrollees receive.

Providers in the network may have access to pharmacy benefit management (PBM) services through their contracted private pharmacies. ACMC also contracts with a PBM service. Medication reconciliation services (a review of patient medications) are a key standard of panel management, which is being implemented at all of the primary care sites in the ACE network. The county currently monitors to what extent individual clinics are meeting panel management standards, including medication reconciliation, through panel management assessments done by the ACE Quality Coordinator.

Health Information Technology

The ACE program uses O*ne-e-App* for eligibility and enrollment. As of spring 2008, *One-e-App* is rolled out

systemwide, and is available to all providers within the network. *One-e-App* has been customized to the ACE eligibility guidelines. The program staff at each clinic within the network has a unique electronic appointment scheduling system.

Most clinics in the ACE network have some form of electronic patient information system available to providers. However, electronic patient information is only available to each patient's medical home, and is not available to other providers in the network. There is no centralized electronic patient information system in use in Alameda County at this time, although the county is planning for development of systemwide electronic medical records (EMRs) within the next three years.

There is an electronic referral (*e-referral*) system called *RefTrak* available to all providers in the ACE network. The system provides two-way electronic communication between the medical home and specialists, and was recently updated to send automatic email alerts to referring providers to view updates on patient status and clinical notes when available. Additionally, panel managers at the clinics may conduct informal referral tracking by telephone or email. The system also sends progress notes back to the PCP electronically. The level of feedback is still dependent on specialist utilization of the system. By the end of this year, *RefTrak* is expected to do *auto-calls* to remind patients of follow up visits. In addition to using *RefTrak*, referral followup is also done via telephone and fax, typically by panel managers.

ACE utilizes a diabetes registry, which is a key standard of panel management. Diabetes registry use is led by a panel management team at each clinic**.** Panel management targets patients for chronic care management activities in a manner tailored to each site. All clinics within the ACE network use *i2iTracks*, which is an electronic chronic care registry. The *i2iTracks* system in each clinic is not linked to others, but patient information is standardized in some.

Electronic prescribing is not currently is use in Alameda County. The ACE program does not incentivize or require providers to use available health information technology at the present time.

System Design Innovations in Care Coordination and Delivery

Specialty care access is promoted with onsite specialists such as podiatrists and optometrists at some ACE network clinics. The ACE program does not rely on volunteers or alternative sources of specialty care personnel, although it does use contractual agreements to supplement the provider pool where needed.

The ACE program has received multiple grants to increase access to specialty care in HCCI. Under a *Specialty Care Access Initiative* grant from Kaiser Permanente, Alameda County has created a Specialty Care Task Force, consisting of staff from the county medical center and the local community clinics. This task force has met monthly to work on several specialty care issues since mid-2008. Activities include decentralizing the provision of specialty care, improving the electronic consultation and referral processes, expanding PCP competencies, and utilizing telemedicine. Through a grant from California Health Care Foundation (CHCF), telemedicine with the UC Berkeley Optometry Clinic for remote diabetic retinopathy screening is available at both ACMC and several of the community clinics. Currently, consultation with specialty providers is done via telephone or email. ACMC is also planning to pilot other electronic consultation methods between network primary and specialty care providers in the spring of 2010.

ACE is working to extend the scope of practice of primary care physicians through mini-fellowships. The mini-fellowships are designed to reduce unnecessary specialty care referrals. To date, two specialty care providers, one in dermatology and one in orthopedics, have agreed to work with ACE primary care providers. It is anticipated that the primary care providers will begin the mini-fellowships by December 2009.

The county offers specific ongoing trainings in panel management and the chronic care model for primary care providers and staff. Panel management has been adopted by the ACE program as a strategy for improving outcomes for individuals living with chronic

disease and reducing the need for specialty care. Panel management is a data-driven multidisciplinary team approach in which a primary care team jointly plans and manages the care of clients with chronic disease; the team uses a disease registry to identify clients' unmet care needs, to gather summary information for care interventions and to communicate with clients.

A grant from the National Association of County and City Health Officials assisted in funding recruitment of additional clinic staff needed to implement the ACE program. The funding also covered several trainings: a *train the trainer* event to teach clinical staff about panel management, the chronic care model and action planning; in-house training at clinics; and an all-day training for 95 ACE clinic personnel on the implementation and use of *i2iTracks*.

The County Public Health Department collaborated with the California Department of Public Health *Heart Disease and Stroke Prevention Program* and received funding to provide an *Improvement Leadership Workshop*. This two-day workshop trained 29 participants on: understanding basic clinical outcomes data; how to analyze the system of care at their clinic for improvement; and how to organize and support a quality improvement project. All participants created action plans that included measurable results for specific indicators. As follow up, each clinic will receive monthly coaching calls to see how the implementation of the action plan is progressing and to offer support and/or recommendations.

PCPs refer to specialists through the *RefTrak* electronic referral system. *RefTrak* includes a detailed protocol for PCPs to follow before referring a patient. Additionally, plans are underway to add admitting, diagnosis and treatment data to the system to streamline the process. ACE has established quality assurance mechanisms conducted under the leadership of the *Clinical Implementation Committee*. The committee ensures dissemination of best practices and clinical performance measures, including evidence-based guidelines. ACMC also has a Referral Coordination Unit that reviews the referrals made via *RefTrak* and triages referrals based on either guidelines or the specialists review.

Future Plans

During the remaining period of the HCCI program, Alameda County plans to expand or enhance multiple aspects of the network and its infrastructure tools. Specific plans include:

- Completing standardization of information contained in *i2iTracks* across the network.
- Improving capability for two-way communication within the electronic referral system, to allow enhanced referral tracking and follow up.
- Continued focus on quality improvement and panel management.
- Systemwide access to electronic medical records.

Network Sustainability

Although many of the enhancements made under HCCI to the safety-net network in Alameda County are sustainable, loss of HCCI funding will reduce or eliminate the enhanced rates paid to providers through the ACE program and access to care would be diminished. Most importantly, panel management services would not be possible to maintain without the enhanced reimbursement rates currently in place. Similarly, access would be further restricted, as both the system as a whole and primary care providers in particular, are already challenged to meet the needs of the adult low-income uninsured population of Alameda County.

Alameda County's Ideal Network

Alameda County provides services to almost 60,000 low-income uninsured patients a year, but access to care, particularly specialty care, remains a barrier. With sufficient funding to provide care for all uninsured, Alameda County would enhance primary care capacity. HCSA is looking at options to provide lower cost episodic care through expanding school-based health centers, increasing services at local community colleges and potentially providing services at fire stations. These clinics would have referral access to the current provider network which would continue to provide full-scope primary care services focused on patients with chronic disease. Alameda County would ideally like to develop a centralized

information system that identifies appointment availability and scheduling capability for all enrolled individuals.

Alameda County's Best Practices

Alameda County has a number of practices which may be replicable in other settings.

- The program has utilized panel management and the chronic care model to promote enrollee health by identifying gaps in patient care and proactive patient management. The program is currently conducting an assessment of the implementation of panel management standards.
- Enhanced compensation is used within ACE as a strategy to incentivize the provision of comprehensive care through the ACE network and encourage provider participation.
- Alameda County has focused intensely on improving quality of care through numerous efforts. The majority of the efforts concentrate on improving care at the primary care level to reduce demand for specialty care, which has had a high level of demand and long waiting times for appointments.
- The program has employed alternative strategies (including telemedicine and a pending mini-fellowship program) to increase the availability of specialty services.

Contra Costa County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The Contra Costa Health Plan (CCHP), a Knox-Keene licensed Health Maintenance Organization owned and operated by the county, administers the Health Care Coverage Initiative (HCCI) program in the county. The program has focused on improving access to services for individuals enrolled in their safety-net program, and increasing the number of individuals enrolled. Contra Costa County has enrolled 10,949 members as of May 31, 2009; 2,349 more than the proposed three-year program target of 8,600.

Safety-Net System Prior to HCCI

Prior to HCCI program implementation, Contra Costa County provided local indigent health care through the Basic Health Care (BHC) program. CCHP administered BHC along with Medi-Cal, Healthy Families and commercial insurance products. CCHP had contracts with Federally Qualified Health Centers (FQHCs) in the county prior to HCCI, which comprised the network for all their products. However, not all of these providers were accessible to medically-indigent adults enrolled in BHC. Prior to HCCI, private community-clinic FQHCs in particular were not part of the baseline network.

Prior to HCCI, network providers were located at sites within Contra Costa Health Services (CCHS), the county health system, which includes Contra Costa Regional Medical Center (CCRMC) and eight county-owned FQHCs. Additionally, CCHP utilized private contractors based in private-practice offices and hospitals to fill gaps in access to sub-specialty and more advanced specialty care. However, low-income uninsured adults in the county had limited access to primary care, and did not typically have an assigned primary care physician or a medical home. BHC members received predominantly episodic care and limited case management services. The program also lacked health information systems that link the private community clinics to the county's HCCI program for eligibility, applications or reporting purposes.

HCCI Network Structure

Contra Costa County's HCCI network is part of the CCHS county hospital system and is administered under the local managed-care system. The HCCI network is a public-private partnership. In order to accommodate the uninsured low-income adults newly covered under HCCI, Contra Costa Health Plan expanded access for enrollees to two private community FQHCs with multiple clinic sites.

Network Services and Reimbursement

The CCHP network for HCCI is composed of Contra Costa Regional Medical Center , eight county-owned clinics with FQHC status, and two private FQHC clinic systems called La Clinica de La Raza (with three clinic sites) and Brookside Community Health Center (with two clinic sites). Additionally, CCHP has contractual agreements with private physicians and private hospitals within the county. In total, there are 12 clinic sites, seven hospitals and numerous private physicians in the network, with a total of approximately 624 physicians and 136 medical homes available to HCCI enrollees.

Some clinics within the network are significantly larger than others, and therefore have more enrollees assigned

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to them. However, due to the use of electronic primary-care-provider assignment for HCCI enrollees in the network, enrollees are distributed fairly evenly among primary care providers.

The primary care providers (PCPs) in the HCCI network are based at CCHS's eight county-owned health centers and the two private FQHC clinic systems. All primary care providers are either county employees or are contracted with CCHP, and are reimbursed through a prospectively-determined fee for each visit, which is negotiated in the contract with each CCHP clinic or physician.

Urgent care is delivered through a nurse advice line and same-day or next-day appointments in the medical home. Several county-owned clinics have after-hours scheduling for urgent appointments, and both county-owned and private-clinic medical homes have same-day appointments available to their enrollees. CCHS also has an open-access scheduling system that allows for same-day visits to primary care physicians and specialists. Additionally, CCHP recently completed contracts with five private community-based urgent care centers, to which enrollees may be directed by the advice nurse to fill a gap in access when necessary. Urgent care services in the network are reimbursed on a per-visit (fee-for-service) basis.

Specialty services for HCCI enrollees are primarily provided at CCHS's eight county-owned health centers. Specialty care services are also available through contracted private physicians and private hospitals which are used to create access in the rare cases where services are not available within the county-operated system. All the specialists in the network are paid a fee- for-service rate with some receiving an enhanced rate coordinated on a case-by-case basis.

Inpatient care for HCCI enrollees is primarily provided at CCRMC. Inpatient care at CCRMC is reimbursed through a bundled per-diem rate. In rare cases where an enrollee requires higher level services that are not available within CCHS, the county covers inpatient care at contracted private and university hospitals, which are reimbursed through negotiated fee-for-service rates.

Ancillary Services and Reimbursement

HCCI enrollees may receive laboratory services at their medical home clinic including advanced laboratory and diagnostic services. The few laboratory and diagnostic services not provided in the medical home clinics are provided at CCRMC. Additionally, enrollees may be referred to contracted private offsite facilities to receive laboratory or diagnostic services not available within the county facilities. All services from contracted facilities require prior authorization by the utilization management department, and are reimbursed through a fee-for-service payment. Laboratory and diagnostic services provided within the medical homes or CCHS are paid via a bundled rate.

CCHP has contracted with a Pharmacy Benefit Manager (PBM) which subcontracts with chain and independent private pharmacies. There are 12 Walgreen's pharmacies located throughout the county. Additionally, there is an inpatient pharmacy at CCRMC. Pharmacies are paid a contracted fee-for-service rate for medications in the network formulary. The PBM provides data on pharmacy use to CCHP. Inpatient medication reconciliation or a review of patient medications, is conducted routinely at CCRMC. Primary care providers are also able to receive data and feedback about prescribing patterns.

Health Information Technology

CCHS has an electronic eligibility and enrollment system. The system was in use in the county prior to the HCCI program, however, it was customized for HCCI to address eligibility guidelines for the program. Additionally, the application was significantly expanded to be available to all providers at medical home clinics within the network. Contracted private specialty providers who do not have access to the application can call an automated telephone service to confirm eligibility.

HCCI enrollees are able to schedule appointments by phone, and can typically receive same-day or next-day appointments. Most medical homes utilize unique electronic appointment scheduling systems to which their own providers and staff have access. The medical center and emergency department also have access to

electronic appointment scheduling. However, a centralized electronic appointment scheduling system is not currently available across the HCCI network.

Contra Costa County does not have a single health information technology (HIT) system that contains all patient information and is accessible across the system. Rather, CCHS operates a range of internal, proprietary and vendor electronic patient information systems which are available to all providers across the county-operated health clinics.

Providers are required to issue a referral for specialty-care services in the HCCI program. Currently, referrals are made by fax or paper, although implementation of an electron referral (*e-referral*) application, called the *Gaudette System* is planned within the next year. The system is to be used primarily for referrals to specialists who are not a part of CCHS. For most procedures, referral requests must be reviewed by the CCHP utilization review department. The utilization review department can track the progress of a referral, and provides updates to primary care providers on referral status. At this time, providers are not able to track referral progress themselves, although the planned *e-referral* system will create this capability.

Currently, medical home providers can follow up on referrals through the CCHS medical record systems, which contain information on all services received by enrollees at county-operated sites. Followup on services provided by contracted private providers is less frequent. However, case managers within the system are responsible for tracking all utilization of case-managed HCCI enrollees, and communicating with primary care providers to coordinate care. Upon implementation of the *e-referral* system, automated two-way communication between providers will be supported.

CCHS operates an immunization registry which is available across the network to both county and private contracted providers. Individual clinics in the network may also have unique disease registries that are not shared across the system. CCHS utilizes asthma and diabetes registries that are not available outside of the county system. Use of the registries by individual providers varies, and is not required by contract.

Electronic prescribing is currently available to providers within CCHS through a system called *RxM*. Prescriptions generated by the system are then printed and faxed directly to the enrollee's pharmacy. Implementation of automated electronic prescription transmission to network pharmacies is planned within six months.

The county does not incentivize for or require the use of the available HIT by HCCI providers, although the majority of county employees do utilize the available information systems.

System Design Innovations in Care Coordination and Delivery

Specialty care is available to enrollees in the same location as their medical home, particularly at the county-owned clinics located throughout Contra Costa County. There are a few specialty services, such as oncology treatment that the majority of enrollees must travel from their primary care medical home to access. The county has also expanded its network of specialists through contractual agreements with non-county providers, but does not use volunteer specialists or other alternate sources of specialty care personnel.

By contracting with La Clinica de La Raza, Contra Costa County has provided HCCI enrollees with access to telemedicine for retinal screening. La Clinica de La Raza was the recipient of a California Health Care Foundation (CHCF) grant which funded retinal cameras, telemedicine software and remote specialty consultation with the UC Berkeley Optometry Clinic. All individuals utilizing La Clínica within the county have access to these services, including HCCI program enrollees. PCPs also have access to specialty consultation in the network via telephone and email.

Some primary care providers within the network receive specific trainings to enhance their scope of practice which then allows them to become *registrars*. PCPs who are designated as registrars carry out additional functions beyond the traditional scope of practice in the primary care setting. In addition, PCPs may receive training at CCRMC on clinical and

administrative issues related to HCCI objectives, such as working with case managers or pharmacy utilization.

Contra Costa County has implemented clear guidelines for primary care providers and specialists regarding policies and procedures involved in making and receiving referrals. For specialty care services outside CCHS, referral requests must be reviewed by the CCHP utilization review department, which uses several types of decision support software, as well as Medicaid and Medicare clinical care guidelines to assess referral appropriateness. These clinical care guidelines and decision support tools are available upon request to all provider types within the network.

Future Plans

Contra Costa County intends to continue developing its HCCI network in the period remaining under the waiver demonstration through August 31, 2010. Specific plans include:

- Implementing the *Gaudette System*, which will include an *e-referral* application and will facilitate electronic referral tracking and two-way communication for referral followup.
- Enhancement of the *e-prescribing* system, such that prescriptions are electronically submitted to the pharmacy rather than faxed.
- Further integration of health information systems within HCCI network.
- Continuing to develop care management services for enrollees with chronic health conditions.
- Continuing to conduct outreach to diverse populations, including homeless individuals.

Network Sustainability

Under the HCCI program, the county in partnership with CCHP has implemented a range of enhancements and innovations to the network, many of which are expected to be sustainable beyond the HCCI program period. In particular, the county will continue to support the infrastructure support tools, and improve the *e-prescribing* and *e-referral* systems.

Contra Costa County's Ideal Network

The CCHP network in Contra Costa County is vast, but may be nearing its capacity to provide care to all low-income uninsured adults in the county. If funding to reimburse care for all medically indigent individuals in the county were to become available, the County would make improvements to the health information technology systems to achieve a more seamless system. Additionally, expanded outreach would be conducted to reach other potentially-eligible individuals and link them with care.

Contra Costa County's Best Practices

- Contra Costa County built on pre-existing CCHP's infrastructure and product lines to create the HCCI network. The CCHP facilitated access to a full scope of services for HCCI enrollees. Additionally, this approach allowed the county to achieve competitive contract rates with providers due to the leverage provided by the size of the patient population and diversity of payers represented by the health plan.
- Upon enrollment, enrollees complete a self-reported health assessment which is used to triage them into the appropriate level of service, including care management. Care managers then provide referral followup and care coordination services, and communicate closely with primary care providers. The county also uses non-clinical case management personnel to assist enrollees with appointment scheduling and social services.
- Access to the 24/7 nurse advice line for HCCI enrollees in Contra Costa County has allowed the program to redirect patients to the appropriate level of care within the network. The county reports that over 40% of calls to the advice line result in a recommendation of *at home care,* thereby reducing inappropriate use of the emergency department.
- The program utilizes electronic primary-care-provider medical home assignment upon enrollment. This tool has allowed for an even distribution of patients across network PCPs, preventing any provider from carrying a disproportionate share of HCCI patients.

Kern County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The Health Care Coverage Initiative (HCCI) program in Kern County is known as the Kern Medical Center Health Plan (KMCHP) and is administered by COPE Health Solutions. KMCHP utilizes an *Integrated Delivery Network* (IDN) approach to build strategic alliances with public and private providers, and to create a system of care that can improve access to the low-income uninsured population in the county. Kern County enrolled 5,356 members as of May 31, 2009; 356 more than the proposed three-year program target.

Safety-Net System Prior to HCCI

Prior to HCCI, Kern County's low-income uninsured residents used Kern Medical Center (KMC) and community clinics for needed care. There were no financial agreements between KMC and private community clinics, nor was there formal coordination of services between providers. KMC provided services for medically indigent adults (MIAs) up to 133% of the federal poverty level (FPL), and covered approximately 90% of hospital outpatient and 83% of inpatient services for uninsured indigent residents in 2005. There were no other county facilities available to MIA patients in the area for outpatient hospital or specialty care. Patients often had to travel long distances to receive services due to the extensive rural areas in the county. Federally Qualified Health Centers (FQHCs) and Rural Health Centers in the area sometimes saw patients who would otherwise qualify for MIA under a sliding-scale fee program, but only for primary care.

HCCI Network Structure

The KMCHP network includes the county hospital system and private community clinics. Negotiations with community clinics were underway in 2008, and in January 2009 the first patients were assigned to private community clinics.

Network Services and Reimbursement

Primary care services are provided at three hospital-based clinics, a Federally Qualified Health Center (FQHC) with 10 clinic sites called National Health Services (NHS), and one free-standing private community clinic called Community Action Partnership of Kern (CAPK). KMCHP enrollees had no cost-sharing initially, but as of November 1, 2009, enrollees between 133-200% of the federal poverty level (FPL) will have copayments for inpatient hospital care, emergency room visits, specialty-care physician visits, non-formulary medications, physical therapy and some imaging diagnostics. The National Health Services clinics and KMC clinics have about 1,000 enrollees and CAPK has approximately 500 enrollees.

There are approximately 20 salaried physicians, 24 internal medicine and 18 family medicine residents in the three KMC clinics. The NHS clinics employ 20 primary care providers (PCPs) and the free-standing community clinic, CAPK, employs four PCPs.

KMC allocates appropriations within its budget to provide services to HCCI enrollees. Providers at county clinics are compensated through salary that covers the care of HCCI enrollees, teaching and administrative duties. The NHS clinics are paid at a bundled fee-for-service payment of $109 per visit, which may be increased to $115. The bundled fee-for-

service rate covers the visit, basic labs, pharmaceuticals on the formulary, and plain film radiology. CAPK fees differ from NHS fees due to lack of onsite ancillary care.

Most clinics provide urgent care. The NHS clinics and CAPK have extended hours during evenings and on some Saturdays. There is an *Immediate Care Center (ICC)* at the KMC campus where patients may go to receive urgent care; the emergency department also redirects patients to the ICC for non-urgent issues. The reimbursement mechanisms and rates for urgent care services are the same as those for primary care.

Specialty care services are provided at the KMC clinics. The specialists provide coordinated chronic care for targeted conditions such as diabetes, heart disease, rheumatoid arthritis, neurological disorders and orthopedics. Specialists employed or contracted by the county are salaried and the salaries differ depending upon the specialty and the individual contractual arrangement with each specialist.

KMC provides the majority of inpatient care and other hospitals are contracted for authorized services that are not available at KMC. Salaried physicians provide inpatient care at KMC, but inpatient care at contracted hospitals is based on Medi-Cal or Medicare rates and individually- negotiated contracts.

Ancillary Services and Reimbursement

Laboratory and diagnostic services are available at KMC clinics and some of the NHS clinics. CAPK had contracts with laboratory, radiology group and pharmacy vendors for these services, but as of November 1, 2009, the CAPK patients will be referred to KMC for these ancillary services. Ancillary services at KMC clinics are covered by salaried staff. Basic ancillary services at NHS clinics are reimbursed as part of their bundled fee-for-service.

Pharmacy services are available onsite at four of the NHS clinics. Medications for patients who receive care at one of the other NHS clinics are held at NHS clinics with pharmacies, or are sent to the designated medical home clinic. NHS clinics use a more restricted formulary than KMC that promotes the use of generic medications; however, NHS patients can receive medications on the KMC formulary with prior authorization. The KMCHP formulary is the same as the MIA and Medi-Cal formulary, but also includes some medications that the county is able to buy at reduced prices from pharmaceutical companies. The KMC formulary often provides more expensive medically-necessary brand medications through their *Patient Assistance Program*. The KMC pharmacy is staffed with salaried county employees. NHS clinic pharmacy services are included in the bundled fee-for-service rate if the medication is on the NHS formulary. Otherwise, patients are referred to KMC. Starting in November 2009, some KMCHP patients will be charged a $4 copayment for approved non-formulary medications. There is no pharmacy benefits manager (PBM) in the network and medication reconciliation services (a review of patient prescriptions) are not required by contract. The county reports that the latter services are performed by physicians and other clinic staff.

Health Information Technology

Kern County has been working on developing health information technology (HIT) across the HCCI network. Eligibility is tracked through the claims processing system. Eligibility lists are uploaded weekly onto a secure FTP server, where all clinics and the KMC pharmacy can download the information. Registration clerks at clinics can consult these lists to obtain patient eligibility when patients call for appointments or are seen at any of the clinics. KMC providers can view program eligibility, medical home designation and the medical record online. However, private community clinics do not yet have access to the online medical records. Kern County is in the process of implementing a Web-based portal to allow the community clinics access to electronic patient information at the county.

KMC clinics use a McKesson program called STAR Scheduling. Community clinics have their own scheduling methods.

NHS clinics have implemented a full electronic

medical record (EMR) system. KMC clinics utilize paper charting, but have an electronic records retrieval system that is combined with the patient's inpatient record. CAPK uses only paper charting. Both CAPK and KMC are evaluating EMR for planned installment in 2010. The system would allow the entire KMCHP network to have access to all records including ancillary services through an online portal.

An electronic referral (*e-referral*) system called *Pre-Services Manager* (PSM) is currently in use but is being upgraded in January of 2010 to *Horizon Outreach*, a McKesson product. The system allows two-way communication to facilitate referrals and referral followup. However, specialists have not yet been instructed on its use. To use the system, the community clinics input the referral into the PSM and a KMC clerk prints it and sends the referral paperwork to the provider. Referrals may also be made through fax and mail. Additional information requested by the specialist is faxed or mailed to KMC, which in turn sends the request back to the PCP through PSM or fax.

Specialists' clinic notes are written or dictated and scanned into the KMC medical records. However, KMC does not routinely send these notes back to the referring physician. This gap in communication is currently being addressed.

The Kern County diabetes clinic located at KMC utilizes a diabetes registry. The registry is currently not available to all providers, but all providers may refer diabetic patients to this clinic. The clinic is staffed by an endocrinologist with significant assistance from a clinical pharmacist who sees patients and assists in management of their diabetic medications. The FQHC clinics utilize *i2iTracks*, a population health management software system, for tracking diabetes, asthma, hypertension and heart disease. The system also keeps track of regular preventive screenings and services, such as immunizations and cancer screening. However, this registry information is not available to KMC or CAPK.

Electronic prescribing was recently instituted at the KMC clinics. Although NHS clinics do not have a specific e-prescribing system, providers can list prescriptions in their EMR system, which are then faxed directly to the appropriate NHS pharmacy. Kern County does not currently require or otherwise incentivize primary care providers in the HCCI network to utilize HIT.

System Design Innovations in Care Coordination and Delivery

KMCHP has implemented a number of strategies to enhance specialty care services and network development.

Onsite specialty care is only available at the hospital-based clinics. However, KMC received a grant from the California Health Care Foundation (CHCF) to support a telemedicine software program through the UC Berkeley Optometry Clinic for remote diabetic retinopathy screening and consultation between primary care providers and specialists. Despite implementation challenges, the program will begin with a diabetic retinal camera at one of KMC clinics. The grant covers only the camera and the first three months of screening; the remaining costs are partially reimbursable under HCCI.

The program does not utilize alternative sources of specialty-care personnel, although community clinics will contract with specialty physicians as needed. Also, KMC clinical pharmacists offer assistance with some specialty-care services at KMC.

Informal methods of consultation between physician and specialty providers are available via phone and email. The electronic referral system will increase information sharing between PCPs and specialists.

KMCHP conducts continuing medical education (CME) training to providers to redesign primary care practice and improve specialty-care access. Kern County has also developed programs to train primary care physicians in the provision of basic specialty-care services and promote the use of evidence-based *consensus care guidelines* for specific medical conditions. The *mini-fellowship* program in selected HCCI clinics allows providers to undergo training with a KMC specialist to gain clinical expertise in a specific area. Training begins with a pre-test for primary care providers, a lecture from the specialist, a review of

relevant literature, and then a visit to the specialty clinic. At the conclusion of the training, there is a post-test and the providers are awarded 10 CME units for the training. Upon completion of the *fellowship*, these clinic providers are known as *specialty champions* and will have access to phone consultations and chart reviews to obtain medical advice from the specialist. *Specialty champions* are also allowed to bill at a higher rate for a primary care visit: $125 instead of $109. This program is currently being instituted in the community clinics, starting with diabetes care.

KMCHP has increased care coordination through monthly in-person meetings called *community grand rounds* between community clinic and KMC primary- and specialty-care providers. Issues discussed include specialty-care access challenges, consensus care guidelines and referral patterns. There are distance challenges in getting providers together and the program will be testing the use of a Web-based meeting (*Webinar*) in November 2009 to try to achieve increased attendance at these meetings.

Referral management policies are drafted for referral to specialty clinics. Procedures are currently being reviewed and updated as the program plans for upgrades to the existing *e-referral* system in January 2010. The administrative process and management are already in place and the policies will be made available to all provider types.

KMCHP is developing clinical care guidelines called *consensus care guidelines* that delineate the level of care expected in a primary care clinic by a provider who has completed diagnosis-specific CME for a particular specialty or by a specialist. The guidelines define diagnostics expected prior to obtaining a specialty consult. In the second program year, KMC and KMCHP developed guidelines for diabetes and rheumatoid arthritis. Guidelines for seizures and headaches are being completed and are under development for chest pain and heart failure; back pain, shoulder pain and fracture care; joint pain; and thyroid diseases. Guidelines are currently available in paper form and will soon be accessed via the county intranet. The program intends to utilize these guidelines within PSM.

Future Plans

During the period remaining under the HCCI program, the county plans to expand or enhance multiple aspects of the network and its infrastructure tools. Specific plans include:

- Improving the KMC intranet site and giving access to private community clinics.
- Developing *consensus care guidelines* for more conditions in endocrinology, rheumatology, cardiology and orthopedics. Post implementation, availability of specialty clinic appointments, appointment denials and deferral rates will be evaluated.
- Redesigning the referral process between community clinics and KMC.
- Evaluating quality improvements as a result of modifications to clinic systems.
- Continuing to reach out to *Clinica Sierra Vista*, another large FQHC clinic system that cares for a number of uninsured patients in the region but is not currently in the KMCHP network.

Network Sustainability

If the HCCI program discontinues by August 31, 2010, the county will likely continue partnerships with the private community clinics, although the cost-effectiveness of these partnerships is still being evaluated. The program intends to maintain access of the community clinics to the KMC electronic patient information once access is provided. Also, specialty referral processes will continue to be improved.

Kern County's Ideal Network

With sufficient funding to provide care for all uninsured in the county, Kern would improve the network by expanding primary-care capacity with more clinics or private physicians; increase mental health and other care coverage; increase specialty capacity with more private community-based specialists; increase utilization review of more costly procedures; and use a pharmacy benefit manager. The latter is expected to reduce cost and improve coordination of medications, particularly for community clinics.

Kern County's Best Practices

- KMCHP has overcome major barriers and developed a strong network of public and private providers.
- KMCHP has instituted multiple initiatives in redesigned primary care delivery of specialty services. The *mini-fellowship* and *specialty champions* programs provide replicable models, and Kern County reports improvements in quality of care and care coordination efforts due to these programs and their case management program.

Los Angeles County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The Los Angeles County Department of Health Services (LACDHS) administers the Health Care Coverage Initiative (HCCI) program entitled *Healthy Way LA*. The Healthy Way LA (HWLA) program targets individuals with specific chronic illnesses; individuals who are pre-Medicare ages 63-64; and previous users of LACDHS and Public-Private Partnership (PPP) clinics who do not have a medical home. Los Angeles County enrolled 29,252 members as of May 31, 2009, not yet at the proposed three-year program target of 94,000 individuals. The county's HCCI contract with the state was only recently executed in September of 2009.

Safety-Net System Prior to HCCI

Historically, LACDHS has provided health services to medically-indigent individuals through the PPP, county hospitals (Los Angeles County University of Southern California Medical Center, Olive View-UCLA Medical Center, Harbor-UCLA Medical Center and Rancho Los Amigos Rehabilitation Center), two multi-service ambulatory care centers, six Comprehensive Health Centers and 11 primary care clinics. The PPP program, implemented in 1995 to improve access to care, includes a network of independent Community Health Centers, most of which are Federally Qualified Health Centers (FQHCs).

The demand for safety-net services has historically been higher than the capacity for care in Los Angeles County. The safety-net system has been difficult to access and primarily has provided episodic and emergency care. Wait times for routine appointments have been long, as long as six to nine months for some specialty care services.

HCCI Network Structure

The HWLA program in Los Angeles utilizes both a county hospital system and a public-private partnership. The county utilizes county-operated clinics and facilities as well as private community clinics to provide services to HWLA enrollees.

Network Services and Reimbursement

The HWLA program has a network of 29 county-operated LACDHS clinics and 38 PPP clinics (with 105 clinic sites). Many but not all PPPs in the Los Angeles County safety-net network participate in the HCCI program.

Enrollment is typically highest among LACDHS Comprehensive Health Centers and lowest among county primary care clinics. Enrollment at PPP clinics varies from over 1,000 at the two larger clinics to as low as eight in others. Currently, there is no cost sharing for HWLA program enrollees.

The LACDHS and PPP clinics are organized in five *clusters* that are responsible to manage patient care. Each cluster group has a medical director and a CEO who oversees the cluster. The county has a centralized budget and allocates monies to each medical center along with its affiliated group of DHS cluster clinics. PPP clinics are paid from separate monies via their negotiated contract rate. The cluster-hospital CEO is responsible to oversee the budget for their cluster.

PPP clinics are reimbursed at a set rate of $109 per

primary care visit, which covers the visit and ancillary services, such as laboratory and diagnostic testing and pharmaceuticals. The majority of LACDHS site providers are salaried employees of the county. There may be physicians in training at county clinics or hospitals at a contracted rate.

Urgent care services are available at some clinic sites. The County Comprehensive Health Centers offer urgent care services and extended hours. Some PPP clinics provide *walk-in* access in lieu of urgent care. Reimbursement mechanisms and rates for urgent care services are the same as those for primary care. There is also a dedicated 24/7 nurse advice line specific to HWLA that is operated by an offsite vendor.

Specialty care services are provided at County Medical Centers and Comprehensive Health Centers, as well as some PPP clinics. Specialists on staff at the county facilities receive salary reimbursement. Some PPP clinics subcontract with specialists who are reimbursed at the Medicare rate, and payment to PPP clinics for specialty care is per Current Procedural Terminology (CPT) code. Some PPPs utilize volunteer specialists.

Inpatient care is provided at the three County Medical Centers. Inpatient providers are reimbursed through salary, though the medical centers receive budget allocations based on expected costs.

Ancillary Services and Reimbursement

Routine laboratory services are provided at county and participating PPP clinics, County Medical Centers and Comprehensive Health Centers. Less commonly ordered tests are sent to external vendors. Laboratory services at county facilities are covered under the budget allocation. The bundled payment to PPP clinics is inclusive of laboratory testing.

Diagnostic services are provided and reimbursed in a similar pattern to laboratory services, though no private imaging facilities are utilized. Occasionally, PPP clinics will refer to local providers who may be willing to provide pro bono services.

Pharmacy services are provided throughout the network. Comprehensive Health Centers have onsite pharmacies. Pharmacy services within county facilities are included in the per-visit rate. Pharmacy services are included in the PPP bundled fee-for-service rate. PPP clinics must make arrangements for the patient to receive the medication free of charge through one of their contracted pharmacies, if they do not stock the needed medication. Some PPPs contract with Target, a private commercial pharmacy chain, to provide pharmacy services.

The county does not utilize a pharmacy benefits manager (PBM) for the program. Medication reconciliation services are performed by the county facilities as part of LACDHS policy, but are not required by contract for HWLA.

Health Information Technology

The LACDHS network is linked by several encrypted appointment and data systems but some health information technology (HIT) systems are not available systemwide. Recently LACDHS and the *Community Clinic Association of Los Angeles* received a grant for the *Health-e-LA* project initiative. Although the grant is not specific to HCCI, the county will receive funding to further develop health information systems, including the *Encounter Summary Sheet* (ESS). These infrastructure enhancements could benefit HCCI patients.

Enrollment information is available through a Web-based interface called *WebSphere,* where enrollment documents are uploaded and scanned, and are available to providers and staff to check eligibility systemwide. *WebSphere* is searchable but does not contain date fields for entering data.

LACDHS utilizes an internal system called *Affinity* for the county clinic and hospital system appointment scheduling. PPP clinics have their own electronic systems for appointment scheduling.

A Web-based health care utilization data retrieval system called *Encounter Summary Sheet* (ESS) provides clinical and demographic patient information to providers in the network. ESS includes information on diagnoses, medications dispensed from LACDHS facilities, primary and specialty care visits, County Medical Center and emergency room utilization and

LACDHS scheduled appointments. Currently providers at all LACDHS clinics and most PPP clinics have access to the ESS.

An electronic referral system called the *Referral Processing System* (RPS) is currently in use and is available to all providers in the network. Primary care providers receive followup information electronically through RPS after patients receive specialty care and other services. Most providers and specialists utilize RPS, although some specialists do not upload their patient information. The county is working to improve the RPS utilization and followup.

The LACDHS disease management program utilizes diabetes, heart disease and asthma registries that are available to some LACDHS clinics. Most of the PPP clinics have a diabetes registry for diabetic patients. Most PPP providers have used a *Patient Electronic Care System* (*PECS*) registry but many are transitioning to *i2iTracks*, a population health management chronic disease registry. At the LACDHS clinics, the county registries are accessible to the providers working in disease management programs, although PPP clinics have limited access to the county registries and individual clinics may only have access to their own disease registries.

Electronic prescribing is not currently available for HWLA.

Currently HWLA-participating clinics are required by contract to utilize *WebSphere* for enrollment. However, the program does not utilize incentives for the use of other health information technology.

System Design Innovations in Care Coordination and Delivery

HWLA has enhanced the structure of the safety-net network and specialty care services in a number of ways.

Prior to HCCI, specialty care was only available at hospital-based clinics. HWLA offers onsite specialty care at the County Comprehensive Health Centers and some of the PPP clinics. PPPs may have specialists on staff or via a sub-contract. Some PPPs also utilize volunteer specialists.

Certain PPP clinics received a grant from the California Health Care Foundation (CHCF) to support a telemedicine software program through the UC Berkeley (UCB) Optometry Clinic for remote diabetic retinopathy screening and consultation between primary care providers and specialists. The PPPs have five diabetic retinal cameras and participating PPPs send screening pictures to UCB for review and diagnosis. The intent of the grant is to enable primary care providers to better diagnose diabetes-related eye problems in the primary care setting, thereby reducing the incidence of diabetes-related ocular complications including blindness among low-income Californians. These program services (taking and reading the images) are reimbursable through HCCI.

A pilot program called *Camino de Salud* is designed to develop a formal system of communication (through phone and email) between the PCP and specialists. The program is run by COPE Health Solutions and utilized by one HWLA cluster. However, the county and HWLA do not yet track this information and do not have data on the extent of utilization. HWLA is also considering formal training for PCPs to expand their scope of practice.

Referral management policies currently vary by clinic. The county has begun to plan for a standardized set of referral requirements to be implemented in the near future. This will include both management policies and clinical care guidelines for referrals.

HWLA utilizes evidence-based condition specific clinical care guidelines in the LACDHS disease management programs. Primary and specialty care providers have access to the guidelines via the intranet. There is also a clinical decision support tool for asthma, called ADST, that is currently being pilot-tested but it is not yet available systemwide.

Future Plans

During the period remaining under the HCCI program, the county plans to continue program activities and complete or expand certain aspects of the HWLA network.

Specific plans include:

- Expanding access to ESS for all HWLA clinics. This will allow both DHS and PPP clinics to access utilization, diagnosis and medication information for the patients that use their facilities.
- Conducting chart audits at LACDHS facilities. This activity replaces an earlier plan to conduct a patient assessment survey for HWLA.
- Converting the ADST asthma tool into a Web-based disease management registry, and incorporating those for hypertension, hyperlipidemia and depression.

Network Sustainability

As HWLA enters the third year of the HCCI program, Los Angeles County continues to conduct *in-reach* to potentially eligible enrollees, and is not yet planning for a ramp-down of the program. In the event that HCCI funding does not continue beyond the August 31, 2010 deadline, the county anticipates that only certain aspects of the HWLA program would be sustainable:

- The ESS and RPS will continue to develop and are not limited to HWLA.
- The county would like to continue to implement and expand the medical home concept, but these efforts will depend on waiver renewal and health care reform efforts.

Los Angeles County's Ideal network

If funding to provide care for all uninsured were available, the county would develop a delivery system that would include a shared electronic medical record for both the DHS clinics and the PPPs as some patients are seen at both types of facilities. The county would also like to have regional ancillary centers, where patients would have increased access to necessary diagnostic testing and some minor outpatient procedures.

Los Angeles County's Best Practices

- HWLA is an example of a strong public-private partnership. The PPPs were safety-net providers prior to HCCI, but these associations have been significantly reinforced through the HWLA program.
- HWLA has improved care coordination and increased access to care as compared to the pre-HCCI network system.
- HWLA utilizes the *Encounter Summary Sheet* to support electronic patient information available throughout almost the entire network.
- Coordinating a number of *quality of care* initiatives, including assessment and network support activities.

Orange County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The HCCI Demonstration Program in Orange County provides health care to low-income uninsured adults and is designed to improve access to primary and preventive care services for eligible individuals throughout the county. Orange County enrolled 33,018 members in HCCI as of July 31, 2009; 15,718 more than the proposed three-year program target. The county enrolled all eligible individuals who had previously utilized the county Medical Services Initiative (MSI) program in HCCI and recruited additional eligible low-income uninsured adults who had not previously used the MSI program.

Safety-Net System Prior to HCCI

The MSI program in Orange County has been in existence since 1983. Prior to HCCI, the MSI program for medically indigent adults (MIAs) in Orange County covered services for episodic care, including inpatient, specialty, emergency, laboratory and diagnostic services for urgent or emergent conditions. The MSI division of the Orange County Health Care Agency paid for services provided by contracted hospitals, clinics, physicians and ancillary service providers. Outpatient primary and preventive care services were not covered under the MSI program prior to HCCI. The safety-net system in Orange County was not organized in a formal network. Private physicians and clinics registered for the MSI program in order to be reimbursed for services without a specified contract. These providers may have delivered limited primary and preventive care services to enrollees without reimbursement for such care. Consequently, many providers were unwilling to provide non-covered services to MSI patients and the few participating clinics were overcrowded. The absence of a formal network and limited coverage of services meant absence of services designed to reduce poor patient outcomes and inefficiencies in care delivery such as referral oversight and disease management.

HCCI Network Structure

Orange County does not have county-operated clinics or hospitals in the HCCI network. Thus the county contracts with private providers working within a variety of facilities, and the HCCI network is based on a public-private partnership.

Network Services and Reimbursement

The network providers include 12 private community clinics, 171 private physicians, all 22 private hospitals with emergency departments within Orange County plus one facility without an emergency room (ER), and 11 urgent *Minute Clinics*. The total physician network including medical homes is 3,761 and there are 525 network pharmacies. Private community clinics serve as the medical home for the majority of members, with 63% of enrollees assigned to the community clinics, and the remainder assigned to one of the 171 private physicians in the network.

The county has recently begun requiring all medical homes to meet certain criteria, including a minimum of at least 25 assigned members and adoption of health information technology (HIT) using the county's free Web-based system called *MSI Connect*. The county began enforcing medical home adherence in year three of the HCCI program, and no longer reimburses for

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primary care visits outside the assigned medical home. Additionally, the county has recently begun enforcing copayment policies for enrollees. Copayments are $5 for primary, specialty and urgent care visits; $25 for ER visits; and $4 per prescription with a maximum of $32 per month. Members at or below 25% of the Federal Poverty Limit (FPL) as determined at enrollment will have the pharmacy co-pay waived.

Primary care providers (PCPs) acting as medical homes, are reimbursed on a fee-for-service basis. The base reimbursement for primary care providers in HCCI was decreased on September 1, 2009 from 70% to 60% of the Medicare rate. PCPs also receive financial incentives through the *Quality and Outcomes Framework* program, which provides additional payment based on the number of enrollees assigned to each provider, and the level of chronic disease management and primary and preventive services delivered to their panel of patients as compared to all other medical home providers.

Urgent care services in Orange County are currently provided through 11 contracted retail *Minute Clinics* and four contracted urgent care centers. The retail clinics and urgent care centers are paid via a fee-for-service rate.

Specialty care in Orange County is provided through private hospitals and private practice specialists in the community. Specialists are paid either on the fee-for-service basis, or through capitation. Some sub-specialties, for which there is great need, may receive an enhanced rate above that paid to other providers. The base reimbursement for specialty providers was also decreased to 50% of Medicare rates on September 1, 2009. Previously the specialist reimbursement rate ranged from 40 to 130% of the Medicare rate. The county has negotiated capitation agreements with Urology, Otolaryngology (ENT), laboratory, and high-cost imaging such as positron emission tomography (PET), computerized tomography (CT) and magnetic resonance imaging (MRI) and hopes to add Dermatology in the near future. The county reports it will not add more capitated providers for the remainder of program year three to allow for evaluation of quality of care and cost efficiency under the targeted agreements.

Inpatient care at the 22 hospitals in Orange County is reimbursed at a bundled per-diem rate via a risk pool based on a point system which is divided at the end of the year.

Ancillary Services and Reimbursement

Effective November 1, 2009, HCCI enrollees receive laboratory services through Quest, a contracted large private laboratory. HCCI enrollees may further receive laboratory services at network hospitals. All laboratory services in the network are reimbursed via a capitated payment system.

Diagnostic and imaging services are available both through hospital outpatient diagnostic centers and private facilities; however, effective October 1, 2009, only PET, CT, MRI and certain x-rays are capitated through a single non-hospital-based group. Other diagnostic services may be reimbursed via fee-for-service payment.

Network hospitals have inpatient and outpatient pharmacies available onsite for HCCI enrollees. All other pharmacy use must be through the approximately 500 RxAmerica/Caremark participating pharmacies in the county. Private pharmacies are reimbursed per prescription dispensed. *RxAmerica/Caremark* also provides pharmacy benefits management (PBM) services for all participating pharmacies. Providers in the HCCI network are not currently required to conduct medication reconciliation services, such as review of patient medications. However, the HCCI program's medical director and pharmacy consultant regularly review pharmacy data and interact with network physicians directly about their prescribing patterns, use of medications available from Patient Assistance Programs provided by pharmaceutical companies, and use of evidence-based guidelines in making appropriate prescription decisions.

Health Information Technology

Orange County uses an electronic enrollment and eligibility application system, which existed prior to HCCI but was updated to include the HCCI criteria. Network providers are able to verify eligibility online through the Web portal called *Provider Online*

Verification. Some primary care providers utilize electronic appointment systems; although centralized electronic appointment scheduling is not available systemwide.

Orange County has implemented a comprehensive electronic patient information system called *MSI Connect*. The rollout of some modules of this Web-based application was underway prior to HCCI. *MSI Connect* consists of three central modules: *ER Connect*, implemented in December 2006, that links all 22 of Orange County's emergency departments; *Clinic Connect*, implemented in Spring 2007, that links the private community clinics participating in HCCI (currently all network clinics are using this module); and *Community Connect*, implemented in May 2009, that links the private physicians. The majority of private physicians in the network have registered through *Community Connect*. The county has promoted the use of *Clinic Connect* and *Community Connect* to all network medical home providers and is looking to mandate use during the second quarter of program year three in order to remain a medical home provider.

MSI Connect includes referral status information; claims data, hospital census data, lab and diagnostic data, and clinical notes from some medical home and emergency providers. The program also uses a *Continuity of Care Record*, which is available to all medical home and emergency room physicians. *MSI Connect* is designed to enhance communication and coordination, and is available to all emergency department and medical home network providers. Specialists do not have access to this system, which the county says is to enforce the concept that the primary care physician/group must coordinate the patient's entire continuum of care in order to promote the medical home model.

Medical home providers can receive electronic referrals from emergency room physicians through *ER Connect*, but other electronic referral capacity is not currently available. Providers are required to submit referral requests to the utilization management department for review and approval by the medical director. Most referral requests are submitted by fax to the utilization management department, although urgent referral requests can be made by telephone. As of September 1, 2009, the county will not cover services delivered outside of the medical home setting without a prior authorization (although some exceptions apply such as basic x-rays, ultrasounds and mammograms).

Referral status is updated weekly in *MSI Connect* by the utilization management department, allowing primary care providers to track referrals. The county is currently working to add an *e-referral* application to *MSI Connect*, which would allow medical home providers to request referrals electronically without phone or fax delay. The planned *e-referral* application within *MSI Connect* is expected to facilitate electronic referral followup and provide enhanced information to providers.

Limited referral followup is currently provided. Some specialists may fax results to medical homes. Additionally, primary care physicians can see claims history, hospital stay data, emergency department notes, labs, diagnostics, prescriptions and case management status in the *Community Connect* system.

An outside vendor provides disease and case management services to HCCI members. A few community clinic medical home providers in the network can use an enhanced case management module under *MSI Connect* to identify certain high-risk individuals assigned to them, including those with diabetes, asthma, hypertension and heart disease. The county is currently looking to expand this capability to all medical home providers to examine patient risk level and whether they are meeting Healthcare Effectiveness Data and Information Set (HEDIS) criteria.

Electronic prescribing is currently unavailable in Orange County's HCCI program.

As noted previously, medical home providers will be required to utilize the *MSI Connect* system in the third program year. This is supported through incentives for use of health information technology by network providers. These include pay-for-performance (P4P) incentives for emergency department physicians to enter clinical notes into the *ER Connect* system and for clinics to complete referrals via the *Community Connect* system.

System Design Innovations in Care Coordination and Delivery

Orange County uses multiple strategies to enhance the provider network. The county has promoted access to specialty care by contracting with more specialists, particularly in disciplines that are in high demand. Specialty care is provided primarily by specialists in hospital or private practice settings, rather than onsite specialty care at the medical home. Alternative sources of specialty care such as volunteers are not currently available. The primary specialist consultation method is currently informal telephone or email communication between PCPs and specialists.

Formalized training of primary care providers to extend their scope of practice is not currently available. Orange County primary care providers are educated in appropriate specialty referrals and prescribing patterns based on national evidence-based guidelines as influenced by the medical director, the Medical Review Committee and the Quality Improvement Committee.

Policies and procedures for referral practices have been in place for primary care providers throughout the HCCI program, and have recently been implemented for specialist-to-specialist and referrals generated by hospital providers. The county has recently enhanced enforcement of referral policies, where care outside of the medical home (other than limited diagnostic and lab services) without prior authorization from the utilization management department is not covered. All referrals are assessed for adherence to clinical guidelines by the utilization management department, using the *Milliman Clinical Care Guidelines*. Primary care and specialty providers must use these guidelines for referrals.

Future Plans

Orange County plans to expand or enhance multiple aspects of the provider network. Specific plans include:

- Implementation of an *e-Referral* system accessible to all medical home providers through *MSI Connect*. This system would allow for electronic referrals and enhanced electronic referral feedback, and is expected to streamline utilization management.
- Bringing a *light* case-management system under *MSI Connect* to all medical home providers. This system is already being piloted with three community clinic homes and it provides *actionable* data in regards to risk profiling and HEDIS measures to improve the efficiency of primary care to the most vulnerable group of assigned patients.
- Requiring that all medical home providers use the full *MSI Connect* system.
- Listing of assigned medical home, including contact information, on member ID cards to further enforce adherence to medical home and copayment by enrollees.
- Supporting continued growth and adaptation of the provider network to meet enrollee needs.

Network Sustainability

Orange County has recently instituted copayment amounts for HCCI enrollees, and closed enrollment to new individuals who do not have urgent or emergent conditions after September 1, 2009. The county also scaled back dental benefits to extractions and maxillofacial procedures only, as of August 1, 2009. The county anticipates its new payment arrangements via capitation to improve program costs and care. And further promoting the use of the medical home via mandatory authorizations for services outside of the home is expected to promote more appropriate use of services. These actions are designed to promote program sustainability, but will reduce access for new enrollees without urgent or emergent care needs. Renewing enrollees will not need to meet this guideline and will continue to be eligible for the program. The program enrollment has exceeded projections and the county is likely to further limit the scope of services covered for the majority of HCCI enrollees if funding for the HCCI program is not renewed after August 31, 2010.

Orange County's Ideal Network

Orange County believes an ideal network would consist of a maximally-integrated network of providers (behavioral, medical, public health) in the form of accountable care organizations that ensure enrollee

access to comprehensive care. This would include building a more geographically distributed network of specialists in all areas of the county. A Web-based specialty referral system to facilitate continuity of care; an electronic rules-based system to monitor utilization management (UM) processes; and expanding patient and provider education outreach efforts to increase awareness of the HCCI program benefits and policies would also be included. Funding to provide care for all uninsured adults between the ages of 21 to 64 who are legal residents of the county would also be essential.

Orange County's Best Practices

- *MSI Connect* enhances communication between network providers and assists in coordination of patient care.
- The public-private partnership has improved incorporation of a larger number of private providers in the county's safety-net system. The county has now succeeded in giving 99% of enrollees access to a medical home within five miles of their residence.
- Intensive and targeted use of claims and pharmacy data has led to changes in patterns of care by network providers, such as adherence to formulary (reducing the cost per member for prescriptions by shifting more than 86% of members onto generic pharmaceuticals) and reducing inappropriate referrals.
- The utilization management and quality assurance programs provide administrative support to increase care coordination and improve efficiency.

San Diego County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The Health Care Coverage Initiative (HCCI) program in San Diego focuses on individuals with hypertension and diabetes, and uses a chronic care model with disease management to achieve the goals outlined for their coverage initiative program. San Diego County enrolled 3,651 members as of May 31, 2009; 391 more than the proposed three-year program target. In January of 2009 the county capped new enrollment to control program expenditures and focused on providing comprehensive care to existing enrollees.

Safety-Net System Prior to HCCI

Prior to the HCCI program, San Diego County provided local indigent health care through the County Medical Services (CMS) program, under their section 17000 obligation. The CMS program prior to HCCI was a fragmented system providing care as a last resort to county residents with urgent medical conditions. While patients in the program did not have any financial responsibility for their care, eligibility was restricted to those below 135% of the federal poverty level (FPL). Providers included community primary care clinics, as well as some specialists. Residents who qualified for CMS were enrolled and then could use any of its contracted clinics.

Clinics in CMS received reimbursement at a lower rate than is currently paid under HCCI. CMS also had a contract with the Scripps Whittier Institute's *Project Dulce*, which provided disease management services to approximately 600 patients through fee-for-service payment rates.

Available services were less comprehensive compared to those under HCCI; while CMS contracted with community clinic organizations, patients received primarily episodic care and were not assigned to an individual clinic site. Access to specialty care was very limited, as availability of these services was restricted to the University of California San Diego outpatient specialty care. Patients also had limited access to dental, behavioral health and inpatient services. Administrative supports were less well developed prior to HCCI, and the program lacked formal referral arrangements between hospital and outpatient providers.

HCCI Network Structure

The safety-net network in San Diego County is built upon contracts with private organizations and vendors as there are no county-owned and operated facilities. The county utilized existing relationships between the county, CMS and private contractors that were already established.

Network Services and Reimbursement

The providers in San Diego County that make up the HCCI network include five Federally Qualified Health Center (FQHC) clinic organizations, four are represented by the local Council of Community Clinics (CCC), while one is independent. The five clinic organizations operate a total of sixteen FQHC clinics. Nine private and three district hospitals are also part of the network and each is associated with an FQHC. *AmeriChoice* is the third-party administrator and provides all administrative services, while *Project Dulce* provides chronic care management services.

The majority of the contracted community clinics have between 200 and 300 enrollees. Two of the clinics have around 60 enrollees. Currently, San Ysidro Health Center in the south of the county, which merged with another FQHC last year, has about 650 enrollees.

Primary care is reimbursed through an enhanced fee-for-service payment of $125 per visit, above the negotiated CMS rate.

Urgent care services are available at the clinics, all of which provide extended appointment and walk-in hours for urgent care. There are no hospital-based urgent care clinics within the network. Reimbursement for urgent care and primary care is the same, with the fee of $125 paid for all urgent care services provided at community clinics.

Specialty care in the HCCI network is primarily provided through privately-contracted physicians, and through inpatient services and outpatient clinics at the twelve network hospitals. Very limited specialty care may be available onsite at clinic medical homes. Specialty care is reimbursed through an enhanced fee-for-service payment based on the CMS-negotiated rates.

Inpatient care is provided at the twelve hospitals in the San Diego County HCCI network. A CMS-negotiated per diem rate is paid for inpatient days.

Ancillary Services and Reimbursement

All network clinics perform basic laboratory and diagnostic services onsite. Additionally, the county has formal contract arrangements with network hospitals and private offsite laboratory and diagnostic facilities to provide access to higher-level services. Laboratory and diagnostic services are reimbursed by fee-for-service payments based on CMS rates.

HCCI program enrollees in San Diego County have access to many private pharmacies, some of which are located onsite where enrollees may receive care. Additionally, enrollees may use the outpatient pharmacies at network hospitals. However, the majority of pharmacies are private entities at offsite locations. Pharmacies are paid a fee-for-service payment based on CMS rates for medications on the network formulary.

AmeriChoice provided pharmacy benefit management (PBM) services to all providers in the network. Although medication reconciliation (a review of patient medications) is not required of all providers, it is performed routinely upon discharge from the hospital. Additionally, *AmeriChoice* frequently reviews patient medications and contacts medical home providers directly to discuss formulary and patient care issues.

Health Information Technology

Certified application assistants in clinics enroll individuals and fax the information to *AmeriChoice* for entry into IDX, an electronic enrollment and eligibility system. *AmeriChoice* sends an updated copy of the enrollment list to clinics monthly. Electronic appointment systems are unique to individual clinics. Some clinics use Web-based portals to register patients and make followup appointments after emergency room (ER) visits.

There is no centralized systemwide electronic patient information system, currently. Some clinics may have real time access to a local hospital's utilization, emergency room and inpatient service data. The county is currently in the pilot phase of implementation of a system called *SafetyNet Connect* to facilitate appointment scheduling between the hospitals and medical homes. An electronic disease registry called *i2iTracks* is fully implemented in at least two of the clinic organizations within the network (separate from *Project Dulce*). Some hospitals in the network utilize unique electronic medical records (EMRs), but they are not specific to HCCI.

All providers have access to disease registries for diabetes, hypertension and hyperlipidemia, which are managed by *Project Dulce* as a part of their chronic care management program and are connected to hospital emergency rooms. Some clinics have additional disease registries such as Patient Electronic Care System (PECS) and Chronic Disease Electronic Management System (CDEMS). The *Project Dulce* team has access to all other patient information at the

clinics, including electronic information.

Referrals in San Diego County are currently made by fax. Providers must submit referral requests by fax to *AmeriChoice*, which reviews these requests and then makes the appropriate referral. The primary care team may track referral progress by telephone.

Primary care providers at some clinic sites may have access to electronic information on use of hospital-based services by enrollees for referral followup. This can include information on labs, diagnostic services, and other ancillary services used by enrollees. Additionally, some specialty providers may follow up with the medical home by telephone or other methods regarding the outcome of a referral, although this is not a formal system.

Electronic prescribing is not currently available systemwide within the HCCI network in San Diego County. However, some hospitals in the network may utilize electronic prescribing.

The county does not require or otherwise incentivize providers in the HCCI network to utilize Health Information Technology (HIT).

System Design Innovations in Care Coordination and Delivery

Project Dulce has trained dieticians and nutrition workers within clinics to expand the scope of the clinic's practice. Although the county does not reimburse for mental health care under the HCCI program, it has leveraged Mental Health Services Act planning money to integrate mental health care into the primary care setting, and to promote consultation with mental health and social work staff.

San Diego County has improved access to specialty care through multiple specialty care enhancement programs. The San Diego Medical Society Foundation runs *Project Access* and focuses on providing volunteer or other sources of free specialty care. *Project Access* case- manages patients who use program resources. The project has succeeded in providing outpatient surgery at Kaiser Hospital at no cost to the patient.

The San Diego County-based Council of Community Clinics was awarded a three year grant under the statewide *Specialty Care Access Initiative* funded by the Kaiser Foundation in January of 2009. The goal is to improve access to specialty care in the primary care setting through coordination of virtual consultation between primary care physicians and specialists; placement of volunteer or other specialists in primary care clinics; development of referral guidelines; enhanced use of data and HIT; and primary care physician training to enhance scope of practice as well as training in the use of care guidelines, HIT and other tools.

Primary care providers and specialists may also consult remotely, although this is not a universal practice. The Scripps Whittier Institute conducted an 18-month mobile unit telemedicine retinal screening program for diabetic retinopathy at 15 clinic sites in the county. A trained retinal imaging technician and a retinal specialist reviewed the results and referred the patient if diabetic retinopathy was present. The program is planned to continue at two clinics.

Currently, primary care providers in the HCCI network receive monthly in-service trainings on chronic care management conducted by *Project Dulce* staff. These trainings are required for clinical providers to certify them to provide chronic care services under HCCI. Additionally, the *Access to Specialty Care* initiative provides education for primary care providers on specialty care topics through *Lunch and Learn* and online sessions.

San Diego County has implemented clear guidelines for primary care providers regarding policies and procedures in making specialty care referrals. The *Specialty Care Access Initiative* grant emphasizes referral guideline use. All specialty care referral requests are reviewed by *AmeriChoice*, and are assessed for appropriateness according to clinical guidelines. All providers within the HCCI program have access to these guidelines. The county also facilitates an HCCI Physician Stakeholder Work Group, which meets regularly with *Project Dulce* and the *AmeriChoice* Medical Director. This group has developed a range of protocols.

Future Plans

During the remaining period of the HCCI program, San Diego County plans to expand or enhance aspects of the network and its infrastructure. Specific plans include:

- Planning for implementation of electronic health records (EHR) is underway between contracted clinics, hospitals and the county.
- Developing multiple HIT interfaces between various network components to enhance capacity for scheduling, referral and electronic patient-information sharing.
- Partnering with hospitals and clinics to implement *Safety Net Connect*. Currently the first phase of implementation is in the pilot stage. Two further phases are planned, which would allow first unidirectional, and then bidirectional data exchange between the network facilities.
- Continuing the use of telemedicine for diabetic retinopathy screening at multiple sites within the network.
- Continuing to expand access to specialty care, including free or discounted care, through the San Diego Medical Society Foundation and the Kaiser *Specialty Care Access Initiative* grant.

Network Sustainability

If HCCI funding is discontinued by August 31, 2010, the county believes it will sustain many of the advances in the network built under the HCCI program. The county is currently participating in an initiative to reengineer the CMS program, and will incorporate lessons and strengths of the HCCI program in this process. Additionally, the enhanced relationships with local clinic organizations and the use of *SafetyNet Connect* and other HIT systems to link these organizations with local hospitals are viewed as sustainable by the county.

San Diego County's Ideal network

San Diego County has not enrolled a high volume of individuals under its HCCI program, but has focused on enhancing the delivery of care to chronically ill patients. With sufficient funding to provide care for all uninsured, the county would increase the quantity of care and enhance the services patients receive. Ideally, the county would like to expand disease management to all uninsured, applying lessons learned under the HCCI program to continue to enhance preventive and proactive care, increase coordination of care and improve health outcomes.

San Diego County's Best Practices

San Diego County has implemented a number of techniques and practices under HCCI which may be replicable in other settings.

- The HCCI program in San Diego has leveraged various stakeholders (including physicians, consumer advocates and clinic organizations) and resources in the community to build a sustainable public-private partnership.
- The HCCI program is narrowly focused on providing comprehensive disease- management services to chronically ill HCCI enrollees.
- The disease management vendor uses registries and trains primary care providers to enhance their scope of practice related to care of chronic conditions.
- The use of a mobile-medical unit and telemedicine for diabetic retinopathy screening has increased access to specialty care and appears to show improved rates of screening in this high-risk population.
- Multiple initiatives to attempt to improve coordination of care have been implemented within the network, including those integrating mental and physical health care.

San Francisco County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The Department of Public Health (DPH) operates the Health Care Coverage Initiative (HCCI) program in San Francisco County. The HCCI program is part of a larger effort known as *Healthy San Francisco* (HSF). Applicants to HSF are automatically screened for HCCI eligibility and enrolled if eligible. Healthy San Francisco began operations in July 2007, shortly before HCCI began enrollment in September 2007. San Francisco County has enrolled 11,604 members in HCCI as of May 31, 2009; 1,604 more than the proposed three-year program target.

Safety-Net System Prior to HCCI

The City and County of San Francisco historically have provided access to care for indigent and uninsured residents through county hospitals and clinics through both public and non-profit providers. Prior to Healthy San Francisco there were several safety-net programs for uninsured residents in the region. DPH as a provider included San Francisco General Hospital (SFGH) and several county-operated, community-based primary care clinics. DPH provided a full range of services, including primary care, inpatient, specialty, diagnostic and behavioral health care.

The county did not have many contracts with community-based, non-profit primary care clinics to actively coordinate care of uninsured individuals prior to HCCI. These local non-profit providers utilized federal or state funding through reimbursement and grants to help subsidize the cost of treating uninsured patients. These providers include *San Francisco Community Clinic Consortium* (SFCCC), a group of ten independent primary care clinics, some of which are Federally Qualified Health Centers (FQHCs). Their patients received specialty or inpatient care at SFGH or another specialty care provider in the community that has arrangements with the group. In addition, all of the non-profit hospitals in the county provided *charity care* to uninsured residents who met the hospital's charity-care criteria. Private physicians also provided care for the uninsured, although the number of uninsured residents who received care this way is largely unknown.

Care delivered to uninsured residents prior to HCCI was primarily episodic in nature and without coordination among providers. Some patients received care from more than one provider and some may have received duplicative services.

HCCI Network Structure

The HCCI network in San Francisco County is restricted to the Department of Public Health providers. The provider network for other HSF enrollees is broader, and includes Kaiser Permanente and SFCCC clinics. The DPH network is strengthened through addition of a uniform eligibility and delivery system, a centralized customer service system, a new patient appointment unit, and other improvements such as expanding clinic and hospital capacity for patient care.

Network Services and Reimbursement

The HCCI provider network includes 11 community-based and three hospital-based clinics. There are an estimated 175 to 200 individual providers (physicians

and nurse practitioners) within the primary care system for HCCI between both community and hospital-based clinics. San Francisco General Hospital (SFGH) provides specialty, inpatient, emergency room (ER) and pharmacy services. The Laguna Honda Hospital provides sub-acute care services used by HCCI participants when SFGH is at capacity, and provides short-term hospital-based rehabilitation/skilled nursing. San Francisco County's HCCI program does not include skilled nursing/long-term care benefits. Behavioral health care is available through the *Community Behavioral Health Services* provider network, which is also part of the DPH delivery system.

All primary care providers (PCPs) within community-based and hospital-based clinics are salaried staff of either DPH or the UCSF School of Medicine that has an agreement with DPH. All UCSF faculty or DPH employees are members of the SFGH Medical Staff and credentialed through the medical staff office.

Urgent care services and extended hours are available at some clinic sites. Certain clinics designate a day or time when urgent care services are available. Urgent care services are also available at the SFGH Urgent Care Clinic which is open for extended hours. This clinic serves as the program's primary urgent care center ─ patients may be referred there by their medical home, or after hours patients may directly access the Urgent Care Clinic. Also, the emergency department at SFGH redirects patients to this clinic for urgent but not emergency care. The urgent care clinic physicians are salaried as specified previously.

Specialty care services are provided primarily at SFGH hospital-based clinics and at UCSF, based on referral. All specialty clinic providers and specialists are salaried UCSF faculty or UCSF trainees/residents.

Inpatient care services are provided at SFGH. DPH has had an agreement with the UCSF School of Medicine for the provision of care at San Francisco General Hospital since 1959. Under this agreement, UCSF School of Medicine provides all of the professional medical supervision for all patient care at SFGH. In exchange, the University faculty instructs residents and conducts research projects at SFGH. San Francisco City and County operate the hospital up to the standards required for intern and resident training. The agreement budget defines the services purchased by SFGH and the amount to be paid for each of the purchased services. The purchased services include salary, fringe benefits and specialty clinical supplies necessary to provide these services. The budget is negotiated annually as part of the SFGH budget process; the service levels are established jointly between SFGH and UCSF to address the needs of the SFGH patients.

Ancillary Services and Reimbursement

Laboratory services are available at some primary care clinics. For most lab services, patients are referred to SFGH. Laboratory staff members are salaried and services are provided under the agreement described previously.

Diagnostic services are primarily provided at SFGH. Diagnostic technicians and staff are salaried. For very specialized diagnostic needs, an HCCI enrollee may be referred to the UCSF Medical Center after the PCP obtains prior authorization, and payment is coordinated through the budget agreement outlined previously.

Pharmacy services are provided at SFGH through agreements between DPH and a community-based chain and independent retail pharmacies. DPH pharmacy staff members are salaried. Retail and independent pharmacies are affiliated with a specific clinic and HCCI participants are eligible to obtain their medication at that site or at SFGH. The affiliated retail pharmacies are compensated at a dispensing fee for each prescription filled. The agreement with community retail pharmacies for dispensing outpatient prescriptions pre-dates the HCCI program and has been in effect since 2001.

San Francisco Health Plan (SFHP), the county's local Medi-Cal managed care plan, administers the HSF and HCCI programs. SFHP provides pharmacy claims adjudication and prescription processing functions, and provides data on prescription claims to assess drug utilization and conduct fiscal monitoring. Clinical management and medication reconciliation are also facilitated by the return of prescription claim data

by SFHP through an electronic interface directly into the patient's electronic health record.

SFHP also creates and manages the HSF program Web site, creates member materials, administers the billing system for participants, manages customer services, and collects encounter data. SFHP further oversees the collection and analysis of all encounter data from entities in the provider network and maintains the HSF and HCCI clinical data warehouse.

Health Information Technology

The HCCI and HSF programs utilize *One-e-App*, a Web-based eligibility and enrollment system. A resource scheduling system allows systemwide appointment scheduling and a new patient appointment unit analyzes appointment availability at clinics. The unit will schedule appointments for new patients and then subsequent appointments will be scheduled directly through the medical home or clinic. Clinics may also access the resource scheduling system to schedule primary, specialty and inpatient appointments as needed.

The entire DPH provider network uses the Siemens Invision *Lifetime Clinical Record* (LCR).
The LCR contains demographic, administrative, encounter, referral, registry and prescribing data that can be accessed by providers across the network. The county is in the process of developing a comprehensive ambulatory-care electronic medical record (EMR) system for use at DPH and satellite sites throughout the county, and at primary and specialty care clinics located at SFGH. The project is currently in the planning phase, a request for proposal (RFP) has been issued and a vendor is being selected.

The LCR also contains electronic referral (*e-referral*) capability. The system increases efficiency, improves quality and enhances access by reducing wait times for routine appointments. Electronic referral was expanded under HCCI and is now available for nine medical subspecialties, eight surgical specialties, three women's health specialty clinics, two diagnostic services and the *Health-at-Home* program. The major benefits of this system over prior paper-based referral forms are the ability to track referrals, guidance of pre-visit evaluation, improved access for non-urgent referrals, and enhanced co-management by primary care and specialty providers of ongoing chronic medical problems.

The program also utilizes *i2iTracks*, an electronic chronic-care registry also linked to the LCR, to track patients with diabetes, heart disease, Hepatitis B and depression. Each of these registries is available to providers across the DPH system. DPH also tracks HCCI and HSF patients with asthma, hyperlipidemia and diabetes through the new *Strength in Numbers* program. Patients are monitored for receipt of medical care and timeliness of available appointments. The program's focus is to support and expand use of *i2iTracks* for diabetes disease management within clinic medical homes. All medical homes are encouraged to actively use this diabetes registry to improve care at the point of service, to improve outreach to patients who may have fallen out of care, and to generate provider-specific data to support quality improvement efforts. The *Strength in Numbers* program provides incentive payments to medical homes for reaching targeted clinical improvements. The program was initially implemented at Castro Mission Health Center, Chinatown Public Health Center, Family Health Center and General Medical Clinic. The program will be expanded to Maxine Hall Health Center, Ocean Park Health Center, Potrero Hill Health Center, Silver Avenue Health Center and Tom Waddell Health Center.

The LCR also has an electronic prescribing capability, which is available systemwide.

System Design Innovations in Care Coordination and Delivery

The county has sought to address possible limitations of specialty care or specialty providers by improving access to specialty care through: (1) development and expansion of the electronic e-referral system; (2) hiring of additional providers in specific specialty areas to improve access; and (3) improving the management of patients with chronic care conditions through patient co-management strategies utilized by both primary care and specialty providers. The program has also expanded access to limited onsite specialty care, such as

podiatry, within the primary care setting.

The LCR along with its electronic referral capability greatly improves the ability of PCPs to obtain Web-based specialty consultation within the network. PCPs may also utilize telephone and email specialty consultations. There are no consultations via video-conferencing at this time but it may be used in the future. There is no specific reimbursement for specialty consultations.

The Department of Public Health trains PCPs on some skills that are typically beyond the PCP direct scope of practice through various methods. These trainings include:

- classes conducted at specific primary care clinics by specialists on issues related to specialty access;
- trainings between primary and specialty care providers on the co-management of common conditions to more efficiently use specialty care services;
- training providers and other clinic staff members in the effective use of team-based care for preventive services; and
- training designated coaches for each primary care or medical clinic director on service delivery, disease registries, clinic flow and demand moderation (use of telephonic visits or group visits).

Referral management policies are utilized for the existing electronic referral system and are part of a comprehensive set of treatment and referral guidelines. These guidelines are maintained and updated by DPH and are available on the DPH intranet for all clinicians. The electronic referral clinical guidelines were developed by specialty providers with input from primary care providers. Referrals receive an individualized review and response by a specialist clinician. There are one to two designated physician- or nurse- practitioner reviewers per specialty clinic. DPH reports that the referral system has contributed to greater coordination between PCPs and specialists (specifically be defining an appropriate referral and an appropriate and useful consultative response). Electronic referral allows for asynchronous, repeated communication between referring and reviewing clinicians on a given patient, which is part of the patient's medical record and functions as an integrated referral and consultation portal.

As part of the electronic referral system, DPH provides condition-specific clinical care guidelines and general preventive care guidelines. These guidelines provide a description of the condition, differential diagnosis, pre-referral checklist, and indications for referral to a specialty clinic. This clinical-decision support is incorporated into the Health Care Maintenance field of the LCR. It summarizes all data on prevention and screening for the individual patient and includes links to U.S. Preventive Services Task Force guidelines as part of an effort to ensure consistent health care monitoring. Prevention and screening information is also interfaced with the *i2iTracks* disease registry, providing an effective tool for true population-based care. Chronic disease management guidelines and clinical decision making software are also embedded in the *i2iTracks* disease registry.

Future Plans

During the remaining HCCI implementation period, the county will continue to enhance or expand certain aspects of the DPH network. Specific plans include:

- Developing and implementing a nurse advice line for the DPH network by January 2010.
- Developing disease registries for hypertension, hyperlipidemia and asthma through an expansion of the *Strength in Numbers* program. There will be an RFP for providers and implementation is expected in June 2010.
- Data reporting on disease management services to be implemented for HCCI.
- Tracking self-reported health status and changes over time through the eligibility and enrollment system. The data will provide trends for changes in health status and perceptions will be compared to utilization to see if patient perceptions are valid.

Network Sustainability

If HCCI funding were to end, the county would continue providing care under the HSF program with appropriations to serve medically-indigent adults.

However, the loss of HCCI funds would reduce the ability to continue program enhancements or implement new ones.

San Francisco County's Ideal Network

With sufficient funding, San Francisco would ideally provide care for all indigent adults and would increase the income eligibility provision under HCCI to 300% of the federal poverty level (FPL) to capture greater numbers of uninsured adults. San Francisco would also adopt the safety- net care pool provision (as outlined in California's 1115 waiver) for discounting potential services provided to undocumented persons; would not use the Deficit Reduction Act of 2005 (DRA) provision since it prevents some individuals with legal status from being enrolled in HCCI; would expand the covered services to include dental and vision services; and would explore potential expansion of the provider network.

San Francisco County's Best Practices

- The DPH-based provider network provides numerous opportunities for data sharing, care coordination and systemwide support services that are accessible to all network providers.
- The HCCI program is part of the Healthy San Francisco program and benefits from advances in access and care delivery implemented in that program. One example of the current structure is the initiation of a quality improvement effort chaired by the county's medical director to address issues related to both HSF and HCCI.
- The LCR provides systemwide access to a large portion of clinical and electronic patient information. Linking of the LCR with other systemwide support systems, including electronic referrals and disease registries, provides a distinct advantage for care coordination and improved patient outcomes.
- Training PCPs in various aspects of specialty care provides the opportunity for efficient and appropriate use of specialty care, and to expand specialty care access and service delivery.

San Mateo County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The San Mateo County Health Care Coverage Initiative (HCCI) program is called Access and Care for Everyone (ACE). It is operated by the San Mateo County Health System (SMCHS) and includes the San Mateo Medical Center (SMMC), the San Mateo Health Department and the Health Plan of San Mateo (HPSM), which acts as the third-party administrator for the program. The ACE program emphasizes primary and preventive care, as well as management of chronic conditions. San Mateo County has enrolled 6,488 ACE members as of May 31, 2009; 4,388 more than the proposed three-year program target of 2,100.

Safety-Net System Prior to HCCI

San Mateo County's local safety-net program prior to HCCI was called WELL (Wellness, Education, Linkage, Low Cost), which continues its' operations to provide care to low-income uninsured undocumented individuals and adolescents not eligible for ACE. The WELL network is centered at SMMC, and includes eleven county-owned clinics with Federally Qualified Health Center (FQHC) status, and one private FQHC called Ravenswood Family Health Clinic (RFHC). Prior to HCCI, the county had an informal relationship with RFHC, and did not pay for services provided by RFHC to WELL program members. Within the WELL network, the county had some contracts for administrative support, including an electronic patient information system.

Prior to the creation of the ACE program, some barriers to care existed with the WELL program, including long wait times for appointments for both primary and specialty care due to the large number of enrollees. Moreover, the program was unable to fully accommodate the uninsured population under 400% of the federal poverty level (FPL), a goal the county has sought to meet. These barriers to access have been reduced though not eliminated through HCCI.

HCCI Network Structure

The ACE network consists of the county hospital system and private community clinics. San Mateo County contracted with HPSM as the HCCI program administrator in conjunction with efforts of the *Blue Ribbon Task Force,* which was convened by the County Board of Supervisors and charged to develop a strategy to care for all uninsured adults under 400% FPL.

Network Services and Reimbursement

The ACE network utilized the existing WELL program providers, but has subsequently contracted with additional private primary care providers due to increased demand. HPSM has also executed contracts to expand access to specialty care services. The ACE network includes SMMC, seven county-owned clinics with FQHC status and RFHC. Two of the county-owned clinics are located on the SMMC campus, one of which is designed to be an ideal medical home called the Innovative Care Clinic (ICC) that has been operational since January 2009.

The majority of ACE enrollees are assigned to two clinics within the network. ICC has about 44% of enrollees and the Daly City Clinic has about 20% of enrollees. The remaining enrollees are distributed across the other county-owned primary care clinics and

RFHC. The county reports this distribution of enrollees is likely due to the fact that enrollees are assigned to a medical home at the time of their enrollment. Enrollment occurs at the point of contact with the county health care system, which is frequently at the SMMC emergency room. Therefore, these patients are often initially referred to the ICC and may later transfer their care to another medical home within the network.

The primary care providers within the ACE network are located at the county-owned clinics and at RFHC. For SMMC and county-owned clinics, primary care providers are typically employees of the medical center and are compensated through salary. Contracted primary care services are reimbursed through a bundled FQHC rate, which is inclusive of ancillary services.

All enrollees have access to a nurse advice line, which provides triage and directs enrollees to the appropriate level of care when needed. Enrollees can receive after-hours care at many of the ACE program medical homes and urgent care at all of the county clinics. Additionally, as of the start of the third HCCI program year, the county has established a new urgent care clinic at SMMC. Urgent care clinic services are also reimbursed with a bundled FQHC rate. The county pays primary care providers through salary and specialty providers at a contracted rate based on relative value units (RVUs).

Specialty care services are available to ACE enrollees at the medical homes in the network, and at SMMC and the ICC. Additionally, HPSM has contracted with private specialists and three private hospitals to provide access to specialty care services not available at SMMC. Enrollees must receive a referral and approval for appointments with any specialists outside of SMMC. All specialists in the ACE network are contracted. Specialists are paid a contract rate negotiated on a case-by-case basis and based on relative value units (RVUs). County and private clinics are reimbursed the FQHC bundled fee-for-service rate for specialty care services.

Inpatient care is generally provided at SMMC. In addition, enrollees may be transferred to one of three contracted private hospitals (Seton, Mills-Peninsula, Sequoia) for inpatient care services not available at SMMC. The HPSM does not yet have contracts with UCSF or Stanford, but for higher-level care they do refer patients to both these institutions. Predominantly, inpatient services are reimbursed at the Medi-Cal per diem rates. However, the health plan also has individually-negotiated contracted rates with some individual providers.

Ancillary Services and Reimbursement

Basic laboratory samples are prepared at the medical home and then sent to the SMMC laboratory. Enrollees may also utilize the outpatient laboratory at SMMC. If required services are not available at SMMC, the provider may refer a patient to one of the private laboratories that are contracted with HPSM. Laboratory services at SMMC are included in the bundled FQHC rate. Private laboratory facilities are reimbursed by the health plan through a contracted fee-for-service rate.

Diagnostic services are primarily delivered at SMMC, and enrollees may be referred to HPSM- contracted private imaging facilities and private hospitals when needed. Diagnostic services at SMMC are also included in the bundled FQHC rate. Private diagnostic services are reimbursed by the health plan through a contracted fee-for- service rate.

The ACE network includes an outpatient pharmacy at SMMC and contracted private pharmacies throughout the county. Each medical home in the network is linked to one pharmacy. ACE enrollees are required to use the pharmacy that is linked to their medical home. Enrollees who select the ICC as their medical home have access to the onsite outpatient pharmacy at SMMC. Pharmacies are paid a fee-for-service rate for medications on the network formulary.

Pharmacy benefit management (PBM) services are available to all pharmacies in the network through *InformedRx*, the PBM employed by HPSM. Medication reconciliation (a review of patient medications) is not required, but San Mateo County reports that it is commonly done by providers. An ambulatory electronic medical record (AEMR) from *eClinicalWorks*, which is currently being implemented,

will automatically alert providers to potential medication reconciliation issues at the time of prescribing.

Health Information Technology

The ACE program uses *One-e-App*, an electronic enrollment and eligibility system which is available at all clinics within the network. An electronic appointment scheduling system is also available to all providers and clinics through the AEMR.

All ACE clinics have access to a lifetime clinical record (LCR), an electronic patient information system. Currently, the AEMR is available at all primary care sites in the network, including the ICC, and at select specialty clinics. The AEMR contains clinical information, as well as disease registry, referral, decision support and prescribing tools, and is expected to be available systemwide in December 2009.

Before implementation of the new AEMR, all referrals in San Mateo County were generated by the primary care provider and sent to the specialist via fax or paper. This method is still in use for specialty clinics that do not yet have access to the AEMR. However, providers that currently have access to AEMR have access to electronic referral through that system. AEMR also provides the ability to track the progress of a referral, which is updated with appointment status.

Referral follow-up within the network varies between practice sites. Specialists based at SMMC dictate all clinical notes, which are then automatically printed and delivered to the primary care provider. However, not every specialist in SMMC uses the dictation service, and this service is not available for specialists outside of SMMC. Some specialists additionally follow up with primary care providers by telephone, although this is an informal practice that varies between providers. The electronic referral system within the AEMR facilitates referral tracking and follow-up, and upon complete roll-out will generate automatic notifications to the referring provider after a referral is approved and once the patient has been seen.

All provider types, including PCPs, specialist, inpatient and the ER, have access to electronic disease registries through the AEMR, although not necessarily at all clinic locations. Currently the diabetes, hypertension and immunization registries are available to primary care providers systemwide, while congestive heart failure, hyperlipidemia and asthma registries are in place at RFHC only. Some specialty and inpatient providers also have access to the registries and availability is expected to be systemwide with the AEMR. There is also a patient communication tool embedded in the registry (*eClinicalMessenger*) that will send reminders to patients, for example, those with hemoglobin A1c (HbA1c) values greater than 8.0. Use of the registries by primary care providers varies.

Electronic prescribing is available within the AEMR, and is currently being used by all primary care providers, as well as in the specialty clinics where the AEMR has been implemented.

Providers within the ACE network are not incentivized or required to use available health information technology at this time.

System Design Innovations in Care Coordination and Delivery

Enrollees in the ACE program who select the ICC as their medical home have access to onsite specialty care, through the specialty clinics located at SMMC. Some of the community-based clinics have limited specialty care onsite, including obstetrics and gynecology (OB/GYN) services. However, most specialty care services within the network are not available at the primary care medical homes.

The San Mateo County ACE network does not use volunteer specialists. However, through the *Specialty Care Access Initiative* grant awarded to the county by Kaiser Permanente, the county has begun to utilize physician assistants and nurse practitioners in select specialty clinics to increase access and capacity. Providers within the ACE network utilize remote consultation with specialists to enhance management of conditions within the medical home setting and to try to mitigate long wait times for specialty services typical in the network. PCPs routinely use phone and email to consult specialists regarding patients with

complex conditions.

Three clinics within the San Mateo ACE network have received a grant from the California Health Care Foundation (CHCF) to support telemedicine with UC Berkeley's Optometry Clinic for remote diabetic retinopathy screening and consultation between primary care providers and specialists. The intent of the grant is to enable primary care providers to better manage diabetes in the primary care setting.

PCPs in the ACE network also participate in continuing medical education (CME) programs related to HCCI objectives, such as chronic care management and the medical home model. SMMC also facilitates regular trainings called *Meet the Specialist*, which occur at monthly department meetings; Ravenswood providers and staff are included in these. These events serve to enhance connectivity between primary care and specialty providers, and advance the scope of practice for primary care providers.

The county has implemented clear guidelines for primary care providers as well as specialists regarding policies and procedures in making and receiving specialty care referrals. While referrals by primary care providers for specialty care within SMMC do not require utilization management approval, referral requests for services outside of SMMC must be submitted to HPSM for review. In cases where a referral from a primary care provider is not possible, a protocol exists for self-referral by SMMC specialists, which require authorization from HPSM as well.

All specialty care referrals reviewed by the HPSM Utilization Management department are assessed according to clinical guidelines. These guidelines are available to primary care providers. Additionally, the county is currently developing a product to integrate decision support software and clinical guidelines into the referral module in the AEMR system through the *Specialty Care Access Initiative* grant from Kaiser Permanente.

Future Plans

During the remaining period of the HCCI program, the county plans to expand or enhance aspects of the network and its infrastructure. Specific plans include:

- Systemwide access to the AEMR planned by December 2009, including electronic prescribing and electronic referral applications.
- Incorporating clinical decision support tools and care guidelines into the electronic referral application, to create a *smart referral system*.
- Updating of existing care guidelines, and creation of new guidelines, as indicated.
- Using additional primary care provider training to further expand scope of practice.

Network Sustainability

If HCCI funding ends on August 31, 2010, the county expects that it would need to dramatically cut back services across the SMMC service delivery system, and that likely this would severely limit access to all services provided within the system. The county reports that it is difficult to assess exactly what those reductions would be at this time, as they would need to be taken in context with other reductions in state and local revenues that are expected over the course of the next several years due to the recession.

San Mateo County's Ideal Network

With sufficient funding to provide care for all uninsured, the county would insure adequately- staffed primary care teams (including physicians, nurse practitioners, nursing staff and medical assistants, social workers, pharmacists and mental health professionals) to provide better access for ACE patients to medical home services. The county would also augment its specialty-care provider teams in order to provide medically-necessary specialty care that cannot be accommodated by its primary care teams.

San Mateo County's Best Practices

San Mateo County has a number of best practices, which may be replicable in other settings.

- San Mateo County has expanded its safety-net network to include private providers. This allows the county to respond to changes in demand for care and address gaps in services.

- Availability of specialty care services are significantly improved through contracts with private specialists and hospitals, use of telemedicine and remote specialist consultation.
- Improved access to specialty care has been achieved by designing the Innovative Care Clinic where specialty care is always available onsite. Onsite specialty care is also promoted in other clinics, though on a more limited basis.
- The AEMR system is expected to greatly enhance network connectivity, care coordination and health outcomes. It includes network supports, such as disease registry and electronic referral and tracking tools, and will function as a single integrated electronic health record.
- The county has successfully incorporated the ACE program into the greater county effort to redesign all services to all its populations. Additional relationships with other hospitals and providers are planned to actively involve these providers in care of the underinsured and uninsured in the county.

Santa Clara County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The Health Care Coverage Initiative (HCCI) program in Santa Clara, known as Valley Care, provides care to uninsured low-income adults through a coordinated network called Santa Clara County Health and Hospital System (SCVHHS). This system includes the Valley Medical Center and clinics, the Valley Health Plan (VHP), private community clinics and an Independent Practice Association (IPA) called Physicians Medical Group. As of August, 2009, Valley Care has enrolled 17,231 members; 4,731 above the proposed three-year program target. The county recently halted new enrollment in Valley Care, but continues to re-enroll existing members.

Safety-Net System Prior to HCCI

The SCVHHS administers the Santa Clara Valley Medical Center (SCVMC), which provided episodic and emergency care through the SCVMC charity care program, *Ability to Pay Determination* (APD). Although some patients were paneled in the program, it was a less formalized system of care. SCVMC provided over 60% of Medi-Cal inpatient days and over 95% of uninsured resident inpatient days in the region. Santa Clara County has collaborated with private community clinics since the early 1990s and owns and operates a Knox Keene licensed health plan (Santa Clara Family Health Plan). These partnerships have remained through the implementation of Medi-Cal managed care and now the HCCI program. With the exception of the addition of the private IPA and two individually-contracted primary care providers (PCPs) the providers are essentially the same as before HCCI.

HCCI Network Structure

Santa Clara County utilizes the county medical system and private providers in their HCCI network. The providers include the Valley Health Plan, a state licensed health plan owned and operated by Santa Clara County, which is administered by SCVHHS and provides administrative management of Valley Care. Other providers are county operated clinics, private community clinics, an Independent Practice Association (IPA) and two privately-contracted PCPs.

Network Services and Reimbursement

SCVMC is the county hospital and provides all the inpatient care for HCCI enrollees. Six county clinics, which are Federally Qualified Health Centers (FQHCs), and private community clinics with over 16 sites provide ambulatory care. Approximately 85 private practice sites are also included in the network through the IPA and private physician offices. About 7,500 HCCI enrollees receive care at the county sites, and the rest are spread throughout the network with 3,000 in the IPA and varying numbers at the community clinics. There are currently 694 physicians throughout the network.

Currently there is no cost sharing for enrollees up to 100% of the federal poverty level (FPL). There is minimal cost sharing in the form of copayments for enrollees from 100-200% FPL.

PCPs are reimbursed differently depending on the clinic and the relationship to the county. At county clinics providers are paid by salary. At private community clinics and private practice sites, including the IPA, providers are paid at Medicare rates for each

of a defined set of procedures.

Urgent care services are available at most clinic sites. Urgent care hours vary among clinics although there is a dedicated *Express Care Clinic* located at the SCVMC campus that provides walk-in care for non-emergent medical problems. The Express Care Clinic is open from 9:00 a.m. to 1:00 a.m. seven days a week. There is also a dedicated 24/7 nurse advice line available and all after-hours care is covered by the county at Valley Medical Center. Urgent care providers are salaried county employees. If urgent care is received at private community clinics and private practice sites, including the IPA, providers are paid Medicare rates for each of a defined set of procedures.

Specialty care services are provided at SCVMC and the new *Valley Specialty Center* which opened in January 2009 on the SCVMC campus. The Valley Specialty Center brings together many of Santa Clara Valley Medical Center's adult outpatient specialty services. It also houses laboratory services and an outpatient pharmacy. Patient education, financial counseling and many diagnostic imaging services are provided there as well. The majority of adult specialty services are provided at the medical center or at the specialty center with a few exceptions (i.e., ophthalmology, dermatology and optometry) that are available at the primary care clinic sites. Specialty care providers are salaried county employees. Specialists at contracted sites are paid Medicare rates for a defined set of Current Procedural Terminology (CPT-4) codes.

Inpatient care services are available for enrollees at SCVMC; all inpatient services are paid on a capitated basis. For higher-level specialty or inpatient care, patients may be referred to the Stanford Medical Center. Services at this level are reimbursed through an existing contract with SCVMC.

Ancillary Services and Reimbursement

Laboratory services are provided primarily at SCVMC and at the Valley Specialty Center, although some primary-care clinic sites offer basic laboratory services. Laboratory services at all county clinic sites are provided by county employees, but VHP pays the county facility on a capitated basis for all VHP enrollees. Private community clinics and providers send all laboratory work to VMC sites.

Diagnostic services are provided primarily at SCVMC and at the Valley Specialty Center, although some primary-care clinic sites offer basic diagnostic services. Diagnostic services at all county clinic sites are provided by county employees, but VHP pays the county facility on a capitated basis for all VHP enrollees. Private community clinics and providers are paid Medicare rates for a defined set of procedures.

Pharmacy services are provided at SCVMC and at the Valley Specialty Center, as well as at the six county FQHC clinics. Pharmacy services are reimbursed via a capitated rate for the county clinic and medical center sites. No out-of-network pharmacies are used.

There is not a pharmacy benefits manager (PBM) for the program. Medication reconciliation services (a review of patient medications) are often performed by physicians, but are not required by contract.

Health Information Technology

The SCVHHS network is linked to several encrypted referral, appointment and data systems where provider and staff communications occur.

Valley Care has a Web-based enrollment system called *dot-net*. Patient information is sent from *dot-net* to the claims system known as *Diamond.* Staff can access eligibility information through another system called *HDX* that downloads data regularly from the *Diamond* system.

Scheduling systems for Valley Care enrollees are not centralized but do go through a central call center that can schedule for the county clinics. Enrollees who are assigned to the private community clinics, private physician offices or the IPA must schedule through their provider's office even when they contact the central call center for information.

The county utilizes a *Lifetime Clinical Record* to access clinical and demographic patient information which is available to providers in the county clinic and hospital system.

The county is also in the process of implementing a full electronic medical record (EMR). The EMR system is being implemented in the ambulatory departments first before it moves to the inpatient records. The roll-out sequence for the EMR is still in the planning phase. Currently 200 primary care physicians are using the ambulatory electronic medical record. Encounter data resides in both the *Diamond* system, which is the managed-care claims payment system, and the *Invision* system, which is the hospital and clinics billing system.

An electronic Web-based referral (*e-referral*) system called *Valley Express* (a customized version of *Access Express*) is currently in use and is available to all providers systemwide. *Valley Express* has been in place for several years and the county is implementing the new version (4.2). This system links PCPs to specialists and provides clinical guidelines, case management, eligibility and other related communication tools throughout the entire network. Primary care providers receive followup information after specialty care and other services via telephone and electronically through the *e-referral* system on a regular basis.

The program utilizes a diabetes registry that is available to some providers. The use of disease registries is still under development. The county would like to implement a more robust system with centralized registries for providers but presently it is not a seamless system.

Electronic prescribing or *e-prescribing* is currently being implemented in the SCVMC, but the county reports that it is still in the early stage of implementation.

Providers in the internal county system are required to use the network resources for health information technology (HIT); however, the program does not currently utilize incentives for HIT use.

System Design Innovations in Care Coordination and Delivery

Valley Care has implemented a number of strategies to enhance specialty care services and the safety-net network. Valley Care offers onsite specialty care at the hospital-based clinics and Valley Specialty Center, as well as other local clinics in the community including Valley Health Center Bascom, East Valley, Gilroy, Moorpark, Silver Creek, Sunnyvale and Tully. Each clinic offers an array of specialty care services that Valley Care enrollees may receive. Most specialties require a referral but some (dermatology for example) may be contacted directly by patients. The county does not utilize alternative sources of specialty-care personnel.

Valley Care specialty consultation methods for primary care providers include telephone and electronic methods of communication. Most of the communication is through email or the *e-referral* system, *Valley Express*. The county reports that physicians in the network have long established relationships, and formal and informal communication across sites varies.

Valley Medical Center is a teaching facility with two residency programs, one of which is a joint venture with Stanford. Continuing Medical Education (CME) trainings such as chronic care management and diabetes education are provided to county physicians, although not all contracted-private physicians go to the county for training. Specialty consultation via *Grand Rounds* is also available to primary care providers on a regular basis through SCVMC.

Referral management policies including referral criteria and medical review are utilized to ensure appropriate referrals via the existing *e-referral* system and are available to various provider types.

Valley Care utilizes clinical care guidelines that are condition-specific and that outline diagnostics necessary to obtain a specialty consult. Providers have online access to SCVHHS's evidence-based practice guidelines. Providers also have access to two clinical decision support software programs, *InterQual Clinical Guidelines* and *Milliman Care Guidelines.*

Future Plans

During the remainder of the HCCI program, the county plans to continue program activities and complete or

expand certain aspects of the Valley Care network. Specific plans include:

- Continued implementation of full electronic medical record (EMR).
- Increasing availability and utilization of clinical data for case management and disease management programs.

Network Sustainability

In the event that the HCCI program does not continue beyond the August 31, 2010 deadline, the county is planning for continuation of care in the following ways:

- The county is currently in the process of developing a new licensed insurance product called *Healthy Workers* which is the result of local legislation known as the *Adult Health Coverage Expansion Program* (Assembly Bill 12, Beall, chaptered 2007).
- The county intends to continue a roll-out of the medical home model at all county sites and develop ways to support private community-clinic partners to do the same.
- Chronic disease management will continue to expand.

If there are continued funding cuts by the state and local government with a diminishing supply of primary care providers, the county reports it may develop other care models for patients unable to be assigned to a PCP. For non-eligible individuals (excluded due to DRA requirements or other factors) the county will continue to expand partnerships with the Public Health Department and community-based organizations to provide some level of care. The county is also looking at shifting more resources to childrens' services as funding for both children and adults is becoming increasingly hard to secure. The overall plan is to eventually allocate resources based upon a risk-stratification methodology to maintain current investments in systems and facilities.

Santa Clara County's Ideal Network

The county believes that the ideal network for the low-income uninsured population should include medical care, mental health, and alcohol and drug services available at several geographically accessible primary care sites. The PCPs should be supported by a care manager and social worker and possibly a nurse practitioner, and utilize several different registries for key chronic conditions. Data management for clinical data from all delivery points should be organized through a data warehouse so that laboratory, pharmacy, inpatient and other services could be grouped by individual patients, providers, disease states, expense or specific utilization criteria. The clinical delivery system would be in partnership with community-based organizations to support patients in understanding how to manage their chronic conditions, as well as enhancing their ability to improve their lifestyle choices. Hospitals, emergency and urgent care providers should have electronic records so that patients would be continually referred back to the same primary-care team.

Santa Clara County's Best Practices

- The county has successfully incorporated an array of community-based private practice physicians, community clinics and the county medical system to develop a managed care style network.
- The two-way communication and *e-referral* system (*Valley Express*) has greatly enhanced communication between primary care providers, specialists, case management staff and administrators.

Ventura County's Health Care Coverage Initiative Network Structure: Interim Findings

Introduction

The Ventura County Health Care Agency (HCA) administers the Health Care Coverage Initiative (HCCI) program in Ventura known as ACE (Access, Coverage, Enrollment). Ventura County has enrolled 12,440 members as of May 31, 2009; just under the proposed three-year program target of 12,500. The county has ceased enrollment of new ACE members as of April 24, 2009, due to increased costs of providing services to the ACE population.

Safety-Net System Prior to HCCI

Historically, 78% of services provided by HCA were for low-income uninsured residents and Medi-Cal recipients. There are disparities in Ventura County in income and access to health care services, and this is correlated with rural areas since these areas are primarily agricultural and have fewer providers. The county system consists of 14 primary care and 13 specialty care clinics providing care to the medically-indigent residents of Ventura County. Prior to HCCI, the Health Care Agency did not have a formal system to manage patient care and lacked payment mechanisms for primary and preventive care. Federal funding for care of the uninsured was limited to disproportionate share hospital (DSH) revenue for hospitals. Lack of sufficient funding led to access barriers (such as limited specialty care) and uninsured residents would often delay receipt of care until the problem became urgent.

HCCI Network Structure

Ventura County's ACE provider network includes the county hospital system and contracted private non-profit community clinics and providers.

Network Services and Reimbursement

The ACE network includes the HCA delivery network consisting of the Ventura County Medical Center (VCMC), the Santa Paula Hospital, the Ambulatory Care Clinic System, the Department of Public Health (DPH) and the Behavioral Health Department (BHD). Outpatient services are delivered through 31 ambulatory care clinics (14 primary care and 17 specialty care); DPH family planning and immunization clinics, eight BHD clinics, and three urgent care centers. A fourth urgent care center will be added to the network soon. ACE also includes *Clinicas del Camino Real*, a Federally Qualified Health Center (FQHC) with nine clinic sites. In the second year of the program, *Clinicas* began providing dental services for ACE enrollees. Currently there are over 240 providers in addition to the residency program in the ACE network. The size of enrollment varies, with three clinics having the largest share of program enrollees. Ventura County is currently working on expanding capacity in four clinics to better accommodate primary and urgent care services in the region.

HCA Ambulatory Care Administration conducts fiscal management, data collection and administrative management for the ACE program. The county has a centralized budget and utilizes a pro-rated allocation based on actual billed charges for primary, specialty, ancillary and inpatient care at county operated facilities. All county providers are paid a salary. *Clinicas del Camino Real* is paid at a bundled fee-for-service rate for primary care, urgent care and ancillary services. This includes $90 for each primary care visit

and $105 for each dental visit. There is a cap of $1.3 million for ACE services at *Clinicas*; $1 million for dental care and $300,000 for medical services.

Urgent care services are available at three ACE network clinics. A fourth location in Simi Valley will open in Fall 2009. Urgent care services are reimbursed as described previously.

Specialty medical services are provided at ACE clinics throughout the network and at or adjacent to the VCMC or at Santa Paula Hospital. HCA is currently building a new clinic and a new neurology center at VCMC.

County-employed specialists are salaried. HCA also contracts with private practice specialists that work as part-time network contractors. Reimbursement is negotiated with each provider and supplemental payments (in addition to base salary) are paid using relative value units (RVUs) for services provided by each specialist.

ACE plans to integrate mental health services using Mental Health Services Act (MHSA) funds. BHD services are specific to *severely mentally ill* individuals, so patients who do not meet these specific criteria frequently use the emergency room. ACE plans to fund mental health practitioners to partner with PCPs at clinics to provide mental health and therapy services.

Inpatient care services are available for enrollees at VCMC and Santa Paula Hospital, which are both county-owned and operated. Reimbursement is based on a prorated allocation of billed charges.

Ancillary Services and Reimbursement

Laboratory and diagnostic services are available at VCMC and Santa Paula Hospital. There is no copayment for ACE patients at this time. Reimbursement for laboratory and diagnostic services is part of the hospital budget. However, higher-level diagnostic services are not covered under the ACE program. No private imaging facilities are included in the ACE network. A private vendor is included for durable medical equipment (DME). The county has two to three outside contracts for respiratory supplies.

Ventura County contracts with a pharmacy benefits manager (PBM) called *Express Scripts.* The PBM follows the ACE program formulary. The ACE program covers medications for two months while enrollees apply to patient assistance programs available from pharmaceutical companies for more expensive medications. VCMC provides staff support to assist enrollees to apply for these programs. Medically-necessary medications may be covered by ACE when enrollees do not qualify for such programs. A copayment of $5 applies to medications, but medications costing $4 or less that may be obtained at retail pharmacies are not covered. Pharmacy reimbursement is part of the hospital budget.

Medication reconciliation (a review of patient medications) is not a formal requirement in the PBM contract. However, Ventura County reports that providers often review patient medications prior to hospital discharge. Additionally, providers at the clinics often have a standing requirement that patients bring in their medications for review during their visit.

Health Information Technology

Ventura County has been building its health information technology (HIT) capacity across the ACE network since inception of the program. HCA manages an electronic enrollment database where eligibility and medical home assignment listings are prepared and sent to clinics.

An electronic patient information system called *Medi-Tech* is used by HCA and VCMC. This system contains some clinical information, claims data and patient demographics. The primary data available at the contracted private clinics are provider notes, but these are not consistently available due to lack of access by these providers to *Medi-Tech*.

Ventura County uses a *homegrown* case management system called the *Nursing Referral System* (NRS) to document patient information. The system came online in August 2009, and an upgraded version of NRS will be implemented in the fall of 2009 with more detailed data, including each case management visit and group

health education classes.

The county is currently considering an electronic medical record (EMR) for both the hospitals and the Ambulatory Care System. The county will be examining bids from numerous vendors in the next few months.

The ACE program has a referral center that is run by the Clinical Nurse Manager of Ambulatory Care at VCMC. Currently, the program is working on developing an electronic referral (*e-referral*) system through a Kaiser Permanente *Specialty Care Access Initiative* grant. The system is about three-fourths complete as of December 2009. Currently, all referrals are done by fax.

Authorization is required for referral to surgery and specialty care visits. A pre-admitting department at VCMC reviews and approves referrals using *Milliman Care Guidelines*. Some provider notes may be documented in the *Medi-Tech* system, but specialists tend to follow up with PCPs via phone, email or paper summary. Although communication is not formalized, most specialists do provide some followup to the PCP.

Some clinics utilize a Patient Electronic Care System (PECS) registry for diabetes and preventive care. The county has recently centralized data entry and has over 6,000 patients registered in PECS. These program data are available for analysis for the first time. There is also a PECS registry for disease management of hypertension and hyperlipidemia.

Electronic prescribing is currently not in use within the ACE program.

The ACE program does not require or incentivize providers to use HIT for ACE enrollees.

System Design Innovations in Care Coordination and Delivery

HCA has implemented strategies to enhance access to specialty care services and strengthen the safety-net network in Ventura County. The ACE program experienced a significant increase in demand with about 7-8,000 in the first program year. This surge in demand led to an increase in the number of providers for primary, specialty and urgent care services, and an increase in use of Santa Paula hospital specialists.

ACE offers onsite specialty care at some primary care sites and at the hospital-based clinics. Of the 14 primary care clinics, three do not have a specialist onsite: one because it is small (Piru) and only has a half-day clinic twice per week; one because it is brand new (Las Posas); and one where only the family-practice residents practice. The county has placed orthopedics, neurology, endocrinology, rheumatology, cardiology and obstetrics practitioners at numerous primary care clinics. Two of the larger primary care clinics are specialty-medicine clinics. The program continues to focus on managing patients with more complex and/or chronic conditions in an outpatient setting.

The county is also working to obtain specialists in certain disciplines, such as dermatology, and will hire a second otolaryngologist. In the interim, ACE utilizes physician assistants for otolaryngology and orthopedics.

Ventura County, as part of the Kaiser *Specialty Care Access Initiative*, is partnering with UC Berkeley Optometry Clinic and the EyePACs Program for remote diabetic retinopathy screening and consultation between primary care providers and specialists. Ventura has just received two diabetic retinal cameras. UCB providers trained HCA staff and physicians in October of 2009 in the use of the cameras and the EyePACs Program. The intent of the collaboration is to enable primary care providers to better manage diabetes in the primary care setting, thereby reducing the incidence of diabetes-related blindness among low-income Ventura residents. Under the same grant, Ventura is planning to expand the role of the PCP through specific provider trainings. The strategy is to provide fellowships and hands-on practice with specialists to interested PCPs. Clinical areas under consideration are dermatology and rheumatology.

Primary care providers in ACE utilize telephonic and email communication for specialty consults. Next year the program intends to utilize more telemedicine in the form of video conferencing, particularly for

dermatology as there is currently no specialist available in the ACE program.

Referral management policies are being developed for the new electronic referral system. Ten clinical specialty care guidelines have been developed with the Ventura County Safety-Net Specialty Care Access Coalition. These include rheumatology, otolaryngology, endocrinology, adult neurology, epidural injections, cardiology, orthopedic hand specialty, pulmonology and nephrology. Two other guidelines for gastro-intestinal procedures and hepatitis C are under development. ACE utilizes the recently purchased *Milliman Care Guidelines* that are condition-specific, and are used for procedure and surgery review.

Future Plans

During the period remaining under the HCCI program, the county plans to complete or expand certain aspects of the ACE network. Specific plans include:

- Completing the new specialty center for neurology services, expected to be open in the summer of 2010 on the VCMC campus.
- Expanding the ACE disease management program.
- Implementing the electronic referral system under the Kaiser Permanente *Specialty Care Access Initiative*, expected January 2010.

Network Sustainability

In the absence of HCCI program funds after August 31, 2010, Ventura anticipates that only certain aspects of the ACE program would be sustainable. These include sustaining the provision of medical care, but with lower reimbursement per visit. Case management services would also continue, but cost sharing for enrollees may be required. Dental care may not be sustainable without continued HCCI funding. Support services such as HIT would continue, but could not be expanded without further funding support.

Ventura County's Ideal Network

With sufficient funds to provide services to all uninsured individuals, Ventura County would like to continue expanding access to primary care and enhancing specialty care capacity. The county would continue the provision of dental care services and would not need to implement cost sharing for individuals receiving care. In addition, the county would continue to develop centralized information systems, more formalized communication between primary care providers and specialists, and increase the collection and analysis of data on ACE enrollees.

Ventura County's Best Practices

- Incorporation of private providers in the care of ACE program enrollees. The county reports that the development and expansion of the provider network has allowed for more comprehensive care for patients and better communication between provider groups. Ventura County has formed new alliances between VCMC, *Clinicas del Camino Real*, and private physician groups for certain specialty services.
- Provision of behavioral health services under the ACE program provides necessary mental health care to a high-need population. Incorporation of behavioral health providers within the clinics has expanded onsite access to these services.
- Multiple efforts at expanding specialty care capacity have improved access to specialty services.
- Network implementation and expansion has reduced emergency room use within the county. The county increased its patient education efforts to reinforce the use of the medical home and reports a reduction from a high of 36 to a low of 19 visits per 1,000 enrollees during the first year of ACE.