ALAMEDA COUNTY
●ACCESS TO CARE
COLLABORATIVE

Expanding Health Coverage and
Increasing Access to High Quality Care

Response to Serving the Medi-Cal SPD Population in Alameda County

As the State has acknowledged in the 1115 waiver concept paper, the Medi-Cal fee-for-service (FFS) system does not provide the best and most cost-effective care for Seniors and Persons with Disabilities (SPDs). Due to the increased rates of chronic illness, multiple diagnoses, and needs that extend beyond primary care, SPDs would benefit most from a more coordinated and integrated healthcare delivery system.

> *"The FFS system often fails to provide consistent and coordinated care*
> *for California's most vulnerable populations…"*

There are three ways to achieve a more coordinated system in Alameda County, listed in the Alameda County Access to Collaborative (Collaborative) order of preference:
1) Mandatory managed care through a County Organized Health System (COHS) model
2) Voluntary managed care through the existing Local Initiative model plus an Enhanced medical home (EMH) model
3) Mandatory managed care through the existing Two-Plan model

The Collaborative is interested and ready to partner with the State in administering <u>any </u>of the approaches above. However, we strongly believe that mandatory managed care through a COHS model has the greatest potential to achieve the waiver goals of increased coordinated care for SPDs.   We also support the development of an EMH model in Alameda County and prefer this over an expansion of mandatory managed care through the existing Two-Plan model.   An EMH delivery system would provide a good platform for transitioning the county from a Two-Plan to a COHS model. Under this scenario, Alameda Alliance for Health (the Alliance) would serve as the lead administrative entity, with the Collaborative acting in an oversight/advisory capacity.

Our support for a local solution is consistent with the principles outlined by the California Association of Public Hospitals (CAPH) in its recent waiver document released on October 16, 2009.   The Collaborative is committed to designing a coordinated care model that improves health care, expands coverage and access for low-income individuals, and supports and sustains Alameda County's public hospital system.

Acknowledging the role of Medi-Cal managed care

> *"Medi-Cal's managed care program embodies the essential elements of*
> *organized delivery systems."*

The Collaborative appreciates that the State has acknowledged the role that Medi-Cal managed care has played in the State's healthcare delivery system, as well as the role that it will play as the State moves

towards creating a more effective and efficient system. Medi-Cal managed care programs have historically provided a coordinated system of care for the beneficiaries they serve, some of whom are the very beneficiaries that the State identifies as the most vulnerable and high cost/high risk. We believe this is the ideal platform from which to expand the healthcare delivery system to better serve those Medi-Cal beneficiaries who have the highest need for coordinated care but are not currently served by managed care.

The Collaborative has been instrumental in Alameda County in helping to ensure that Medi-Cal managed care through the Alliance supports safety net providers and the patients that they serve. This shared history leads us to collectively support mandatory managed care through a COHS model or an EMH solution administered by the Alliance for improving coordination of care for Medi-Cal SPDs in our county.

Who we are

The Alameda County Access to Care Collaborative is comprised of the leadership of the county safety net system. The Collaborative meets monthly and focuses on issues related to healthcare coverage, access to high quality healthcare and racial and ethnic health disparities. Members Include:

- Alameda Alliance for Health (Alliance)
- Alameda County Health Care Services Agency
- Alameda County Medical Center
- Alameda County Social Services Agency
- Alameda County Behavioral Health Care Services
- Alameda County Public Health Department
- Alameda Health Consortium (association of community health centers)

Why the Collaborative is a good partner for coordinating care for all SPDs

The Collaborative has a history of working together to bring "systemness" to fragmented care for the Medi-Cal FFS and indigent populations. For example, the Collaborative partners formed a county-wide specialty care task force to improve access and coordination of primary and specialty care services for the uninsured, underinsured, and Medi-Cal populations. The Collaborative also formed a county-wide task force to improve the integration of primary care and behavioral health services. In both of these examples, the Collaborative successfully planned and executed interventions that improve access, resource coordination, and quality of care.

Collaborative member organizations have all the components necessary to administer, and benefit from, a more coordinated system of care for SPDs. We know that the County and community clinics already serve a large number of SPDs and have much of the infrastructure in place to serve as an integrated healthcare delivery system for SPDs.   The Alliance and its delegated providers are also well positioned to help administer and coordinate some of the overarching elements that would be required by the State for either mandatory enrollment of SPDs into managed care or an alternative EMH model for SPDs, such as: 1) assignment of beneficiaries to a medical home, 2) centralized multi-lingual, multi-cultural customer service, 3) repository of county-wide utilization data to enhance care coordination, risk profiling, and matching risk to intervention, 4) real-time discharge planning and close follow-up post-

hospitalization, 5) EMH performance measurement and reporting , and 6) administration and distribution of financing.

Under any of the aforementioned scenarios for improving the healthcare delivery system for SPDs, the Collaborative would work together to keep the resources local and ensure that resources are used effectively. The Collaborative would provide an accountable system of care that 1) enhances the capacity of existing safety net providers to serve as medical homes for SPDs, 2) coordinate county-wide health information technology and exchange (HIT/HIE) planning and resource deployment to support a patient-centered approach and minimize waste, 3) increase the coordination of care through the dissemination of clinical information to and from the medical home, and 4) use savings as incentive payments to providers for navigating patients to the most medically appropriate and cost-efficient source of care.

COHS is the best option for Alameda County for providing coordinated care to all SPDs

We consider COHS to be the best option for the county to achieve the system changes necessary to improve care for all Medi-Cal beneficiaries, particularly Medi-Cal SPD beneficiaries. By expanding the COHS model into Alameda County, Medi-Cal can more fully leverage an effective model for delivering care while achieving program savings.

The Alliance has taken the lead in engaging stakeholders in discussions to gauge support and concerns with a COHS model in the county and the response has been largely positive. In March 2009, the county Board of Supervisors unanimously approved a resolution supporting the pursuit of the COHS model for Alameda County. We met with stakeholders such as providers, labor, hospitals, medical groups, and advocates for seniors, the disabled, and children with special needs to obtain input on what a county-organized health system should look like and address any concerns. We also worked at the federal level to obtain the support of Congressmen Pete Stark and Henry Waxman and to begin the process of obtaining the federal legislation required to allow the county to transition to a COHS. We are also analyzing state FFS data to ensure that the county safety net will not be adversely affected by this transition, but will be strengthened by it.

The COHS option will not only maximize the county's capacity to provide a more integrated system of healthcare delivery and achieve the state's goals for improved healthcare (as stated in ABx4 6), it will also position the county well for upcoming potential changes to Medicaid via national healthcare reform. Any changes that result from national healthcare reform will likely not take place for several years. As such, the COHS option will give the county a head start on implementing and incorporating changes that are likely to be part of national healthcare reform.

Alameda County is ready to administer a system of coordinated care for all SPDs through managed care or an EMH model

The Alliance already serves more than 10,000 SPDs, has more than 1,500 members enrolled in its Medicare Advantage Special Needs Plan for dual eligibles, and provides services to more than 50 members who transitioned into community-based homes from Agnews Developmental Center. Since 2001, the plan has experienced a 10-15 percent annual increase in enrollment of SPDs and a retention rate of approximately 85 percent among voluntary Medi-Cal enrollees, most of whom are SPDs. In addition, Alameda County has many resources for SPDs, including the Community Health Center Network, Alameda County Medical Center, LifeLong Medical Center, Center for Independent Living, and Center for Elders Independence.

The health plan has developed expanded facility site review criteria for measuring accessibility of provider offices. The criteria was approved by DHCS and incorporated into the existing tool. Plan nurses are trained on how to use the tool and identify disability access issues. New accessibility information is shared with Member Services staff to assist members who are seeking accessible services.

The Alliance conducted an analysis of the overlap of our network with FFS Medi-Cal providers serving SPDs. There is significant overlap. The Alliance continues to outreach to FFS providers in and outside of Alameda County that are serving SPDs.

The Alliance also currently provides care management for high-risk populations, many of whom are SPDs. Last year, the program managed more than 200 individuals with chronic and severe health problems, improving the continuity of their care, and providing member education and encouragement. The program is administered by a vendor that uses a predictive model that incorporates inpatient, outpatient and pharmacy claims data, clinical profiles, and membership data to assess members most likely to benefit from care management services; it also employs qualified nurse care managers who have experience working with SPDs.   Member Services and Care Management staff assist members in coordinating out of plan services, include carve-outs.

In addition to the care management work done by Alameda Alliance, the Collaborative would also bring its experience from implementing the Coverage Initiative (Alameda County Excellence, or ACE Program), and its frequent emergency department (ED) user project. The frequent ED user project is a collaborative project of the Alameda County Medical Center (ACMC), a community health center (LifeLong Medical Care), and Alameda County Behavioral Health Care Services, providing intensive case management to frequent users of the ACMC emergency department. The project has a multidisciplinary care management team including a consulting physician, nurse practitioner, psychiatrist, clinical social worker, case manager, and a benefits advocate. The intervention helps patients navigate the medical system's referral processes and links them to social services such as housing subsidies and employment assistance.

Alameda County's experience in providing care and support to SPDs is equally applicable in a managed care or EMH delivery system.   The Collaborative members have the infrastructure and commitment to implement the structural reforms necessary to create a more accountable, coordinated system of care for Medi-Cal SPDs.   We hope that the State will support our efforts to transition to a COHS, and depending on the timing of the COHS transition, work collaboratively with us to develop a EMH model as an interim solution.   The next section summarizes our initial thoughts about processes that would need to be put in place to enhance care coordination for SPDs in Alameda County through an EMH delivery system.

Local approaches to the key elements of coordinated care

Below is a summary of how the Collaborative could fulfill the essential functions of a more coordinated healthcare delivery system and provide targeted interventions to improve care management and coordination for SPDs through managed care or an EMH model.

Key Element	Current Managed Care Processes	New Processes to Support an Enhanced Medical Home Model

Establishing a mandatory relationship with a primary care provider or clinic	▪ Through State processes, members select plan and primary care physician via a third-party vendor.
	▪ The Alliance's Customer Service Center assists members to select primary medical home using provider location, provider language, accessibility and other information.
	▪ Beneficiaries are allowed to change primary medical home at any time.
		▪ At the beginning of the program, the Alliance would:
		  1. Maximize voluntary enrollment of beneficiaries into an EMH. For those who do not select an EMH,
		    • Use recent utilization data to assess where beneficiaries are currently receiving care.
		    • Use utilization and medical history data to determine most appropriate assignment. For example, continuity of care would be most important if individual is under chronic care management, pain management, etc.
		    • Default beneficiaries into medical home site using provider location, provider language, accessibility, utilization history and medical history.
		
		The Alliance could also assist the State in certifying that providers meet EMH standards.
		
		▪ At the beginning of the program, the Collaborative would:
		  1. Develop a default algorithm for assigning members who choose the EMH program but fail to select a medical home.
		  2. Review member assignment reports from the Alliance to track implementation of the default process.
		
		Once program is in operation:
		▪ New enrollees would access the Alliance customer service

Key Element	Current Managed Care Processes	New Processes to Support an Enhanced Medical Home Model
		center to choose a medical home. Default algorithm is used to assign new members who have not selected a provider. ▪ Beneficiaries would be free to choose a different medical home, i.e. change in residence, complaint or grievance, etc. ▪ Beneficiaries would access customer service center to change medical home provider, obtain transportation and interpreter services for appointments if needed, and register grievances if needed.
Provider network development, education, and monitoring	▪ The Alliance continuously monitors network to ensure geographic access, and adequacy of coverage for specialty and ancillary services. ▪ The Alliance uses FFS claims data from the State to identify Medi-Cal fee-for-service providers who should be added to the network. ▪ Delegated providers conduct regular training opportunities. ▪ The Alliance provides training opportunities for directly contracted providers. ▪ The Alliance monitors delegated and directly contracted providers to ensure compliance with Medi-Cal contract requirements.	▪ The Collaborative would support smaller learning collaboratives to help clinic administrators and physicians embed practice guidelines into everyday procedure, sponsor continuing education, and assist smaller physician practices to enhance medical home features. ▪ The Alliance would monitor medical home contract sites and compile data. ▪ The Collaborative would review evaluation data and recommend actions to achieve consistent quality across the entire program.

Identification, assessment, stratification of population	▪ Currently, Alliance contracts with a several vendors to review claims data to stratify member population.
	  1. Healthways receives claims data and identifies members for voluntary enrollment in telephonic high-risk case management program.
	  2. The Alliance's actuarial vendor is reviewing claims data to risk profile member population using Medicaid-RX and CDPS risk adjustment models. Information may be used to modify capitation payments,
		▪ The Alliance would obtain retrospective claims data and use proven methods to assess risk, e.g. proprietary software, Medicaid RX, etc.
		▪ Alliance would provide claims data and risk profile to medical homes on a regular basis.

Key Element	Current Managed Care Processes	New Processes to Support an Enhanced Medical Home Model
	identify members for care advisor program, etc.	

Care management interventions tailored according to need	▪ The Alliance uses telephonic case management services for the highest risk members. Currently there is a 7.00 ROI on this intervention.
	▪ Delegated providers have care management programs for members (risk based and/or disease-based).
	▪ The Alliance works closely with directly contract physicians and medical groups to manage members who have chronic health conditions (e.g. ESRD) or health issues (e.g. pain management) and/or who need intensive support services post hospital discharge.
		▪ The Alliance would:
		  1. Stratify risk data to assign beneficiaries into targeted case management programs.
		  2. Determine if there is need for home visits for further assessments to supplement claims-based assessment.
		
		▪ The Collaborative would:
		  1. Identify a variety of case management interventions to meet needs and match risk.
		  2. Oversee a rigorous evaluation to track ROI overtime, document outcomes, and determine distribution of risk-share payments.
		
		▪ Interventions can be locally based at the medical home site which would give beneficiaries ability to access a variety of medical and social support services in a single visit.
		▪ Interventions may be phone or internet based to meet the access needs of beneficiaries.
		▪ Interventions may be home-based.

Care coordination across multiple psychosocial systems	▪ The Alliance is developing a program to jointly case manage members with severe behavioral health conditions. Some limited data sharing has started.
	▪ The Alliance participates in the Agnews pilot managed care program. This program has fostered a more effective working relationship between the plan and the regional center. This is benefiting the Agnews program and all Medi-Cal and Healthy Families children who rely on Alliance and regional center services.
		▪ The Collaborative would:
		  1. Build on its work in data-sharing, joint case management, provider education and other efforts to integrate primary care and behavioral health.
		  2. Propose a set of non-medical services that should be reimbursed to support care management for the highest risk beneficiaries.
		  3. Formalize work groups consisting of community-based organizations, county service providers, IHSS Public Authority and others who provide support services for this population. The work group would sponsor collaborative efforts, strengthening of

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		- referral systems, and data sharing. - Many of the public clinics and community clinics have on-site behavioral health, social work, and community resources. All clinics have effective referral arrangements as well. These should be supported. - Medical homes without readied access to psychosocial systems can partner with clinics.

HIT/HIE to support data sharing and quality measurement	- Individual collaborative members will participate in regional efforts; but not in a lead position.	- The Collaborative would:
		  1. Work with medical home providers to access available federal HIT/HIE money and coordinate county-wide planning to support medical home initiatives.
		  2. Enforce interoperability standards across all providers.

Measure performance to promote accountability and quality improvement	- The Alliance analyzes data using managedcare.com, Business Objects, and other analytical support tools to compare individual provider performance to benchmarks. - Benchmarks are also used to compare aggregate member service utilization to national, state, and other local initiative's benchmarks. - The Alliance uses facility site reviews process, HEDIS measurement/reporting, and other routine plan quality improvement activities. - Complaints, grievances and other information are used to identify potential quality issues.	- The Alliance would analyze EMH and hospital claims data to report on baseline and ongoing performance.

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Financing to support EMH performance goals and accountability	▪ The Alliance is at full risk for medical costs. ▪ The Alliance is developing a program to enhance the medical home capacities of directly contracted physicians and may use a combination of bonus payments, supplemental case management fees or some other type of payment to help providers achieve performance goals.	▪ Favorable outcomes, resulting in reduced costs for each medical home cohort would be monitored. ▪ Expect that there may be increased cost for primary care, specialty care, and diagnostic services as beneficiaries may be accessing comprehensive health assessments for the first time after assignment to a medical home. ▪ Expect largest savings from hospital admissions in the beginning.