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### Permalink

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### Journal

Policy brief (UCLA Center for Health Policy Research), 1(PB2009-11)

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### Publication Date

2009-12-01

Peer reviewed

December 2009

# 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.<sup>1,2</sup> 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).<sup>3,4</sup>

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.<sup>5</sup> 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.<sup>5-9</sup> 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.<sup>10-12</sup> 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.<sup>9,13</sup> Over time, the



Support for this policy brief was provided by a grant from The California Endowment.

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.<sup>14,15</sup> Moreover, facilities grapple with regional health care workforce shortages, rising costs of care, limited access to information technology and limited infrastructure resources and support.<sup>7,16</sup>

The limited development and implementation of provider networks within the safety net are due to numerous challenges.<sup>7</sup> Safety-net systems vary considerably in size, scope and organization.<sup>7,11</sup> Most systems provide fragmented and episodic care and are burdened with compromised quality and high costs.<sup>7,17</sup> 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.<sup>7</sup> 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.<sup>7,17-19</sup> 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.<sup>7</sup> 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.<sup>7,20</sup>

Safety-net providers generally lack the capacity to provide a full range of services to their patients.<sup>10</sup> 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.<sup>14,16,21</sup>

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.<sup>12,14,21</sup> The fractured nature of funding contributes to an absence of organized safety-net systems and little coordination between providers.<sup>12</sup> 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.<sup>7,11,22,23</sup> 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.<sup>7,11,16,24</sup>

Evidence indicates that participation in an organized care delivery network can mitigate many of the challenges faced by safety-net health care providers.<sup>8</sup> Despite this evidence, instances of such coordinated networks in the United States are infrequent.<sup>7,25</sup> 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.<sup>8,21,26</sup>

#### *Existing Examples of Safety-Net Provider Networks*

Several examples of organized safety-net provider networks exist.<sup>10</sup> 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.<sup>25,27</sup> 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.<sup>26</sup> Each medical center created a “health plan” that issued membership cards to eligible individuals and assigned them a primary care provider.<sup>28</sup>

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.<sup>25</sup> Other states, including Michigan, Maine, Georgia, New York, New Jersey and Wisconsin have implemented similar health care coverage systems based on uncompensated care pools.<sup>25, 27</sup> These systems are models of effective, coordinated networks operating within the safety net, and have enhanced access and improved outcomes while reducing costs.<sup>25, 27</sup>

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.<sup>29</sup> 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.<sup>7, 10, 29</sup> FQHCs have demonstrated success in providing primary and preventive care and reducing health care disparities.<sup>30-32</sup> 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.<sup>33</sup>

### **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.<sup>7</sup>

### *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.<sup>26, 34-36</sup> 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.<sup>26</sup> However, the extent to which these models improve clinical outcomes is as yet unknown.<sup>26, 37</sup>

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.<sup>38, 39</sup>

### *Specialty Care Redesign*

Access barriers to specialty care within the safety net are significant.<sup>19</sup> Formal agreements with specialty care providers have been suggested as a way to remedy this problem.<sup>10</sup> 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.<sup>21</sup> 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.<sup>18, 40</sup> These methods are advocated to encourage appropriate referrals and ensure that adequate clinical information is available to specialists upon referral receipt.<sup>17, 18, 40</sup>

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.<sup>17, 18</sup> 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.<sup>7</sup> Implementation of such features is challenging since they require consistent entry of patient information and scheduling, physician participation in data entry and staff training.<sup>41</sup> 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.<sup>18, 21</sup>

#### *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.<sup>5, 7, 42, 43</sup> 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.<sup>40</sup> 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.<sup>44</sup> 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.<sup>45</sup> 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.<sup>45</sup> Despite these advantages, public programs are slow to adopt electronic enrollment and eligibility systems, in part due to the costs.<sup>10, 46</sup>

#### *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.<sup>17, 47</sup> 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.<sup>17, 48</sup>

#### **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.<sup>49, 50</sup> 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
<b>HCCI Network Structure</b>										
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
<b>Network Services and Reimbursement</b>										
<b>Primary Care</b>										
<b>Setting:</b> 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
<b>Reimbursement Method:</b> 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
<b>Urgent Care</b>										
<b>Setting:</b> 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
<b>Reimbursement Method:</b> 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
<b>Specialty Care</b>										
<b>Setting:</b> 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
<b>Reimbursement Method:</b> 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
<b>Inpatient Care</b>										
<b>Setting:</b> county hospital (CH), private hospital (PH), district hospital (DH)	CH PH	CH PH	CH PH	CH	PH	PH DH	CH	CH PH	CH	CH
<b>Reimbursement Method:</b> 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
<b>Ancillary Services and Reimbursement</b>										
<b>Laboratory Services</b>										
<b>Setting:</b> 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
<b>Reimbursement Method:</b> 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
<b>Imaging/Diagnostic Services</b>										
<b>Setting:</b> 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
<b>Reimbursement Method:</b> 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
<b>Pharmacy Services</b>										
<b>Setting:</b> 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
<b>Reimbursement Method:</b> 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
<b>Pharmacy Benefit Manager (PBM):</b> all (A), some (S), none (N)	S	A	N	N	A	A	N	A	N	A
<b>Medication Reconciliation Services Required by Contract:</b> all (A), some (S) none (N)	S	S	N	N	N	N	A	S	N	N
<b>Health Information Technology (HIT)</b>										
<b>Electronic Eligibility Check Available to:</b> 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
<b>Electronic Appointment Scheduling Available to:</b> 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
<b>Electronic Patient Information System:</b> EMR, LCR, electronic summary sheets, care records, or other (O)	O	O	EMR O	O	O	O	LCR	EMR LCR	EMR LCR	O
<b>Electronic Patient Information Available to:</b> 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
<b>Electronic Specialty Referral/Tracking Available to:</b> 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
<b>Health Information Technology (HIT) (cont.)</b>										
<b>Method of Specialty Referral Followup to PCP:</b> Web-based (W), other electronic 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
<b>Disease Registries Utilized:</b> 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
<b>Disease Registries Available to:</b> 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
<b>Electronic Prescribing Available to:</b> 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
<b>Incentives for HIT Use:</b> 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
<b>System Design Innovations in Care Coordination and Delivery</b>										
<b>Onsite Specialty Care at Primary Care Practice Sites:</b> all (A), some (S), none (N)	S	S	S	S	S	S	S	S	S	S
<b>Alternative Sources of Specialty Care:</b> volunteer specialists (V), telemedicine (T), none (N)	T	T	T	V	N	V T	N	T	N	T
<b>Clinical Specialty Consultation Methods Available to PCPs:</b> telephonic (T), electronic (E)	T E	T E	T E	N	N	T E	T E	T E	T E	T E
<b>Expanding Training or Scope of Practice for PCPs:</b> 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
<b>Existence of Referral Management Policies for:</b> 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
<b>Clinical Care Guidelines for Appropriate Specialty Referral Available to:</b> 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.<sup>51</sup> 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 identified 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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### Acknowledgements

The authors wish to thank Gwen Driscoll and Sheri Penney for editorial and publication assistance. Special thanks also go to numerous individuals from participating HCCI counties that provided information on their respective programs.

### Suggested Citation

Roby DH, Reifman C, Davis A, Diamant AL, Meng YY, Kominski GF, Kally Z and Pourat N. *Creation of Safety-Net-Based Provider Networks Under California Health Care Coverage Initiative: Interim Findings*. Los Angeles, CA: UCLA Center for Health Policy Research, 2009.

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The views expressed in this policy brief  
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**PB2009-11**

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*Editor-in-Chief: E. Richard Brown, PhD*

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