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Safety Net Delivery System Redesign in California: Innovations in the Low Income Health Program (LIHP)

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Safety Net Delivery System Redesign in California: Innovations in the Low Income Health Program (LIHP)

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Safety Net Delivery System Redesign in California: Innovations in the Low Income Health Program (LIHP)

Executive Summary

The Low Income Health Program (LIHP) provides coverage for underinsured or uninsured nonelderly adults in California, who will be eligible for the Medi-Cal expansion and Covered California (the state's health insurance exchange) as of 2014. LIHP is an optional, locally administered health care coverage program and is effective from November 1, 2010, to December 31, 2013. The two main program components are the Medicaid Coverage Expansion (MCE) for those living at or below 133 percent of the Federal Poverty Level (FPL), and the Health Care Coverage Initiative (HCCI) for those above 133 percent and up to 200 percent FPL.

LIHP participating counties are distinguished as legacy and new LIHPs. Legacy counties are the 10 counties that participated in the previous Health Care Coverage Initiative (HCCI) program, which was scheduled to end August 31, 2010, but was extended through October 31, 2010. Legacy counties continued and expanded their original HCCI programs during the transition period (November 1, 2010 – June 30, 2011) to meet the new LIHP requirements that began on July 1, 2011. New LIHPs are those that launched programs in 2012 or 2013. A specific goal of LIHP is to design local health care delivery systems that comply with the network adequacy and access requirements; they would thus be more closely aligned with managed care delivery systems in anticipation of Affordable Care Act implementation in 2014. The Special Terms and Conditions (STCs) that defined program rules and requirements allowed participating LIHPs flexibility in how to achieve this program goal. A number of STCs required significant redesign in how care is

delivered within the safety net delivery system. In this report, we examine the strategies and innovations used by LIHPs to change the safety net delivery systems in their counties.

This report combines earlier assessments of the legacy counties with a survey of LIHP program administrators and a survey of primary care providers within LIHP networks to assess system redesign efforts during LIHP. In addition to data collected from LIHPs, we include responses from 60 clinics in legacy counties and six new LIHPs (Riverside, San Bernardino, Santa Cruz, San Joaquin, Placer, and the County Medical Services Program, or CMSP, a consortium of 35 mostly rural counties) that implemented their programs prior to August 1, 2012. The findings indicate significant changes in delivery of care under the LIHP program and a number of remaining challenges and barriers, as noted below.

LIHP Infrastructure of Provider Networks and Support Systems

- established a standard set of core benefits within the safety net system statewide
- created and expanded safety net provider networks by contracting with existing or new providers and enhancing or establishing relationships with TPAs and PBMs
- established methods for assessing network adequacy and addressing provider shortages
- monitored provider supply and established open communication channels and collaborative arrangements with providers
- created and utilized referral management to provide timely and cost-effective specialty care to program enrollees
- invested in HIT systems to facilitate better access to patient records across the provider network
- developed HIT systems with comprehensive electronic medical records (EMRs) that allow access to patient information across county health systems; made these records available to contracted providers

Encouraging Use of Primary Care and Appropriate Care-Seeking Behaviors

- enforced medical home adherence to improve continuity of care
- provided care coordination and teamwork training for primary care providers
- conducted health risk assessment to stratify patients into varying intensities of disease/case management
- supported patient self-management through disease-specific educational materials, provision of trained health educators, and health promotion programs
- maintained continuous quality improvement initiatives, with reports to providers on performance measures

Results of UCLA's provider survey indicate that the outcomes of the above strategies varied at the clinic level, as follows:

- Medical home adherence remained a problem for 26 of the 60 surveyed clinics.
- Fewer than 10 of the clinics reported that the disease/case management, educational materials, or health promotion programs were helpful.
- Care coordination strategies were more widely implemented, and access to specialty care was improved. Thirty-six clinics reported holding meetings among physicians and other staff at least weekly to discuss individual patient care. Forty-six clinics reported always following up on referrals to specialty care, and 19 clinics said access to specialty care had improved under LIHP.

Integrating Physical and Behavioral Health Services

- Almost all LIHPs reported some form of administrative support to increase integration between primary care and behavioral health providers. This support included streamlining the referral system and having access to a patient's medical records for both providers.
- Non-colocated facilities reported traditional forms of communication, such as telephone and/or fax. Five legacy LIHPs reported having the capacity to make e-referrals.
- All but one of the LIHPs had the capability to verify whether a patient followed through with a referral.
- Six LIHPs reported that their behavioral health providers had access to different aspects of a patient's medical record, while only one county reported that its physical health provider had access to a patient's behavioral health data.
- Care coordination served as another method of facilitating integration of services, specifically by promoting provider integration and centralizing care coordination.
- Two LIHPs formed committees or subcommittees to promote primary care and behavioral health provider interaction or to monitor the progress of integration through quality improvement efforts.
- Centralizing care coordination to facilitate integration was used by Contra Costa County in a centralized case management pilot, and in Kern County through a behavioral health coordinator who acted as a liaison between physical and behavioral health services.
- Colocation was one of the preferred modes of integration of physical and behavioral health services. Fourteen LIHPs with colocated facilities had behavioral health providers in a primary care setting; six LIHPs had physical health providers in a behavioral health clinic.

- Those with colocated facilities referred patients by walking them over to the appropriate provider, provided same-day visits, improved collaboration between both types of providers, and reduced the perceived stigma of visiting a mental health provider.
- LIHPs reported significant barriers to integration, including funding, administrative, organizational, service delivery, and clinical issues. Funding and a limited workforce were noted as barriers by the majority of local LIHPs. Three legacy counties also reported having an inefficient integrated HIT system.

Conclusions and Implementation

LIHPs not only succeeded in implementing the program as intended but also went beyond defined program criteria to enact innovative strategies that changed health care delivery in California's safety net system. The innovations and implementation methods of LIHPs are described in detail in this report. These innovations included developing robust provider networks and centralized support systems, promoting changes in provider and patient behavior, and integrating physical and behavioral health care. The success of LIHPs in system redesign through these strategies and innovations will benefit many parties, including LIHP enrollees who are eligible for coverage through the Affordable Care Act (ACA), safety net providers who participated in LIHP, California counties that implemented LIHP, and managed care plans and commercial providers that will insure and provide care to LIHP enrollees through the ACA.

LIHP enrollees eligible for coverage through the ACA will benefit from receiving care in an improved setting with comprehensive benefits, enhanced and expanded infrastructure for care, and systemic improvements in care delivery. Many LIHP enrollees have received assistance in managing their chronic conditions, learned to seek care from primary care providers in their assigned medical homes, received coordinated care from teams of providers, obtained access to needed specialty and behavioral health care, received higher quality care, and received coordinated physical and behavioral health services in colocated or other integrated settings. Collectively, these changes in care delivery are expected to have addressed the needs of LIHP enrollees, improved their health outcomes, and reduced their health care costs. Further analysis is required to assess the impact of these changes in care delivery on outcomes and expenditures.

Safety net providers who participated in LIHP and California counties that implemented LIHPs will also benefit in the long term. Safety net systems of counties that participated in LIHP will be well prepared to help LIHP enrollees transition to Medi-Cal or Covered California in 2014

because of the established relationships these enrollees have with their primary care providers. Counties and providers will benefit from network and support system expansions developed under LIHP. While significant challenges remain, investments made by LIHPs in building provider capacity and system support have transformed the delivery of care within the safety net in California. LIHP efforts positively impacted delivery of care in some clinics in LIHP networks. LIHPs helped providers improve their care coordination and disease management skills. Infrastructure development, including referral and HIT systems and telemedicine capacity, will continue to improve efficiencies in patient care delivery.

Commercial providers, managed care plans, and the Medi-Cal program are also likely to benefit from the advances achieved through the LIHP program. LIHP enrollees no longer face extensive barriers to primary and specialty care and will have significantly reduced pent-up demand once they are transitioned to Medi-Cal or Covered California. The costs of providing care to LIHP enrollees are likely to be similar to those for previously insured populations, and patients' chronic conditions are more likely to be controlled and managed.

The redesign of the safety net system under LIHP is also likely to positively impact individuals who remain uninsured upon ACA implementation. These individuals are likely to continue using the safety net system. The lessons learned by LIHP counties concerning provider network development and systems support, changes in provider behavior, and integration of physical and behavioral health care can be used by county indigent care programs, which will face significant financial incentives upon ACA implementation to deliver more efficient and effective care.

Introduction

The Low Income Health Program (LIHP)

In November 2010, California's "Bridge to Reform" §1115 Medicaid waiver was approved by the Centers for Medicare and Medicaid Services (CMS). The waiver authorized California to create the Low Income Health Program (LIHP) to provide coverage for underinsured or uninsured nonelderly adults in California, who will be eligible for the Medi-Cal expansion and Covered California (California's health insurance exchange). LIHP is effective from November 1, 2011, to December 31, 2013, and is an optional, locally administered health care coverage program for low-income individuals. It expands coverage to low-income childless adults who are not categorically eligible for Medi-Cal. Half of local program expenditures are reimbursed by federal funds through the waiver administered by California's Department of Health Care Services (DHCS). The two main program components are Medicaid Coverage Expansion (MCE) for those living at or below 133 percent of the federal poverty level (FPL), and the Health Care Coverage Initiative (HCCI) for those above 133 percent up to 200 percent FPL. Participation in the HCCI part of LIHP was optional. The specific goals of the program are to (1) begin early implementation of key coverage expansion components of the Affordable Care Act (ACA); (2) promote stability in the health care delivery system; (3) maximize the use of federal funds for care provided to low-income adults.

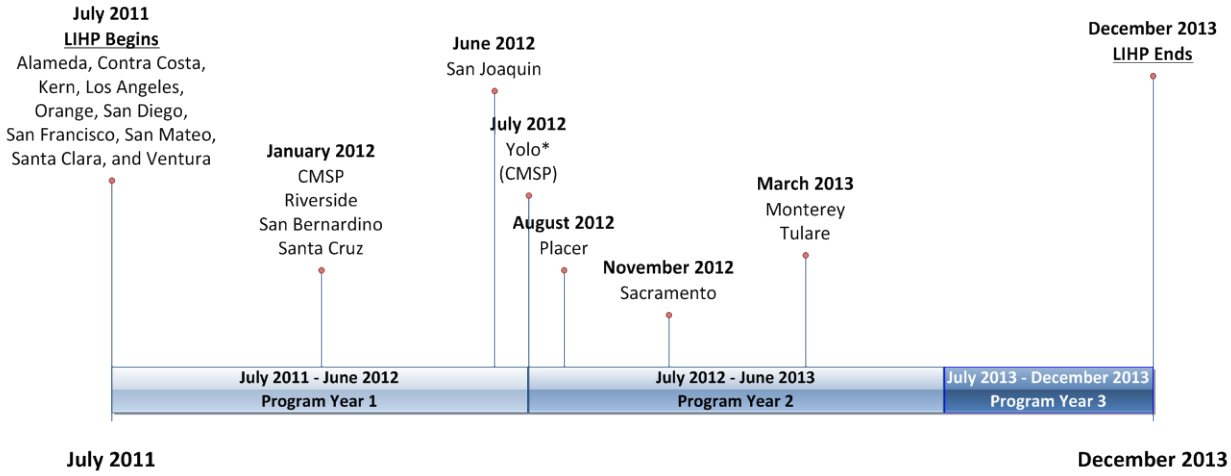
LIHP builds upon the previous HCCI demonstration waiver program, which was scheduled to end August 31, 2010, but was extended through October 31, 2010. An additional transition period (November 1, 2010 – June 30, 2011) allowed the 10 legacy counties that participated in HCCI to expand their original programs to meet the new LIHP requirements that began on July 1, 2011. The previous HCCI program was similar in many respects to LIHP, including defined eligibility criteria; provision of a benefit package; building of a county-operated, safety net-based provider network; establishing medical homes for program enrollees; improving access and quality of care; and implementing efficiencies in care delivery.

The two programs differ in three major areas. First, LIHP was to be expanded to all California counties that chose to participate in the program. Second, participating counties had more flexibility to select an income criterion lower than the maximum of 200 percent of the federal poverty level (FPL). Among LIHPs, income eligibility limits range from 25 percent to 200 percent FPL. And third, LIHP included an expanded set of benefits and other programmatic requirements compared to the first HCCI demonstration.

Participating LIHPs are distinguished as legacy and new LIHPs. The legacy LIHP counties are those that participated in the original HCCI program: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Participation in the previous waiver provided these counties with the opportunity to begin significant changes in their safety net care delivery systems and to implement many innovations in response to program requirements from mid-2007 to mid-2010. In particular, these counties made notable progress toward integrating their care delivery systems.[1,2]

LIHPs were implemented from July 2011 to March 2013. The 10 legacy counties implemented their programs in July 2011 (Exhibit 1). In January 2012, Riverside, San Bernardino, and Santa Cruz counties, and CMSP (County Medical Services Program), launched. CMSP is a consortium of 35 primarily rural California counties that centrally administers medically indigent programs in these counties.[i]

Exhibit 1: LIHP Implementation Timeline



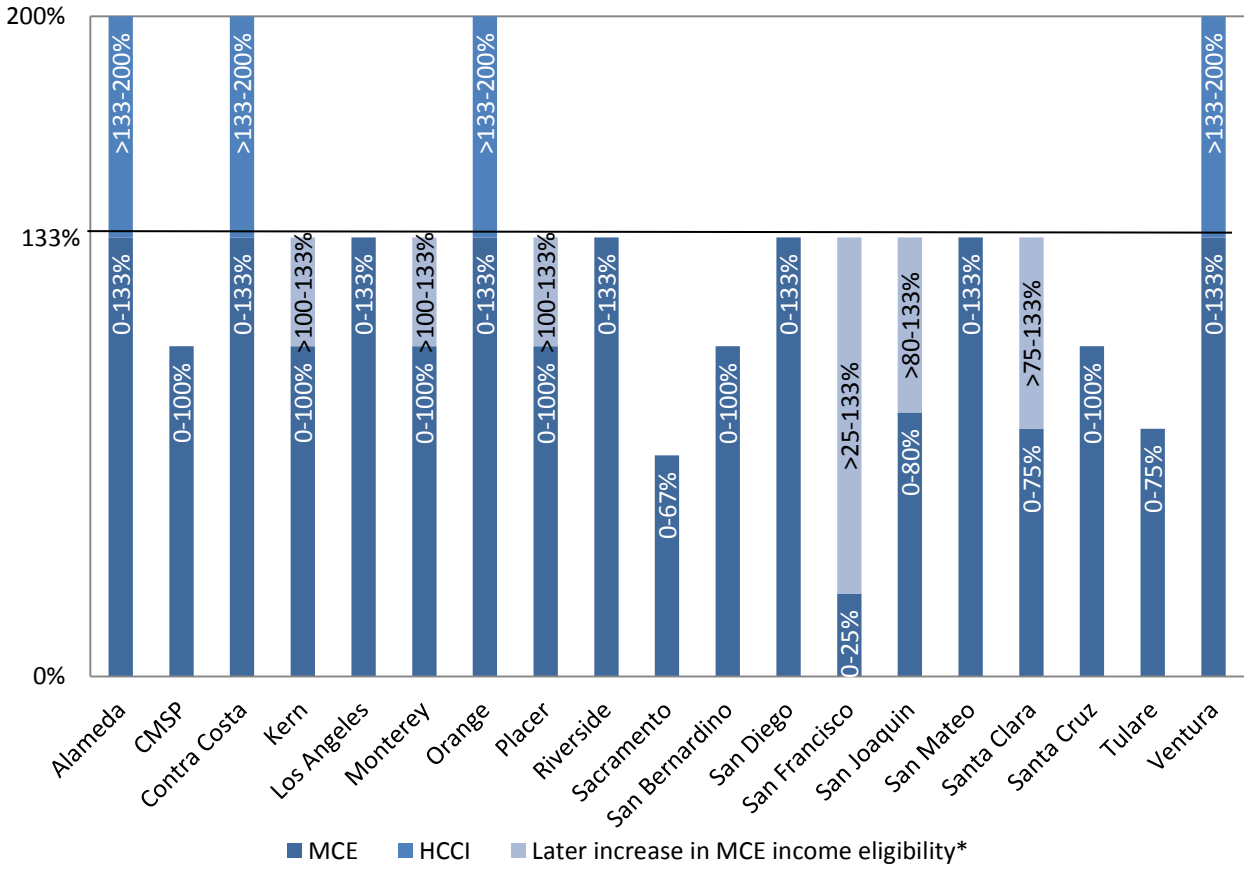
Source: Low Income Health Program contracts with the California Department of Health Care Services, updated as of May 1, 2013.

Four legacy LIHPs chose to implement the HCCI component of the LIHP and enroll individuals up to 200 percent FPL (Exhibit 2). The other six legacy LIHPs did not implement the HCCI component but continued to provide benefits to existing enrollees from the previous HCCI

*The County Medical Services Program (CMSP) includes 35 rural counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo (joined on July 1, 2012), and Yuba.

program. Fourteen LIHPs enroll Medicaid Coverage Expansion (MCE) individuals up to 133 percent FPL, and the remaining five LIHPs have chosen to enroll individuals at different FPLs ranging from 67 percent to 100 percent.

Exhibit 2: Federal Poverty Level (FPL) Limits by Local Low Income Health Program (LIHP)



*Six LIHPs increased their MCE income eligibility in 2013. Santa Clara increased in February, Kern in March, San Francisco in June, Placer in July, and Monterey and San Joaquin in August.
Note: This exhibit includes only LIHPs that were operational as of March 31, 2013.
Source: Low Income Health Program contracts with the California Department of Health Care Services, May 1, 2013.

The core benefits of LIHP are expanded from HCCI to include mental health benefits and nonemergency, pre-authorized medical transportation (Exhibit 3). LIHP also differs from the original HCCI program in three other program requirements. LIHPs pay for out-of-network emergency room visits for program enrollees, cover LIHP-eligible HIV/AIDS populations in their counties, and choose whether or not to participate in the county inmate program. Services for county inmates under LIHP are limited to acute inpatient hospital services provided by a hospital that is located off the grounds of the correctional facility, for hospitalizations that last for 24 hours or more.

Exhibit 3: Low Income Health Program Core Benefits

MCE and HCCI Core Benefits	Additional Core Benefits for MCE
i. Medical equipment and supplies ii. Emergency care services iii. Acute inpatient hospital services iv. Laboratory services v. Outpatient hospital services vi. Physical therapy vii. Physician services viii. Prescription and limited nonprescription medications ix. Prosthetic and orthotic appliances and devices x. Radiology	i. Minimum mental health services ii. Prior-authorized nonemergency medical transportation when medically necessary

Source: Low Income Health Program contracts with the California Department of Health Care Services.

The University of California, Los Angeles (UCLA) Center for Health Policy Research was selected by the California Department of Health Care Services and funded by the Blue Shield of California Foundation to conduct an independent evaluation of LIHP. Among other goals, the evaluation includes an assessment of "care delivery system redesign in anticipation of ACA implementation in 2014." This report provides a detailed examination of the progress of LIHPs in implementing changes to their safety net-based delivery systems.

Measuring System Redesign

A specific goal of the program is to design local health care delivery systems that comply with the network adequacy and access requirements to more closely align with managed care delivery systems, in anticipation of Affordable Care Act implementation in 2014. The Special Terms and Conditions (STCs) determined by California DHCS and Centers for Medicare and Medicaid Services (CMS), which approved the waiver, define program rules and requirements but do not dictate the specific ways in which this program goal is to be achieved.[3] However, a number of STCs require a significant redesign of how care is delivered within the safety net delivery system to achieve program goals. Among other rules, LIHPs are required to (1) have a defined provider network; (2) assign enrollees to a medical home that maintains the patient's records; (3) provide a comprehensive set of services, including preventive, primary, specialty, urgent, and hospital care; (4) provide case management and/or disease management services; and (5) provide adequate access to services.

However, most safety net systems in California provide sporadic urgent services to low-income eligible populations that seek care from safety net providers. Counties often face barriers due to limited funding and shortages of providers willing to see low-income uninsured patients. Providers may or may not have contractual arrangements with counties that pay for these services, electronic medical records or registries to manage chronic conditions, or quality improvement initiatives to improve patient care. Providers also face multiple resource barriers and high levels of patient need and pent-up demand. Patients frequently face multiple barriers to access and high-quality care, including limited numbers of providers and long waiting times in crowded waiting rooms, lack of continuity with primary care providers, inconsistent or poor management of chronic conditions, and very long waiting times for specialty appointments. Faced with these challenges, many uninsured low-income patients forgo primary care, seek care in emergency rooms, or are hospitalized for preventable conditions. The underutilization of primary and preventive services and inappropriate use of emergency room and hospital care in turn contribute to inefficient use of limited county funds and to poor patient outcomes.

Implementation of LIHP and the original HCCI program by California counties required a significant redesign of the safety net health care delivery system to address the problems faced by counties, providers, and patients. In this report, system redesign is assessed by examining the development of infrastructure, including implementation of provider networks and support systems, changing patterns of care delivery by changing provider and patient behaviors, and reducing inefficiencies in care delivery by moving toward integrated delivery of physical and behavioral health care.

Methods and Data

This report builds upon earlier assessments of the legacy counties under the HCCI program. UCLA conducted a survey of LIHP program administrators and a survey of primary care providers within LIHP networks. Sixteen LIHP program administrators were surveyed between January and March 2013. These surveys contained three modules: medical home, network, and behavioral health integration.[1] Legacy counties received only the behavioral health integration module, because they had completed a similar survey at the end of the HCCI program. New LIHPs responded to all three modules despite the short time period between implementation and the survey, which ranged from six months in the case of Placer County to one year in the case of the four LIHPs that launched in January 2012. Each survey response was followed by a follow-up telephone interview to collect further detail on various aspects of the program. Orange County declined to respond to the interview because the county was at the beginning stages of integration efforts.

During the past data collection effort, at the end of the original HCCI program, most program administrators considered LIHP as a continuation and expansion of the HCCI program, with some modifications in response to administrative requirements of LIHP and to experiences gained during HCCI.[1] The majority of the data previously collected from legacy LIHPs are applicable, and any programmatic changes are reflected in the current report.

UCLA conducted a second survey of the majority LIHP providers, including clinics, medical groups, and individual physician practices in LIHP networks, to assess the impact of system redesign efforts on providers. Very few medical groups and individual physicians responded to the survey, and those data are not reported here. Responses from 60 clinics in legacy counties and six new LIHPs (CMSP, Riverside, San Bernardino, Santa Cruz, San Joaquin, and Placer) that had implemented their programs prior to August 1, 2012, are included. For detailed information on our methods, please see Appendix A: Methodology and Data Availability. The data included in this report are presented separately for legacy and new LIHPs to account for differences in length of LIHP implementation and participation in the original HCCI program.

Chapter 1: Provider Networks and Support Systems

System redesign requires restructuring and enhancing infrastructure to decrease inefficiencies in care delivery. Creation of a provider network establishes clear contractual relationships with providers with defined compliance requirements and reimbursement mechanisms. A defined provider network can also ensure access to providers. Support systems such as health information technology can be established within a network, and services such as telemedicine and referral management can enhance care delivery. LIHPs have made significant advances in building safety net provider networks and have developed new and promising innovations to improve access and quality of care.

LIHP Provider Networks

Network Composition

In compliance with program requirements, LIHPs have made substantial progress in creating robust networks of hospitals, community clinics, private practice primary and specialty care providers, pharmacies, and behavioral health providers. LIHPs were required to ensure that enrollees had access to providers for covered services within a specified distance and certain appointment times. The STCs specify the following, unless the LIHP has a DHCS-approved alternative access standard:

- Primary health care services are provided at a location within 60 minutes or 30 miles of an enrollee's place of residence.
- Primary care appointments were made available within 30 business days of request from the beginning of the demonstration through June 30, 2012, and within 20 business days from July 1, 2012, forward.
- Urgent primary care appointments are provided within 48 hours (or 96 hours if prior authorization is required).
- Specialty care appointments are provided within 30 business days of request.

Fourteen of the 16 LIHPs had an existing county system comprised of county-operated clinics and hospitals (Exhibit 4), with 14 LIHPs operating county clinics and 11 operating hospitals. All LIHPs but San Francisco contracted with community clinics for primary care services and five LIHPs contracted with independent primary care providers (PCP).

Exhibit 4: Characteristics of LIHP Provider Networks, by LIHP, 2013

	Total Program to Date Enrollment (as of March 2013)	County-Operated Clinics	County-Operated Hospitals	Number of Primary Care Clinic Sites	Number of Independent PCPs in Private Practice
New LIHPs					
CMSP	129,149	✓	-	400	140
Placer	3,073	✓	-	4	-
Riverside	31,813	✓	✓	14	-
San Bernardino	36,580	✓	✓	8	18
San Joaquin	2,799	✓	✓	6	-
Santa Cruz	2,441	✓	-	5	-
Legacy LIHPs					
Alameda	70,615	✓	✓	36	3
Contra Costa	23,262	✓	✓	12	-
Kern	12,947	✓	✓	25	-
Los Angeles	278,987	✓	✓	155	-
Orange	67,022	-	-	108	122
San Diego	52,294	-	-	29	-
San Francisco	18,852	✓	✓	16	-
San Mateo	15,153	✓	✓	12	-
Santa Clara	20,193	✓	✓	24	67
Ventura	17,623	✓	✓	20	-

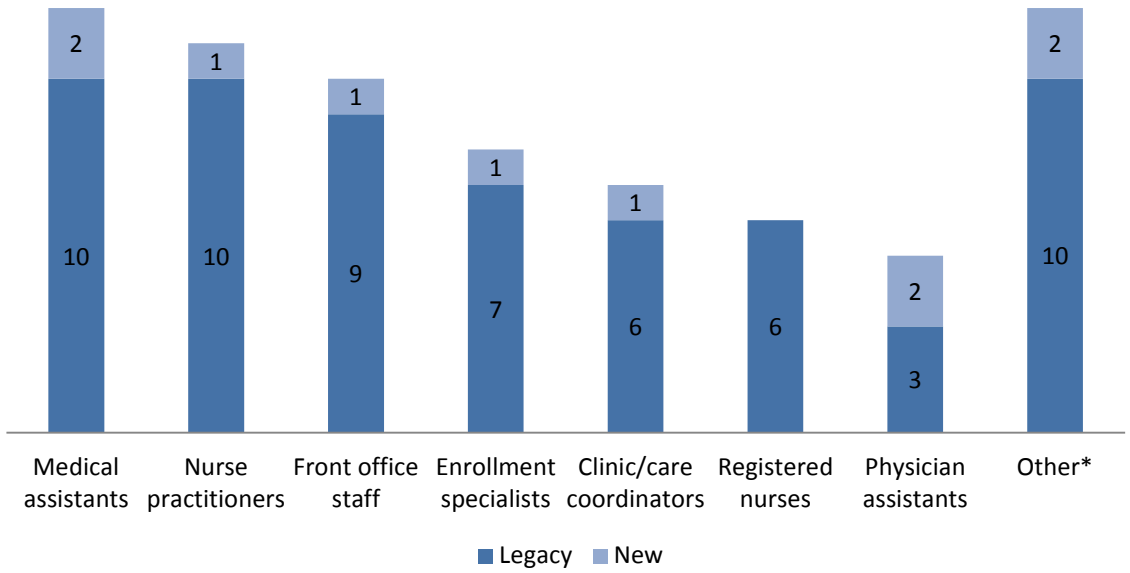
Source: Low Income Health Program Network Provider lists (Deliverable #3) and Individual-level unduplicated cumulative enrollment data submitted to UCLA Center for Health Policy Research by operating LIHPs as of March 31, 2013.

Legacy counties made the necessary changes in their HCCI network to comply with LIHP requirements. The challenges of compliance with LIHP requirements were somewhat different for new LIHPs, as they were faced with the challenge of developing their LIHP provider network. CMSP expanded its existing network, which is administered through Anthem Blue Cross and has been in operation since 2005. The other new LIHPs developed their networks based on preexisting relationships that were often informal. In follow-up interviews, new LIHPs discussed the necessity of establishing new contractual relationships with specialists to meet network adequacy requirements. Though CMSP had a robust network of providers, it expanded its network to include more than 800 additional behavioral health providers. San Bernardino released a request for proposals in February 2013 to contract with any interested clinics that met credentialing requirements, with the goal of providing better primary care access to enrollees.

In 2011, the federal Health Resources and Services Administration determined that the Ryan White HIV/AIDS Program (RW) is the payer of last resort. Individuals who receive care through RW-funded programs and who are eligible for LIHP are required to enroll in LIHP to receive LIHP-covered services. LIHPs are required to ensure adequate access within the service provider network for this transitioning RW population. In addition to providing services through county-owned clinics, Riverside contracted with the other major HIV/AIDS provider in the region, Desert AIDS Project, to provide better continuity of care for their HIV patients. Some LIHPs, such as CMSP, reported that all Ryan White health care providers in their service area were part of their LIHP network, and that contracts with additional providers were not necessary in order to have an adequate number of HIV/AIDS specialists. All LIHPs ensured that medications for HIV/AIDS patients were incorporated into their pharmacy formularies.

Participating clinics reported an increase in new hires as a result of their participation in LIHP (Exhibit 5). Of the 60 clinics that responded to this survey question, many reported hiring medical assistants (a total of 12), nurse practitioners (11), and front office staff (10) to care for new patients who gained health coverage under LIHP. This increased capacity enhanced access to care. Six clinics in legacy LIHPs and three clinics in new LIHPs said their participation in LIHP helped their ability to offer nonurgent, same-day appointments (data not shown).

Exhibit 5: Number of Clinics Reporting New Hires As a Result of Participation in LIHP, 2013



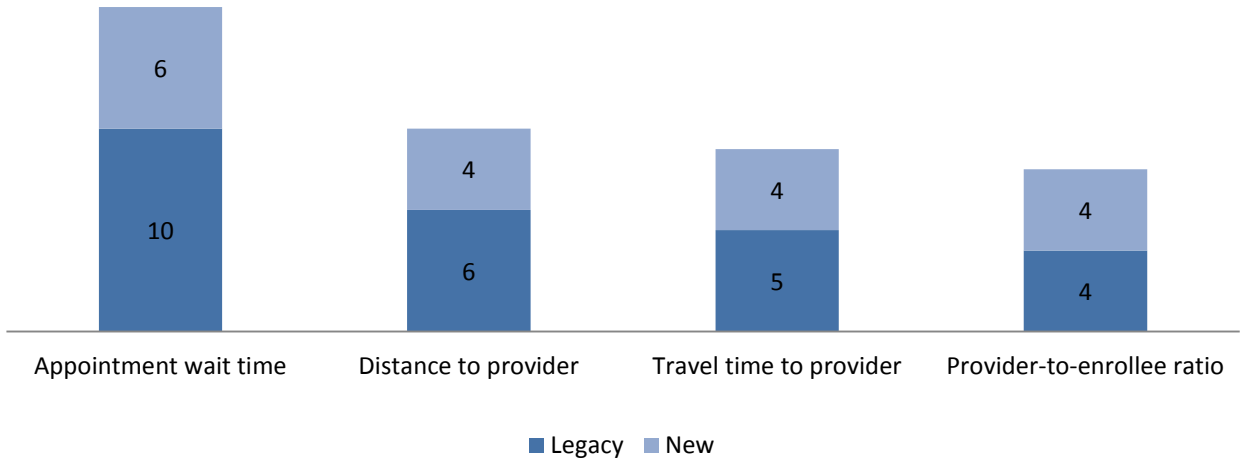
* "Other" includes licensed vocational nurse, nutritionist, health educator, community health worker, and social worker.
Source: UCLA Center for Health Policy Research survey of clinics that provide care to LIHP enrollees.

Network Adequacy Assessment

LIHPs are charged with ensuring a sufficient workforce to meet network adequacy requirements throughout the length of the program. In doing this, LIHPs developed data systems to monitor specialty and primary care provider supply in their counties (Exhibit 6). Provider supply was monitored by all new LIHPs and all legacy LIHPs. LIHPs assessed primary care and specialty provider supply by monitoring appointment wait time (16), distance to provider (10), travel time to provider (9), and provider-to-enrollee ratios (8).

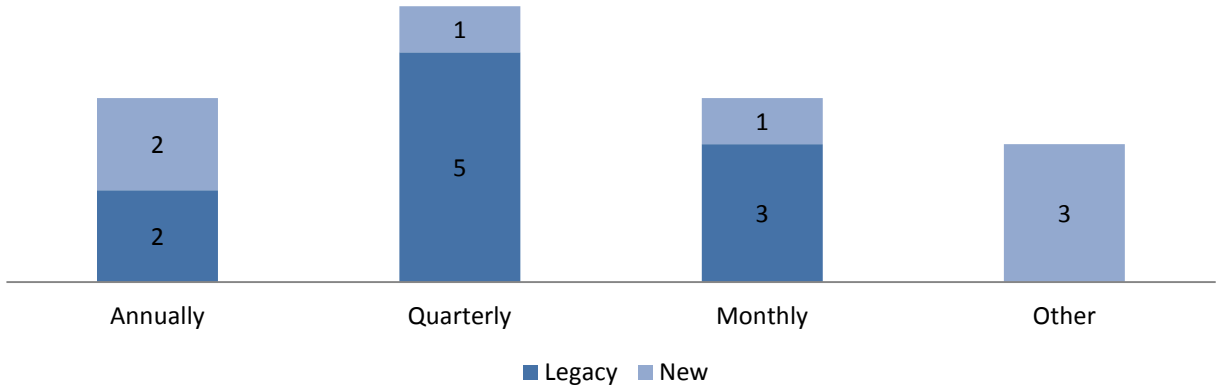
More than half of LIHPs assessed provider supply data quarterly or more frequently to determine whether they should hire or contract with additional providers (Exhibit 7). Other LIHPs, such as San Joaquin County, reported monitoring provider-to-enrollee ratios more regularly and using these data to assign medical home and coordinate care. Placer County indicated that collaboration and communication were the key criteria for assessing provider supply and meeting network adequacy requirements, because constant communication with providers ensured that members were not delayed in receiving services.

Exhibit 6: Number of Legacy and New LIHPs who Assessed Network Adequacy, by Method of Assessment, 2013



Note: Includes 10 legacy LIHPs and six new LIHPs.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Exhibit 7: Frequency with Which LIHPs Assessed Provider Adequacy, 2013

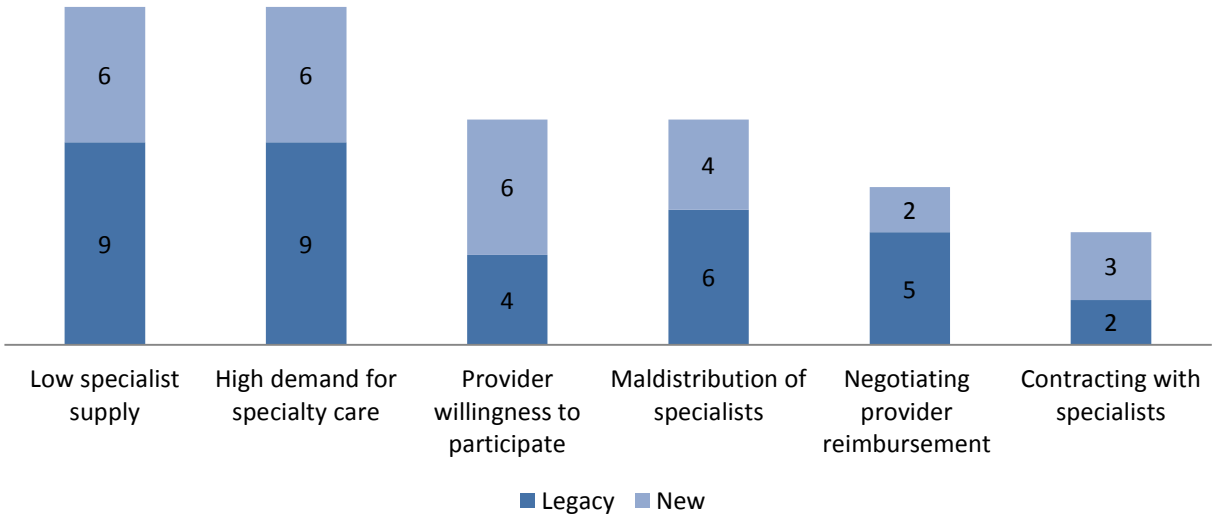


Note: Includes 10 legacy LIHPs and six new LIHPs.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Barriers and Challenges

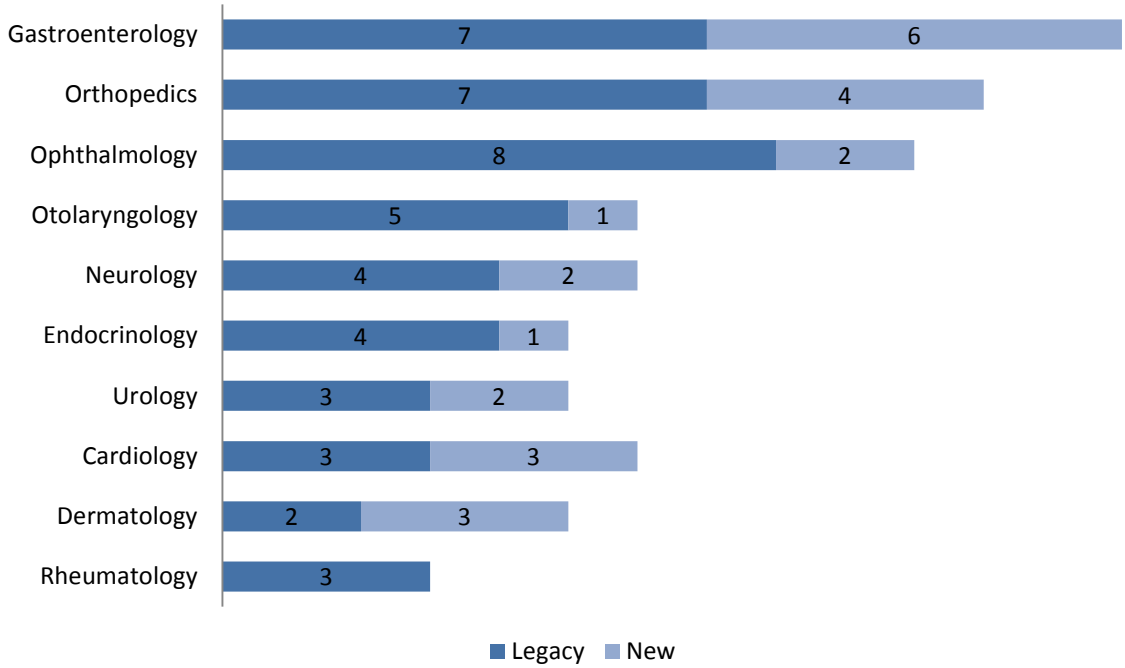
LIHP has strengthened the safety net through an expanded network of providers; however, barriers and challenges still exist. Low specialist supply and high demand (15) were most frequently identified as being a barrier or challenge to maintaining a strong provider network (Exhibit 8). The specialties in highest demand were gastroenterology, orthopedics, and ophthalmology (Exhibit 9). LIHPs reported that these specialties were difficult to contract with because there were either too few specialists in the region or existing providers were not willing to take new patients. Some private practice specialists chose not to participate in LIHP due to low reimbursement rates.

Exhibit 8: Number of LIHPs Reporting Barriers and Challenges to Provider Network Structure, by Type of Barrier or Challenge, 2013



Note: Includes 10 legacy LIHPs and six new LIHPs.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Exhibit 9: Number of LIHPs That Reported a Specialty in High Demand, by Specialist Type, 2013



Note: Includes ten legacy LIHPs and six new LIHPs.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Uneven distribution of providers was a challenge for 10 LIHPs, particularly in rural areas that are geographically dispersed and have fewer specialists per capita than urban areas. To mitigate this barrier in rural counties, LIHPs often provided transportation and medication delivery services. CMSP's third-party administrator (TPA) also worked with patients to contact charity organizations and leverage family support to help with transportation issues. Providers in CMSP counties organized an entire day for high-demand specialists to visit community clinics to provide consultations to LIHP enrollees once a month.

Three of the six new LIHPs reported difficulty in contracting with private practice specialists. LIHP implementation led to new legal challenges in Placer County, where providers historically provided care to medically indigent patients at a negotiated rate as needed or in-kind. Under LIHP, Placer underwent a major effort to establish contractual agreements with all providers it had previously worked with. In some cases, LIHPs were expected to contract with specialists they had never contracted with before for services that were rarely used by LIHP enrollees. Several LIHPs felt that the contracting process was burdensome for staff and providers, and that it delayed LIHP implementation.

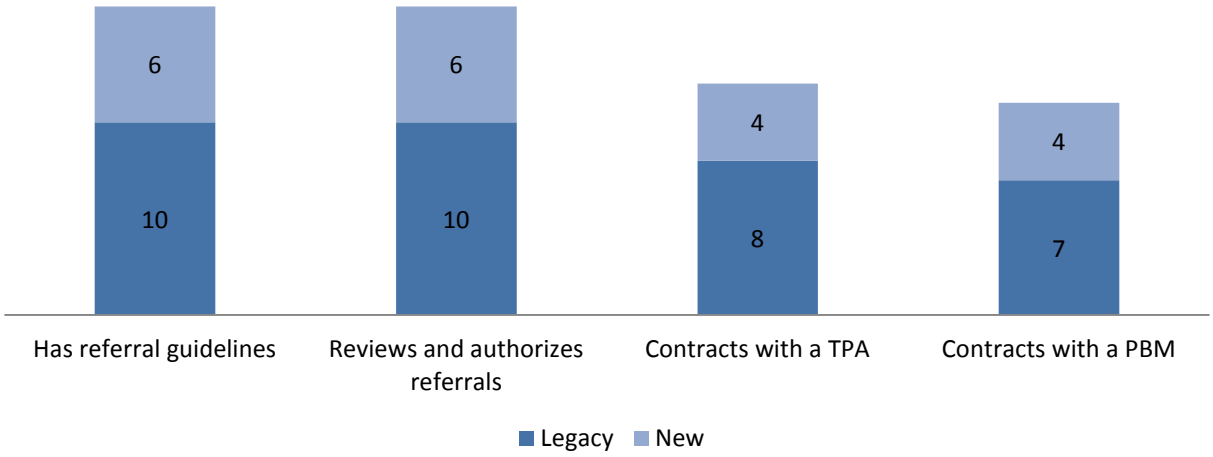
Provider Support Systems

Referral Management and Administrative Support

LIHPs used varying approaches to give administrative support to their providers (Exhibit 10). All LIHPs maintained referral guidelines and processes for referral authorization. Several new LIHPs implemented referral authorization at the start of their program to decrease the number of unnecessary referrals and improve communication between PCPs and specialists. In Riverside County, specialty appointment access increased when the county began using medical necessity criteria to manage the volume of specialty referrals and increase efficiency, leading to a reduction in inappropriate referrals. Providers struggled with the new referral program, but the county felt that referral management was necessary for transition of patients to managed care in 2014. San Joaquin tracked referrals, specialty appointments, and the exchange of information from the specialist to PCP through a panel management office. Originally, the county's panel management office resolved patient complaints and interfaced with the health plan to assign patients to primary care providers. For LIHP, San Joaquin County added specialty referrals to its activities in response to complaints that information on consultations was not being sent to primary care providers. Placer County had a team approach to referral authorization, with clerical staff assessments and nursing reviews used to determine the medical necessity for referrals.

Eleven LIHPs (eight legacy counties and three new LIHPs) used an electronic referral system with the capacity to submit, review, and authorize referrals. The five LIHPs that did not have electronic referral systems used a paper process; however, San Bernardino County simplified its referral process and reduced data-entry error by developing a homegrown system that automatically scans and converts faxed referrals into an electronic file, which is then routed to the specialist for review.

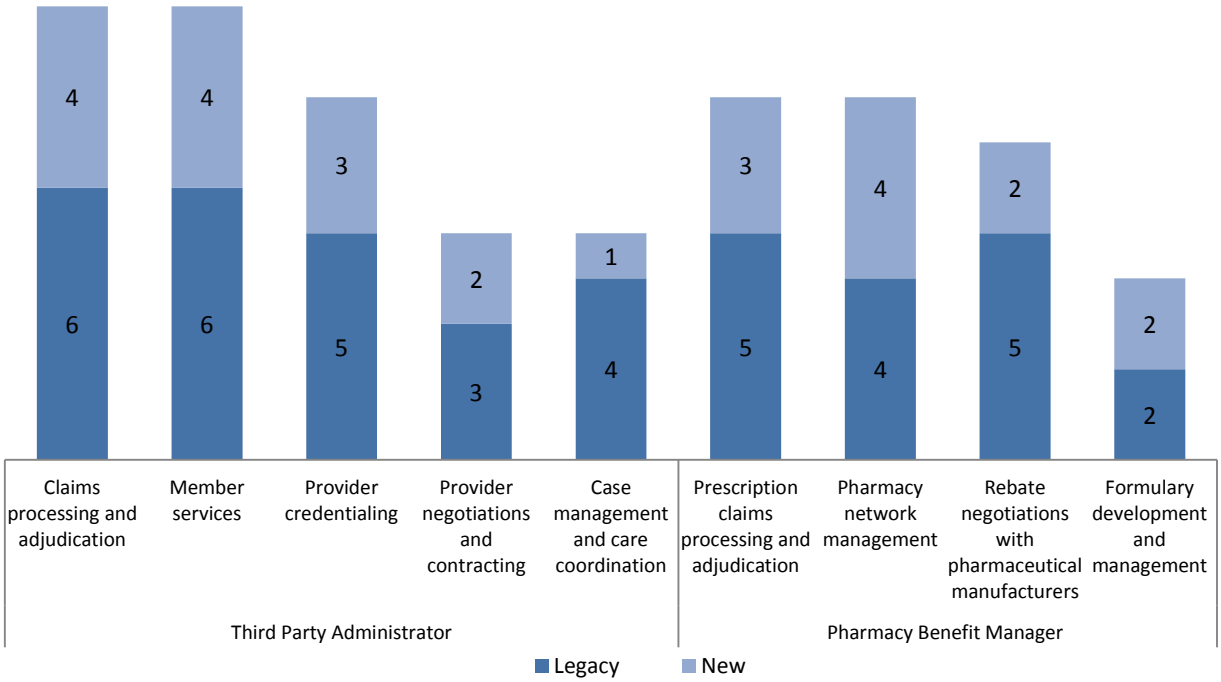
Exhibit 10: Number of LIHPs That Provide Administrative Support Services, by Type of Service, 2013



Note: Includes 10 legacy LIHPs and six new LIHPs.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

LIHPs frequently reported that they contract with TPAs (12) and pharmacy benefit managers (PBMs) (11) to support administrative services for their provider and pharmacy networks. TPA services most frequently included claims processing and adjudication (10), member services (10), provider credentialing (8), provider negotiations and contracting (5), and case management and care coordination (5) (Exhibit 11). PBM services often included prescription claims processing and adjudication (8), pharmacy network management (8), rebate negotiations with pharmaceutical manufacturers (7), and formulary development and management (4) (Exhibit 11).

Exhibit 11: Third-Party Administrator and Pharmacy Benefit Manager Services, 2013



Source: UCLA Center for Health Policy Research surveys of LIHP administration.

TPAs and PBMs can fill gaps and expand services when LIHPs are unable to invest resources in building a comprehensive range of administrative services or choose to delegate administrative responsibilities for cost or logistical reasons. This was specifically relevant to new LIHPs, some of whom did not have an existing network of providers and established infrastructure. Three of the four new LIHPs contracted with a TPA for the first time. Similarly, two new LIHP counties contracted with a PBM to expand services for LIHP. San Joaquin County was able to leverage an existing relationship with a subsidiary of the county's local initiative, the Health Plan of San Joaquin. The county had worked with the Health Plan of San Joaquin for other lines of business, but had never used its services for this population prior to LIHP. Likewise, Santa Cruz decided to contract with Central California Alliance for Health, which is a Medi-Cal health plan for Santa Cruz, Monterrey, and Merced counties.

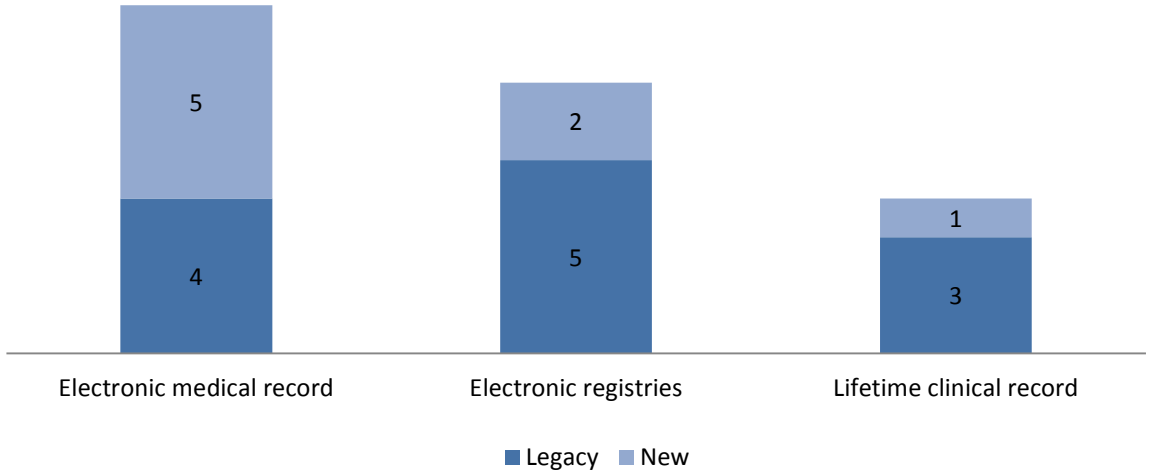
Riverside did not use a PBM, and it reported difficulty in contracting with pharmacies because its LIHP did not have the online prescription claims processing and adjudication systems that most large pharmacy chains require. Though Placer County preferred to contract with a TPA,

the county was challenged in finding one that would work with a small rural county. The TPAs that were willing to work with Placer cost too much and would delay implementation.

Health Information Technology

Health information technology (HIT) is an important and necessary tool for system redesign because it can be used to encourage better access and quality of care.[4] Thirteen LIHPs (eight legacy and five new) invested in HIT systems, and eight counties (six legacy and two new) reported that LIHP played a role in the county's ability to implement or expand their HIT system (Exhibit 12). Most LIHPs invested in an electronic medical record (EMR) (9), and nearly half of this group of LIHPs possessed a lifetime clinical record (4).

Exhibit 12: Number of LIHPs That Have Health IT Systems, by System Type, 2013



Note: Includes eight legacy LIHPs and five new LIHPs with a Health IT system.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

HIT functionality was dependent on a county's progress in implementing its HIT system and on the modules that the county purchased from its HIT vendor. Most frequently, LIHPs reported that users could access patient demographics (14), electronic patient charts (13), laboratory results (13), appointment scheduling (12), radiology results (12), medication lists (12), progress notes (12), and hospital discharge summaries (11) (Exhibit 13). Many LIHPs also granted access to clinical support tools such as drug formularies (11), computerized provider order entry (7), abnormal test result alerts (7), and computer reminders and prompts for preventive services (7).

Exhibit 13: Number of LIHPs Reporting Health IT System Functionality, by System Component, 2013

	Legacy LIHPs	New LIHPs
IT system components		
Electronic patient chart	8	5
Appointment scheduling	7	5
Electronic prescribing	5	4
Electronic referral management	5	3
Data Availability		
Laboratory results	8	5
Patient demographics	9	5
Radiology/ imaging results	7	5
Medication list	7	5
Progress notes	7	5
Hospital discharge summaries	7	4
Problem list	6	5
PCP referral notes to specialist	6	3
Provider Tools		
Drug formularies	7	4
Computerized provider order entry	4	3
Abnormal test result alerts/flags	3	4
Computer reminders and prompts for medications	3	3
Computer reminders and prompts for preventive services	3	4
Clinical decision support	4	2
Clinical guidelines and protocols	5	1
Provider messaging	1	3

Note: Includes eight legacy LIHPs and five new LIHPs with a Health IT system.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Individual clinics, medical groups, and hospitals often managed internal HIT systems when HIT was not available across the provider network. These fragmented systems were not maintained centrally by the LIHP and were unable to exchange information. Progress toward interoperable systems has been described elsewhere for legacy LIHP counties.[1] New LIHPs also implemented HIT initiatives. For example, Placer County launched Epic in August 2012, at the same time that

LIHP began. Although LIHP was not the primary reason for implementing an EMR, the county was able to adopt Epic's managed-care module to automate administrative workflows and tasks for LIHP. All medical providers that work at Placer County medical clinics have access to the data in the EMR.

Riverside County has begun implementing the NexGen EMR at Riverside County Regional Medical Center (RCRMC) outpatient clinics, with the goal of full implementation by the end of 2013. EMR features are launched on a rolling basis, and RCRMC will soon be releasing computerized physician order entry and care plans. Riverside has a robust training schedule for staff whenever a new module is launched. The county uses an approach called Team Train, which is a clinically focused, round-the-clock training conducted by nurses of various disciplines during the first week of EMR implementation. After the first week, the team remains on call, and the help desk and "super users" who receive more extensive training are available for ongoing troubleshooting and questions. Riverside County noted that it will no longer need to manually abstract information with the new EMR system, which will in turn reduce inefficiencies in care delivery.

San Bernardino has an EMR through the hospital system that is utilized by specialists and four hospital-owned primary clinics. EMR read-only access is available to contracted providers through a remote access portal. Contracted providers are able to view laboratory and radiology results, specialty consults, and all other patient information stored in the LIHP's EMR. Access is available to physicians, medical assistants, or any other staff members requiring access. Health information from San Bernardino's EMR can be printed by contracted providers and put into a paper chart.

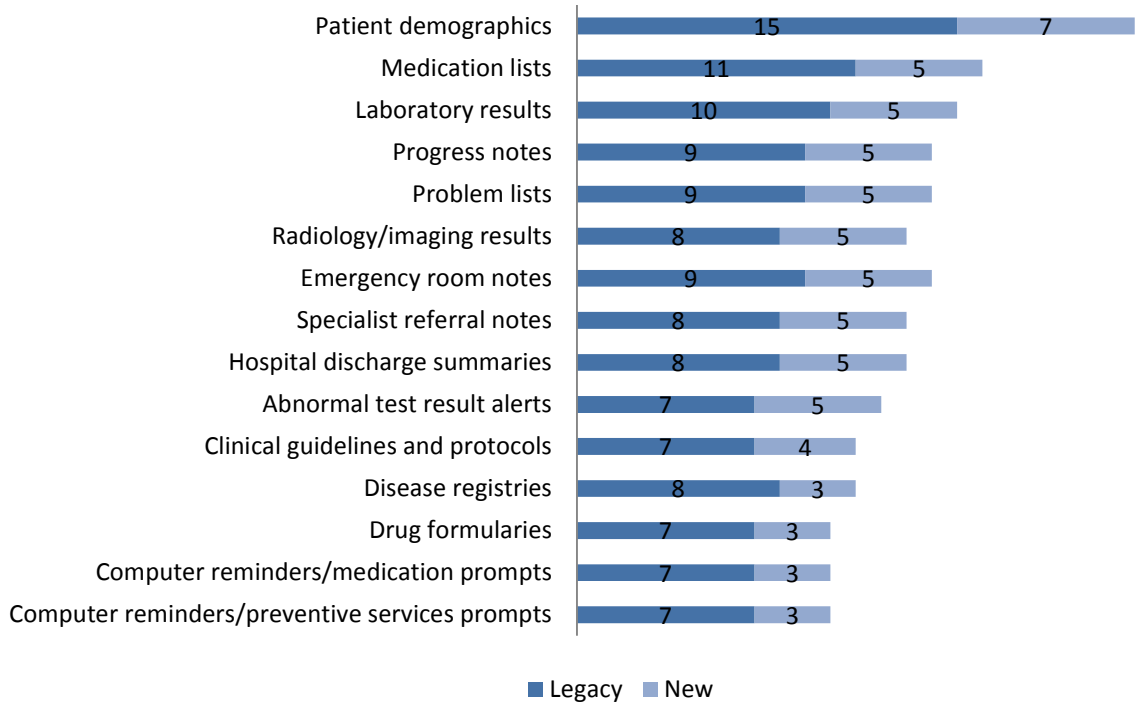
San Joaquin uses a form scanning and automation system called Optio for its HIT system. The county is in the process of upgrading its system and currently has a request for proposal (RFP) for a more sophisticated HIT system. San Joaquin received grant funds from the Blue Shield of California Foundation to make radiology and laboratory results available to its contracted community Federally Qualified Health Center. Additionally, the Health Plan of San Joaquin received separate grant funds for a safety net health information exchange.

Santa Cruz implemented the Epic EMR system in 2006 for electronic charting in all primary care clinics. New providers receive training on Epic through a site specialist who is responsible for setting up Epic workflows, refresher training, and ongoing assistance. The system can connect to contracted specialty providers at Palo Alto Medical Foundation, since both organizations use Epic. Other partner organizations are not able to connect to EPIC, however, and Santa Cruz is considering different options for its health information exchange. The two local hospitals in Santa Cruz use an older style health information exchange; however, the system has become

outdated and is not being used by all providers in the network. This older style system is a clinical messaging system and repository for health information that includes admission and discharge, laboratory results, and pharmacy data.

LIHP clinics reported on their ability to access LIHP-managed HIT systems. Clinics were most frequently able to access patient demographics (22), medication lists (16), laboratory results (15), progress notes (14), and problem lists (14) (Exhibit 14). Of the 22 clinics that had at least some access to the LIHP-managed IT system, seven (five in legacy LIHPs and two in new LIHPs) said they had received adequate health IT training and technical support from their local LIHP administrators (data not shown).

Exhibit 14: Number of Clinics Reporting Access to LIHP-Managed Health IT System, by System Component, 2013



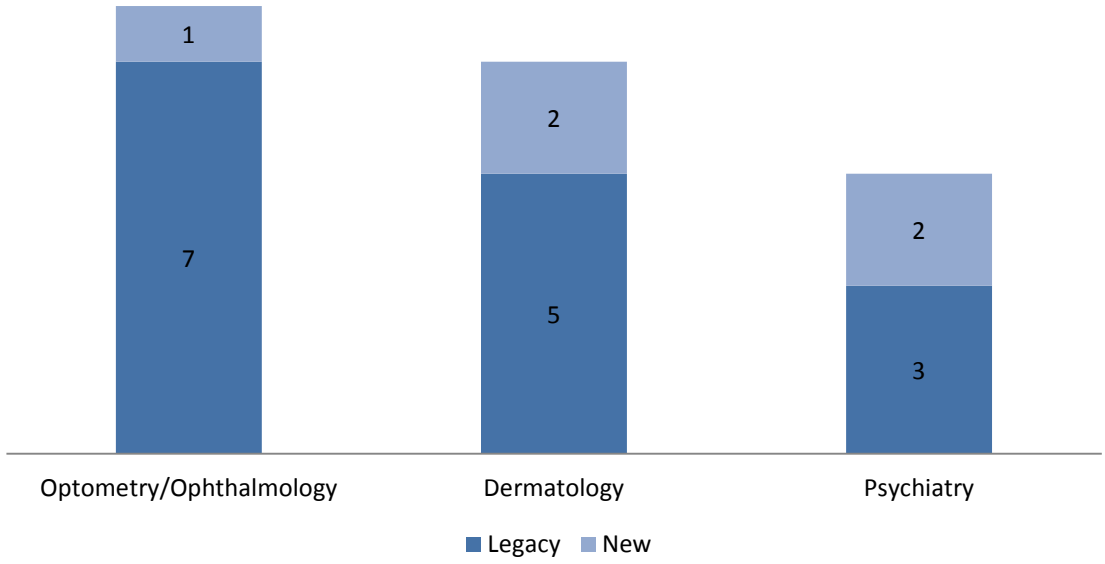
Source: UCLA Center for Health Policy Research survey of clinics that provide care to LIHP enrollees.

Telemedicine

Telemedicine was employed for remote diagnosis and follow-up in areas where access to specialty care is very limited. At least half of legacy counties used telemedicine for optometry and ophthalmology and for dermatology (Exhibit 15). New LIHPs have begun to make progress in developing a telemedicine program, with two new LIHPs operating telemedicine in their

counties. Placer County procured and installed telemedicine equipment in two of its clinics and is working to identify how telemedicine will be used in its LIHP. CMSP uses telemedicine in 65 sites with 25 specialties. A reimbursement strategy that incorporates billing for both the specialty site and the on-site provider was an integral part of the program's success. CMSP also cited strong leadership and support from dedicated site coordinators as being important for telemedicine use.

Exhibit 15: Number of LIHPs Reporting Access to Telemedicine, by Telemedicine Specialty, 2013

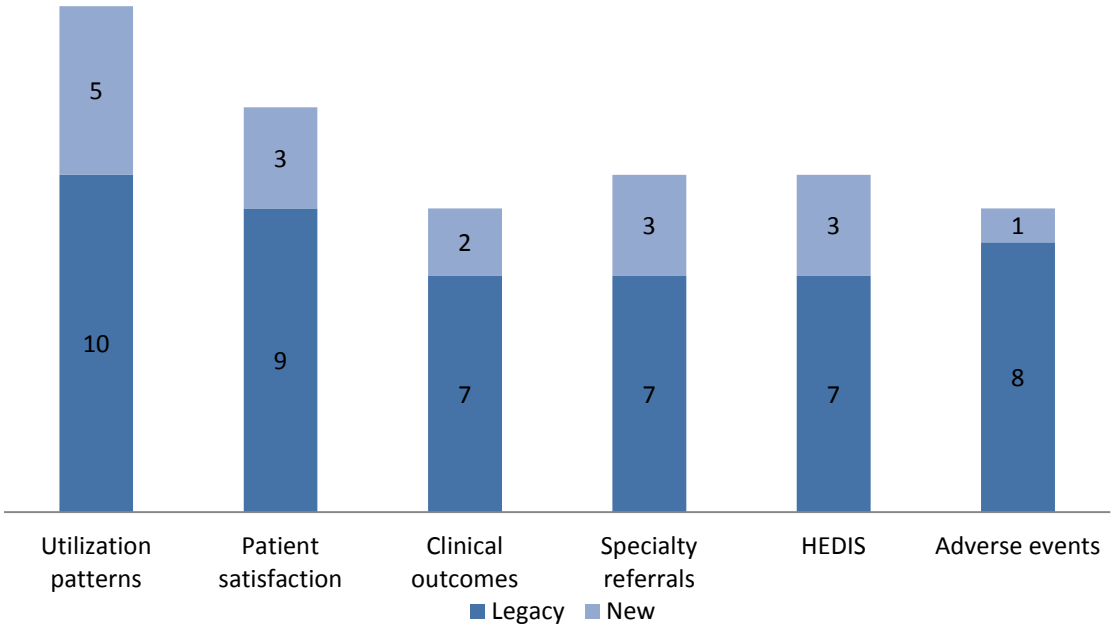


Note: Includes 10 legacy LIHPs and six new LIHPs.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Performance Reporting

All 10 legacy counties and five of the six new LIHPs established quality assurance systems that monitor the performance of one or more of the following measures: utilization patterns, patient satisfaction, clinical outcomes, specialty referrals, Healthcare Effectiveness Data and Information Set (HEDIS), and adverse events (Exhibit 16). Of the 15 LIHPs that monitored performance, 12 provided feedback to network providers. LIHPs provided performance feedback to hospitals and clinics more often than they did to individual physicians. San Bernardino County purchased a system to automatically compile data and generate reports that are sent to providers and used internally for quality improvement activities.

Exhibit 16: Number of LIHPs That Collect Performance Measures, by Measure Type, 2013



Note: Includes 10 legacy LIHPs and six new LIHPs.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

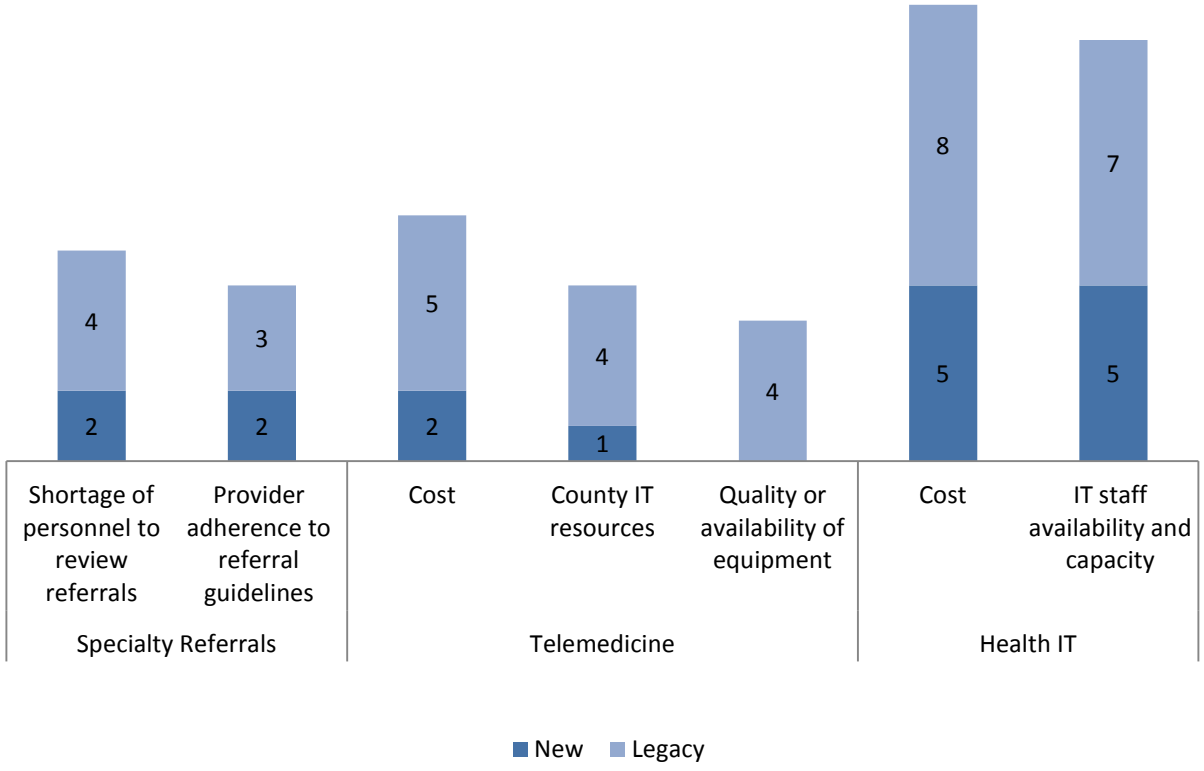
Barriers and Challenges to LIHP Support Systems

LIHPs face a number of challenges when supporting their providers with administrative services, HIT, and telemedicine systems (Exhibit 17). Most commonly, LIHPs reported cost and staff shortages as barriers and challenges with regard to specialty referrals, telemedicine, and HIT systems.

LIHPs were most challenged by the cost of purchasing HIT systems and assembling the resources required to implement a comprehensive EMR. Launching an HIT system is a long and difficult process that impacts daily operations and decreases productivity. LIHPs often experienced some resistance from staff who were less comfortable with the new technology and workflow changes. LIHPs have had less success in creating interoperable HIT systems that can communicate with contracted providers. San Bernardino County offered HIT access to contracted providers through a remote sign-in portal, allowing providers to view laboratory results, radiology reports, specialty consults, and other components of the county EMR. Although providers had access to the LIHP's EMR system, they were often reluctant to use the system even with training and the minimal requirement of having a computer with Internet connectivity.

As with HIT systems, the cost and resources required to operate a telemedicine program were a barrier to many LIHPs. Even when LIHPs received equipment through local or federal grants, the cost of maintaining and upgrading the equipment remained a challenge. Collaboration between institutions and individuals can also be challenging when establishing a network of telemedicine providers. For example, San Joaquin received and installed telemedicine equipment through a grant project, but due to the fragmented nature of the grant funds, the county was unable to determine who would be responsible for providing system content and what specialties the telemedicine system would be used for. San Joaquin is concerned that the telemedicine equipment will be outdated by the time the telemedicine program is operational, since the equipment was purchased in 2009.

Exhibit 17: Number of LIHPs Reporting Barriers and Challenges to LIHP Support Systems, by Type of Barrier or Challenge, 2013



Note: Includes 10 legacy LIHPs and six new LIHPs.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Summary and Conclusions

This chapter described the efforts of LIHPs to expand and enhance the safety net infrastructure. LIHPs have made progress in developing robust provider networks and centralized support systems, including:

- establishing a standard set of core benefits within the safety net system statewide
- creating and expanding safety net provider networks by contracting with existing or new providers; enhancing or establishing relationships with TPAs and PBMs
- establishing methods for assessing network adequacy and addressing provider shortages
- monitoring provider supply and establishing open communication channels and collaborative arrangements with providers
- creating and utilizing referral management to provide timely, cost-effective specialty care to program enrollees
- investing in HIT systems to facilitate better access to patient records across the provider network
- developing HIT systems with comprehensive EMRs that allow access to patient information across county health systems, and making these records available to contracted providers

Chapter 2: Changing Patient and Provider Behavior

System redesign is unlikely to happen without substantive changes in patient and provider behavior. Changing patient behavior is important because many low-income uninsured patients use safety net systems during emergencies without attempting to obtain prior appointments for preventive care. Patients may also frequently change the location of their care based on perceptions of which facilities provide better access. Such patterns of care-seeking do not promote use of primary care or proper management of chronic conditions. Providers working with limited resources and high levels of patient need do not always coordinate patient care by following up on specialty referrals or spending sufficient time with patients to teach them self-care. Such patterns of care delivery do not promote better outcomes and efficiencies in care delivery. Under LIHP, strategies to change patient care-seeking behavior and provider care delivery patterns varied from county to county but included assigning enrollees to a medical home and encouraging adherence to that medical home, coordinating patient care across the network, identifying high-risk enrollees in need of additional education and training in self-care, and providing tailored disease management services.

Promoting Use of Primary Care

Medical Home Adherence

The medical home serves as an enrollee's primary source of health care and information. The medical home's ability to coordinate care depends in part on an enrollee's using this source consistently rather than moving among different providers. One strategy LIHPs have implemented to improve consistent use of primary care is enforced adherence to a single medical home. In all, 12 counties planned to enforce medical home adherence at the beginning of LIHP, including four of the new counties that implemented programs in 2012.

LIHPs emphasized patient education of the medical home concept to encourage adherence. Placer County, for example, works with enrollees who seek care at a location that is not their medical home to help them understand the importance of the medical home and its appropriate use. Enrollees can still be seen at the non-medical home location, depending on the issue and on the facility's capacity to handle nonempaneled patients, but the enrollee will generally get a follow-up phone call from LIHP to explain the proper use of the medical home.

Attempts to enforce adherence did not universally translate into easier coordination for the clinics that served as medical homes to LIHP enrollees. Among clinics contracted with new LIHPs, none reported that lack of adherence was a problem when adherence was enforced, and four reported lack of adherence as a problem when adherence was not enforced (Exhibit 18). Among clinics contracted with legacy LIHPs, 17 still reported lack of adherence as a problem when adherence was enforced, and five reported that it was a problem when adherence was not enforced (Exhibit 18).

Exhibit 18: Number of Clinics Reporting Lack of Adherence to Assigned Medical Home As a Problem, by Type of LIHP and Level of Enforcement, 2013

Lack of Adherence a Problem			
New LIHPs	Yes	No	Total
LIHP enforced adherence	0	1	1
LIHP did not enforce adherence	4	13	17
Legacy LIHPs	Yes	No	Total
LIHP enforced adherence	17	15	32
LIHP did not enforce adherence	5	4	9
Total	26	33	59

Source: UCLA Center for Health Policy Research survey of clinics that provide care to LIHP enrollees.

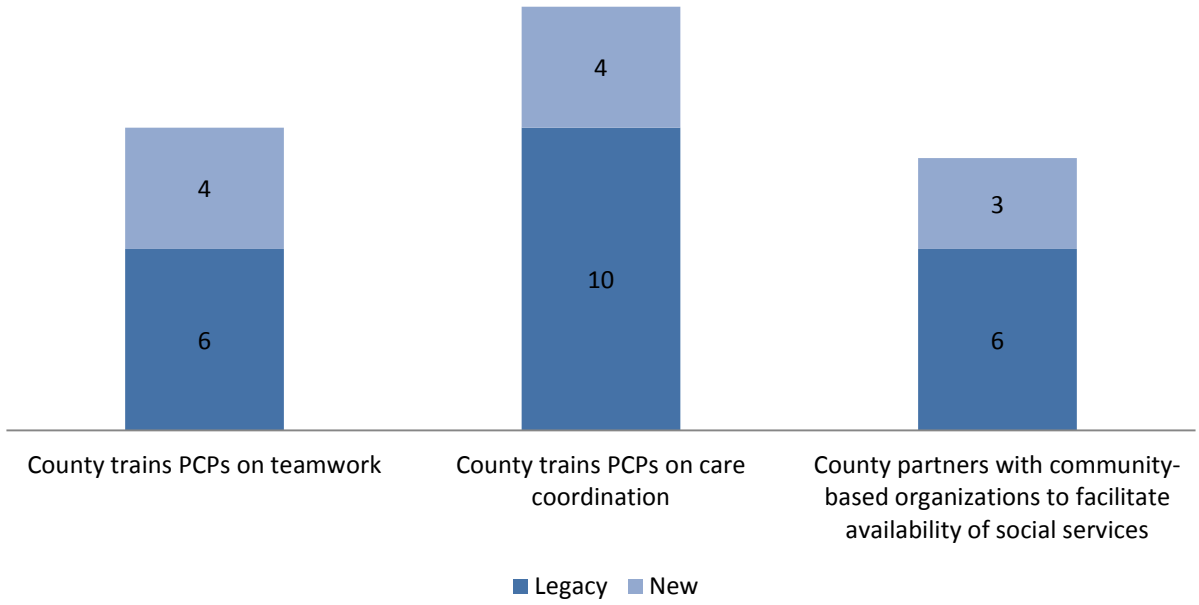
Care Coordination

LIHPs facilitated care coordination across their provider networks. More than half of LIHPs provided training on teamwork to primary care providers in their networks (Exhibit 19). All of the legacy counties and four new counties also provide training on care coordination to primary care providers, in some cases on an ongoing basis. Riverside County, for example, presented care coordination and case management strategies at grand rounds when its LIHP was first launched in January 2012, and it deployed a team of LIHP case managers to provide booster training to physician groups upon request after the launch.

On the systems level, LIHPs altered the way referrals were made between primary and specialty care by providing referral guidelines and processes for referral authorization (see Exhibit 10). Referrals between primary and behavioral health care are described in Chapter 3: Integrating

Physical and Behavioral Health. Nine LIHPs also encouraged care coordination beyond the provider network to community-based organizations (Exhibit 19).

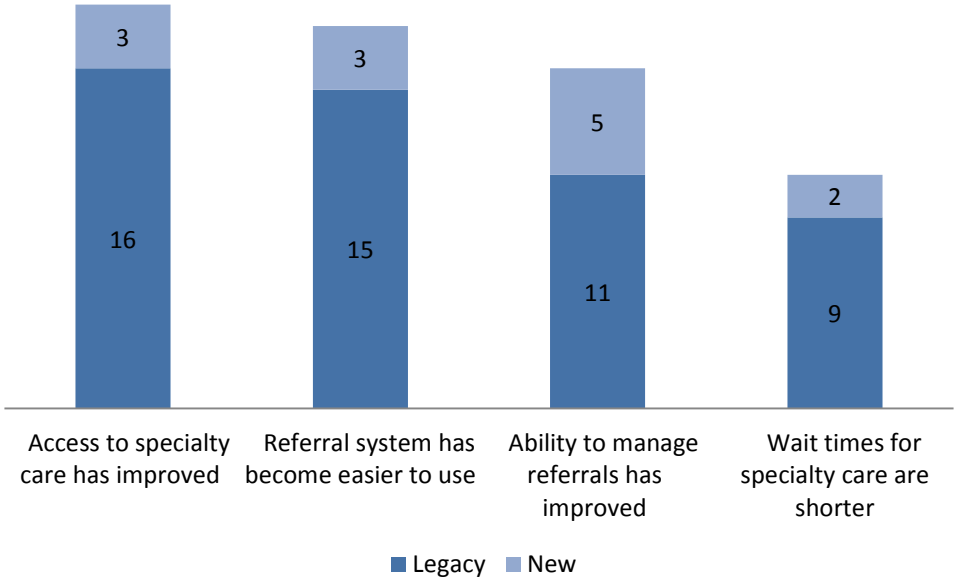
Exhibit 19: Number of LIHPs That Facilitate Care Coordination and Partner with Community-Based Organizations, 2013



Source: UCLA Center for Health Policy Research surveys of LIHP administration.

These changes have positively affected numerous participating clinics, according to the clinic survey results. Ease of use of the referral system (18), ability to manage referrals (16), and improved overall access to specialty care (19), including shorter wait times (11), were all cited by providers as improvements under LIHP (Exhibit 20). Forty-six of 60 responding clinics reported always or often following up on specialty care referrals, and 44 said they always or often obtained specialists' reports after a successful referral, an important step in assuring continuity of appropriate care (data not shown).

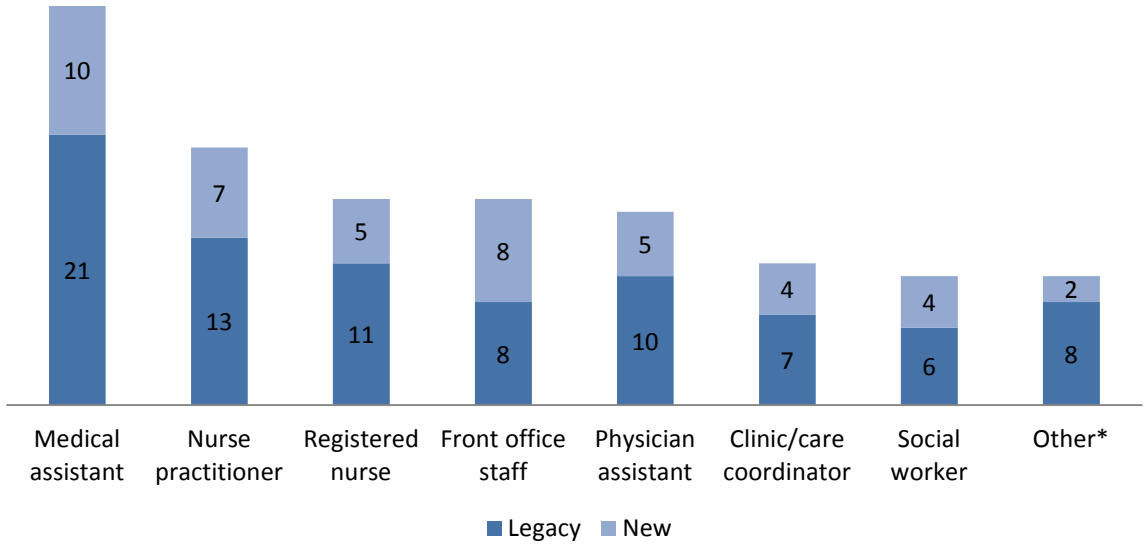
Exhibit 20: Number of Clinics Reporting Positive Change in Referral System Under LIHP, 2013



Note: Includes clinics that responded "strongly agree" or "agree" to the corresponding questions.
Source: UCLA Center for Health Policy Research survey of clinics that provide care to LIHP enrollees.

While not explicitly linked to LIHPs' teamwork training efforts, 43 clinics said their providers and staff receive training on team-based patient care (including from non-LIHP sources). Thirty-six of the clinics reported holding team meetings to discuss individual patients' care at least weekly. The diversity of the personnel involved indicates that these meetings often include nonmedical staff such as front office staff, social workers, and health educators in an attempt to more broadly coordinate care for LIHP enrollees (Exhibit 21).

Exhibit 21: Clinic Staff Involved in Regular Meetings with Physicians, by Personnel Category, 2013



Note: Thirty-six clinics held meetings at least weekly and were included here.
* "Other" includes licensed vocational nurse, health educator, nutritionist, and pharmacist.
Source: UCLA Center for Health Policy Research survey of clinics that provide care to LIHP enrollees.

Supporting Appropriate Care-Seeking Behaviors

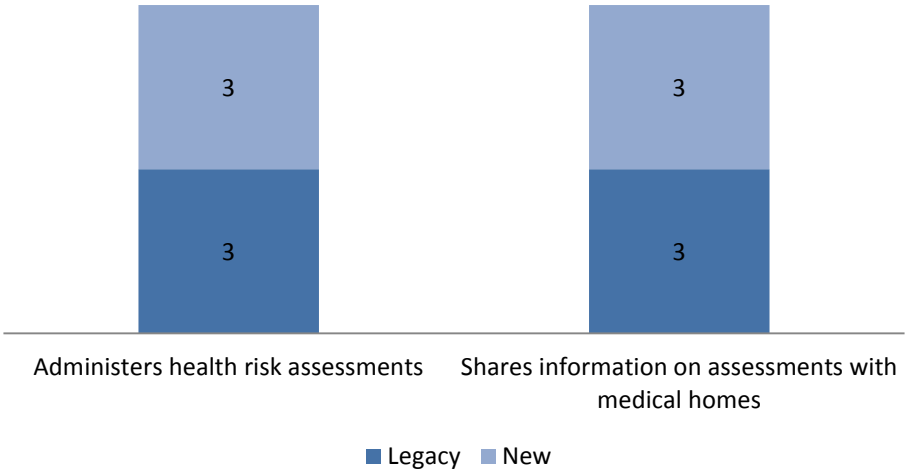
Local LIHPs have employed an array of strategies to change enrollees' care-seeking behaviors, including implementing disease or case management programs. Additionally, LIHPs have provided support services such as health education and promotion programs to encourage self-care and improve enrollees' ability to follow through on care plans.

Risk Assessment and Disease Management

Six LIHPs have used health risk assessments to identify enrollees who need disease or case management services (Exhibit 22). These assessments are an efficient tool for directing limited resources by determining who needs intensive management or other special services. Health risk assessments are used to stratify enrollees into different levels of disease management and to direct more intensive service use to the highest-risk enrollees. CMSP has three different levels of case management, which were in place before LIHP and have continued during the program. The first level focuses on high-risk LIHP enrollees who consult with registered nurses and social workers over the phone to establish and work toward disease management goals. The second level of case management is specific to behavioral health needs and matches psychologists, social workers, or marriage and family therapists with enrollees who have

psychiatric diagnoses or have recently had a psychiatric hospitalization. The third level of case management targets uninsured individuals who have been hospitalized and attempts to enroll them in LIHP. New enrollees then receive in-home visits or phone calls to ensure that they initiate a consistent primary care plan.

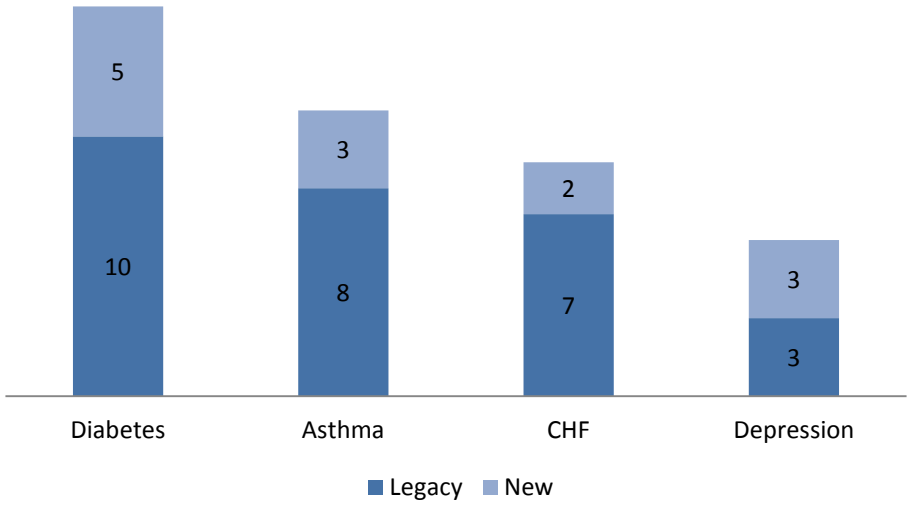
Exhibit 22: Number of LIHPs Reporting Health Risk Assessment Activities, 2013



Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Riverside County has a data-driven approach to case management. The IT department mines claims data to identify enrollees with repeated ER visits and raises a red flag for case management. This triggers phone calls with the patient and the primary care provider to consider the underlying causes of ER use, including incorrect medical home placement. Not all LIHPs employ systematic assessment strategies to identify at-risk patients, but most offer condition-specific disease or case management, particularly for enrollees with diabetes (Exhibit 23).

Exhibit 23: Number of LIHPs That Provide Condition-Specific Disease/Case Management Services, by Condition, 2013



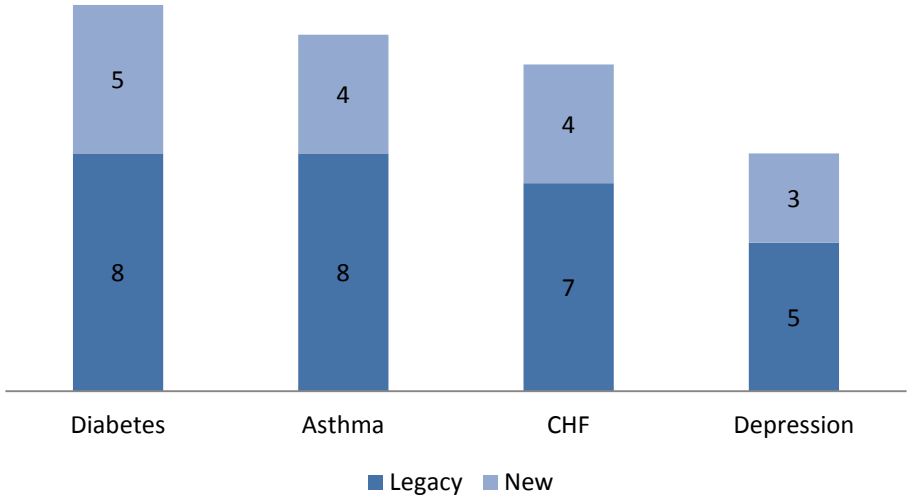
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Patient Self-Management and Support

In addition to offering disease and case management, LIHPs have used various patient education methods to improve the ability of patients to manage their chronic conditions. Educational materials and tailored health education and health promotion programs allow LIHP enrollees to develop the knowledge and confidence to help manage their own care.

LIHPs focused most often on diabetes (13) in their health education efforts. However, new and legacy LIHPs also created and distributed health education materials for asthma (12), congestive heart failure (CHF; 11), and depression (8; Exhibit 24).

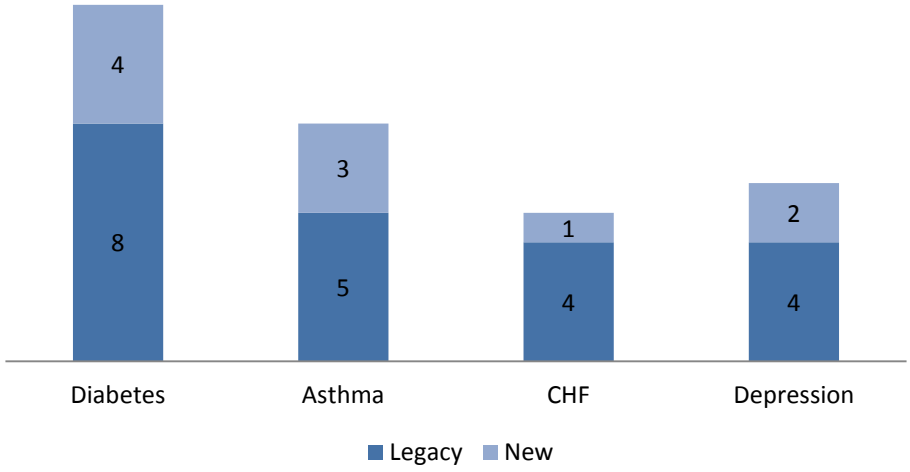
Exhibit 24: Number of LIHPs That Create and Distribute Educational Materials, by Condition, 2013



Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Beyond written materials, many LIHPs embarked on a more intensive effort to train health educators by specific condition (Exhibit 25). In addition to the conditions shown in Exhibit 25, San Joaquin County provides health educators on HIV.

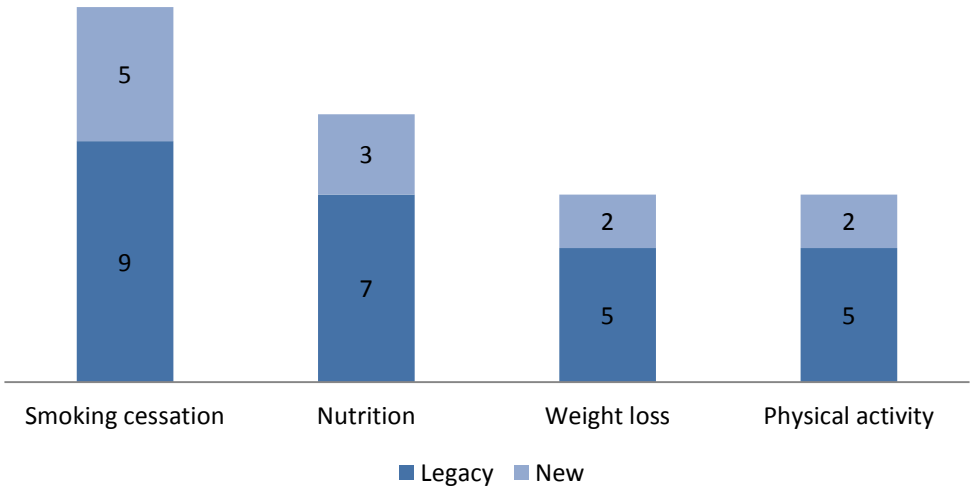
Exhibit 25: Number of LIHPs That Provide Specially Trained and Designated Health Educators, by Condition, 2013



Source: UCLA Center for Health Policy Research surveys of LIHP administration.

All but two LIHPs offered smoking cessation programs (Exhibit 26). The majority also offered nutrition programs, and CMSP provided enrollees with listening libraries on specific health conditions in addition to the standard health promotion programs outlined below.

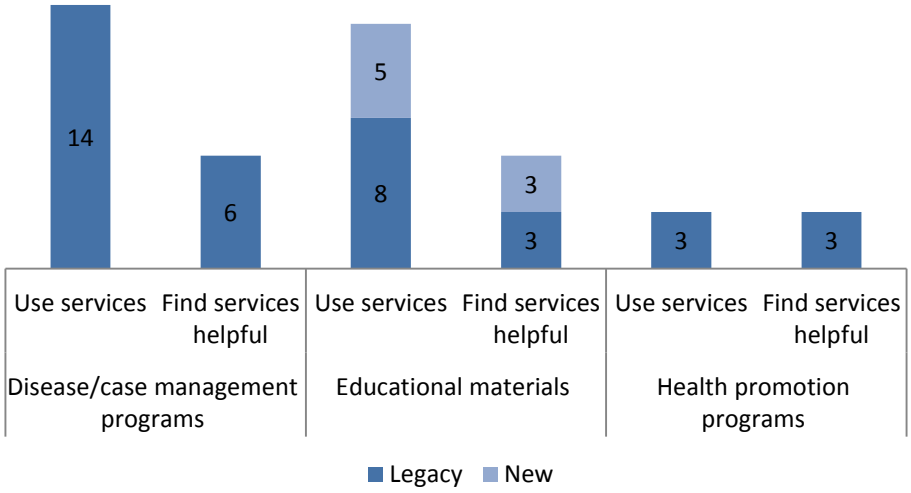
Exhibit 26: Number of LIHPs That Offer Health Promotion Programs, by Topic, 2013



Source: UCLA Center for Health Policy Research surveys of LIHP administration.

The provision of disease/case management and health education services by local LIHPs has not always translated into uptake by individual clinics or provider networks. Twenty of the surveyed clinics run their own disease/case management services, which may help explain why only 14 clinics reported using the LIHP-administered programs (Exhibit 27). Six of the 14 clinics found the LIHP disease/case management programs helpful. Local LIHPs' educational material production (8/10) and health promotion programs (3/3) reached fewer clinics but were more consistently found to be helpful.

Exhibit 27: Number of Clinics Reporting Utilization and Helpfulness of Services Provided by LIHP, 2013



Notes: (1) Includes clinics that responded "very helpful" or "somewhat helpful" to the corresponding questions. (2) Thirty-three clinics responded to the disease/case management program questions, 54 to the educational materials questions, and 11 to the health promotion questions.
Source: UCLA Center for Health Policy Research survey of clinics that provide care to LIHP enrollees.

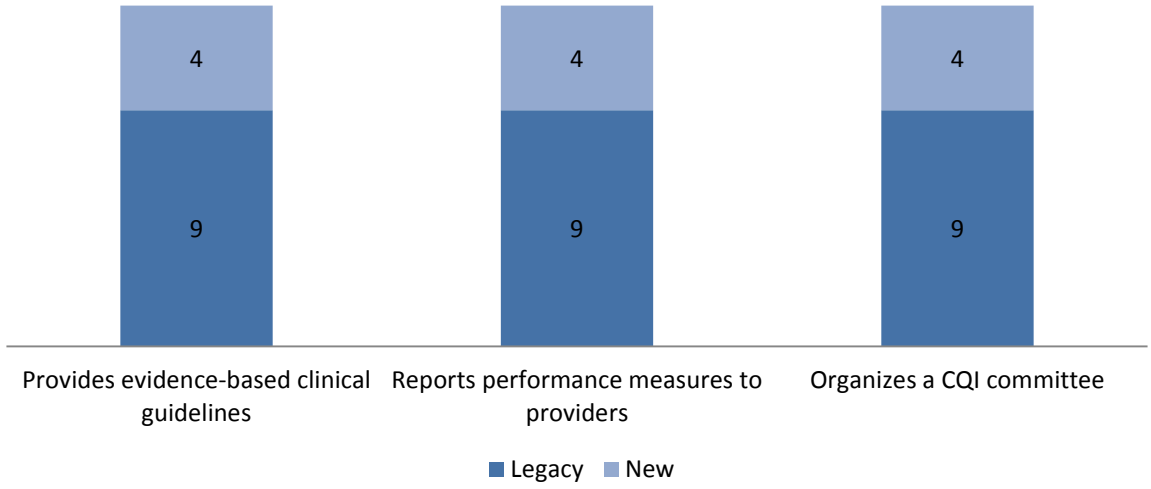
Quality Improvement Initiatives

LIHPs have used three major strategies to improve quality of care: (1) providing evidence-based clinical guidelines, (2) reporting performance measures to providers, and (3) organizing continuous quality improvement (CQI) committees (Exhibit 28). Identifying or developing evidence-based guidelines and disseminating standardized best practices across the network are the first steps in improving quality of care. Providing feedback by reporting performance measures to providers is the second step in promoting provider behavior change. CQI committees develop and formalize quality improvement processes, refine and adapt processes, and reinforce best practices.

CQI committees in LIHPs have implemented numerous strategies to decrease unnecessary care utilization while increasing the quality of appropriate services. Riverside County noted that referral review staff were overwhelmed by the volume of referrals, and the county improved response time by hiring 10 additional staff members to review and authorize referrals. Placer County reviews hospital encounter data in its CQI committee to identify LIHP enrollees who visit the emergency room (ER) frequently or who mainly use the ER instead of their primary care provider. Those patients are referred from the ER to their medical home for follow-up. CMSP

reviews high-cost enrollees with select health conditions for inclusion in care management programs. Overall, LIHPs described their activities as highly collaborative and team-based. More than half of the CQI committees included representatives from contracted community clinics.

Exhibit 28: Number of LIHPs That Implemented Quality Improvement Initiatives, by Initiative Type, 2013



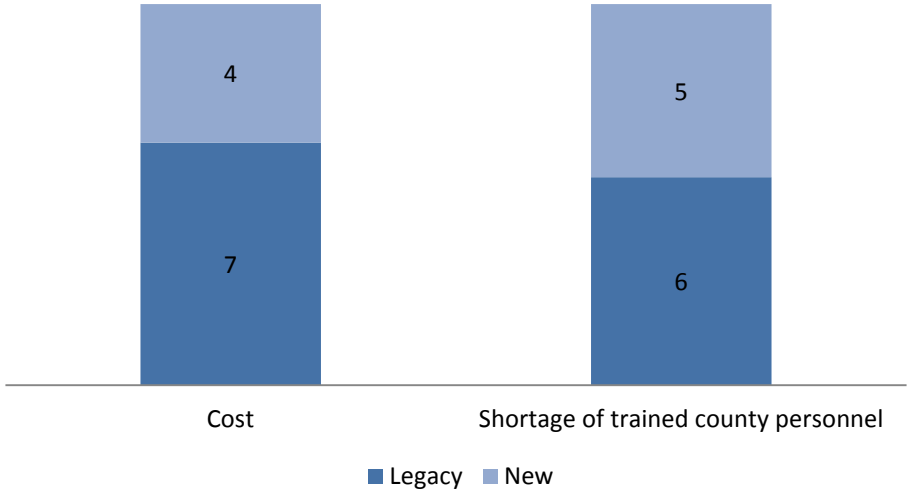
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

The clinic survey provided insight into the effects of LIHP's system redesign efforts on the ability of providers to deliver quality care. As an overall measure, 28 of the responding clinics said that LIHP has facilitated their ability to provide care to enrollees (data not shown).

Barriers and Challenges

LIHPs faced challenges in their disease management and quality improvement efforts, including perceived barriers to county support of patient self-management. Cost was one of the main barriers to patient self-management support (Exhibit 29). An overall shortage of trained county personnel was broadly cited as a barrier. Three counties also cited the lack of both space and time as challenges to support of patient self-management.

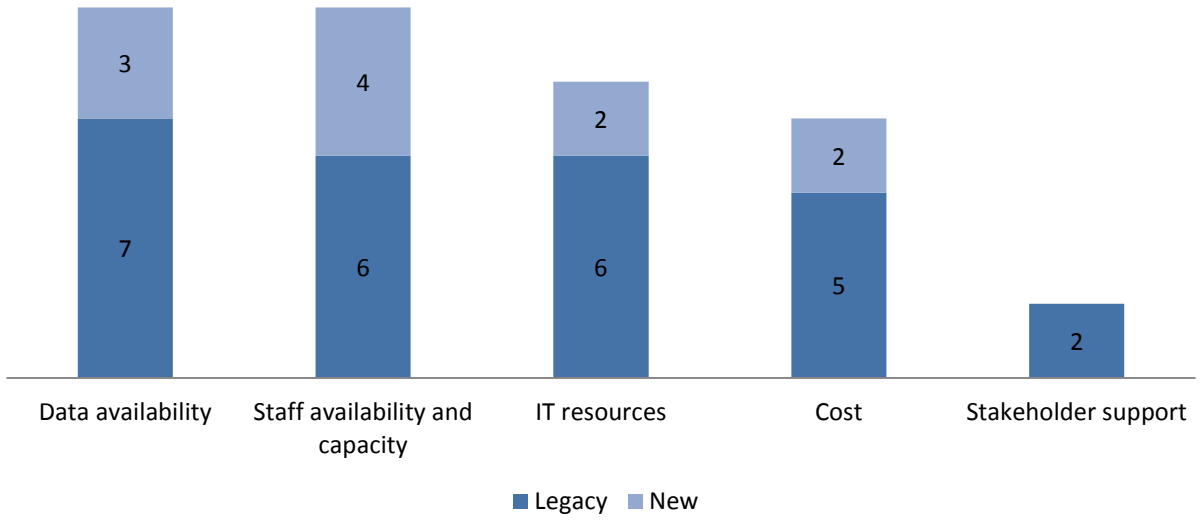
Exhibit 29: Number of LIHPs Reporting Specific Barriers/Challenges to County Support of Patient Self-Management, 2013



Source: UCLA Center for Health Policy Research surveys of LIHP administration.

While LIHPs expressed their commitment to improving quality and health outcomes in their counties, they were challenged with limited data and resources (Exhibit 30). In particular, LIHPs struggled with obtaining data from providers outside the county system, as well as with the expertise and staff time needed to track quality measures. Counties identified the need for strong and sustained programs and for dedicated staff who could focus their efforts on quality issues without having competing priorities.

Exhibit 30: Number of LIHPs Reporting Barriers and Challenges to Quality Assurance and Improvement, by Type of Barrier or Challenge, 2013



Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Summary and Conclusions

This chapter has described the varied strategies implemented by LIHPs to change patient care-seeking behavior and provider care delivery patterns, and detailed providers' reports on the impact of the LIHP program on their organization and practice. The findings indicate that LIHP strategies included:

- enforcement of medical home adherence
- care coordination and teamwork training for primary care providers
- health risk assessment to stratify patients into varying intensities of disease/case management
- support for patient self-management through disease-specific educational materials, provision of trained health educators, and health promotion programs
- continuous quality improvement initiatives that report back to providers on performance measures

Results of UCLA's provider survey indicate that outcomes of these strategies varied at the clinic level. For instance:

- Medical home adherence remained a problem for 26 of the 60 surveyed clinics, including 17 clinics in legacy counties that enforce adherence.
- Fourteen clinics used the disease/case management services offered by LIHP, and six found them helpful. An additional 20 clinics used their own disease/case management programs for LIHP enrollees.
- Care coordination strategies were more widely implemented, and access to specialty care was improved, with decreased wait time, ease of referral system use, and increased ability to manage referral systems. Thirty-six clinics reported holding meetings among physicians and other staff at least weekly to discuss individual patient care. Forty-six clinics reported always following up on referrals to specialty care, and 19 clinics said access to specialty care had improved under LIHP.

Based on these results, LIHPs have had some success changing patient and provider behavior, with more dissemination and development work to be done.

Chapter 3: Integrating Physical and Behavioral Health Care

Mental health services for the MCE (0-133% FPL) population are core benefits offered in LIHP. LIHPs can choose to expand their services to include treatment for substance abuse and hence offer comprehensive behavioral health services. LIHPs can also expand these services to their HCCI enrollees (133%-200% FPL). This chapter examines the administration of mental health and substance abuse services in LIHPs and their efforts toward integrating and coordinating physical and behavioral health care.

The benefits of integrated physical and behavioral health care are demonstrated in existing studies.[5-8] Integration of physical and behavioral health services is found to improve efficiencies and outcomes. This integration brings together inputs, delivery, management, and organization of services and improves access, quality, satisfaction, and efficiency.[9] Integration promotes continuity of care and improves quality, particularly for those with mental illness and substance abuse problems who are inherently vulnerable and face difficulties negotiating the health care system. The low-income populations using safety net services frequently have comorbid mental health, substance abuse, and chronic conditions such as diabetes and heart disease. One or more of these conditions often go undetected or untreated, leading to costly urgent care and poor patient outcomes. Integrated programs are a promising solution for improving quality and efficiency.[9]

Full integration of physical and behavioral health in LIHP is particularly challenging because physical and mental health services have been operating separately within the safety net for many years. Several components are required to integrate these services, including a minimum set of behavioral health benefits, HIT that includes both physical and behavioral health data and is accessible by both types of providers, and streamlined referral systems for effective patient referrals. Coordinating care among physical and behavioral care providers is essential, but it cannot be done without promoting the value of integration among providers and training both physical and behavioral health providers on how to treat and/or refer patients with dual diagnoses. Care coordination systems can be centralized to ensure better integration of physical and behavioral health care services. Colocation of physical and behavioral health providers represents a more intensive integration effort. LIHPs have varied in their implementation of these approaches to integration, but most have reported progress in one of more of these activities.

Behavioral Health Benefits in LIHP

The minimum mental health benefits offered to MCE enrollees in LIHP include:

- acute inpatient hospital services: up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility
- outpatient encounters: up to 12 outpatient encounters per year, including assessment, individual or group therapy, crisis intervention, and medication support and assessment
- psychiatric pharmaceuticals

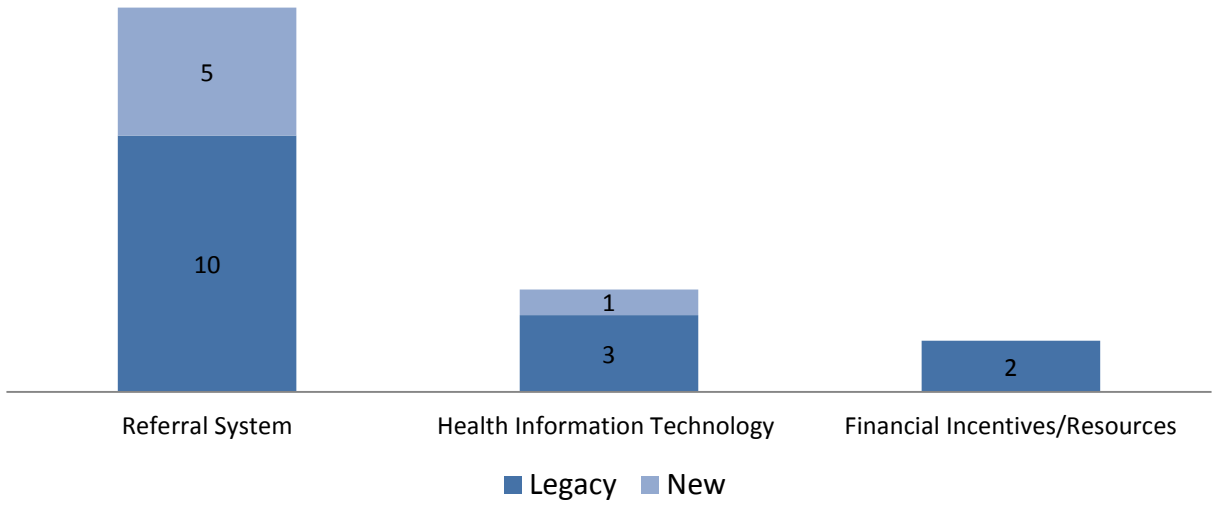
LIHPs can expand these mental health services to include more inpatient days or more outpatient visits; case management; crisis intervention, residential treatment, and stabilization; day rehabilitation; individual, family/collateral, or group therapy; medication-assisted treatment and support; and transitional residential services. Twelve LIHPs (Alameda, Contra Costa, Los Angeles, Monterey, Orange, Placer, Riverside, San Bernardino, San Francisco, San Mateo, Santa Clara, and Ventura) offer at least 20 different types of additional services (see Appendix B, Exhibit 21 and Appendix B, Exhibit 22 for detailed information).

LIHPs can also choose to include treatment for substance abuse as an added benefit. This can include assessment, case management, detoxification, individual and/or group counseling, outpatient care, residential acute stabilization and/or perinatal treatment, and treatment placement. Currently, CMSP, Kern, San Francisco, San Mateo, Santa Clara, and Santa Cruz offer at least some of these services. San Francisco offers 11 additional substance abuse services, Santa Clara offers 14, and San Mateo offers 15 (see Appendix B, Exhibit 23 for additional information).

County Support Systems

Almost all LIHPs reported some form of administrative support to increase integration between primary care and behavioral health providers. The most common form of support is streamlining the referral system. Other local LIHPs (three legacy LIHPs and one new LIHP) named health information technology (HIT) as a method of enabling providers to interact with each other. Still others reported having financial incentives or resources helpful in their integration efforts (Exhibit 31).

Exhibit 31: Methods LIHPs Use to Support Interactions Between Primary Care and Behavioral Health Providers, 2013



Note: Detailed information can be found in Appendix B, Exhibit 24: Methods LIHPs Use to Support Interaction Between Physical and Behavioral Health Providers, by LIHP.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Local LIHPs also noted nonconventional methods to support integration. CMSP received support through its TPA, Anthem Blue Cross, which provides behavioral health management services. The behavioral health unit at Anthem has marriage and family therapists, licensed clinical social workers, and psychologists who work with the medical case management team. These providers focus on patients with a psychiatric diagnosis. Los Angeles County has a similar method, but without the support of a TPA, with the two providers holding joint consultation meetings.

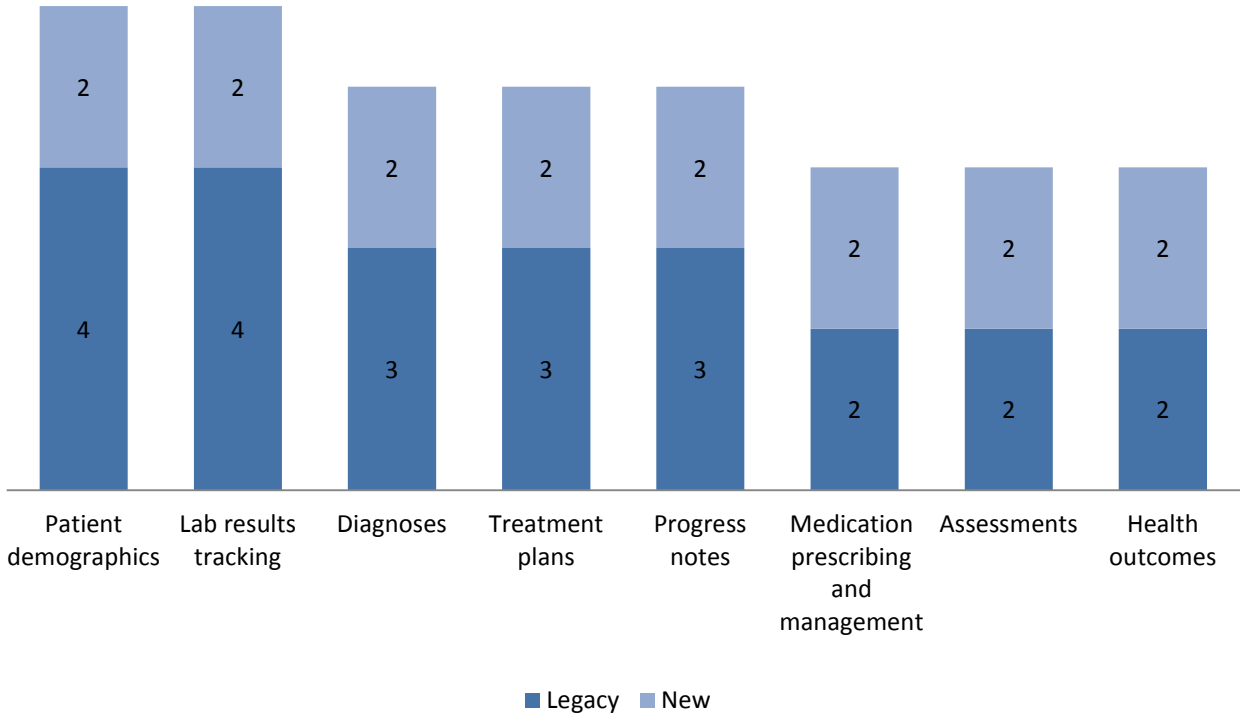
Health Information Technology

LIHPs recognized the value of integrated HIT in facilitating integration of physical and behavioral health care. However, most county systems were not set up for joint access of physical and behavioral health providers to a patient's history. In fact, none of the LIHPs reported having a shared primary care and behavioral health IT system, and only San Mateo County reported that its behavioral health providers can access a patient's physical health medical records. On the behavioral health side, six LIHPs reported that their behavioral health providers had access to different aspects of a patient's medical record.

Exhibit 32 demonstrates the different types of data within a medical record that behavioral health providers could access. The most common form of data they could view were a patient's

demographics and lab results. Progress notes, treatment plans, and diagnoses are accessible in three legacy LIHPs and two new LIHPs. Health outcomes, assessments, and medication prescription and management can only be viewed by two new LIHPs and two legacy LIHPs.

Exhibit 32: Number of LIHPs That Gave Behavioral Health Providers Access to Physical Health Records, by Type of Data, 2013



Notes: (1) Data are for the following counties: Contra Costa, Placer, San Mateo, Santa Clara, Santa Cruz, and Ventura. (2) Detailed information can be found in Appendix B, Exhibit 25: Access to Primary Care Records Among Behavioral Health Providers.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Streamlined Referral Systems

Many LIHPs have identified streamlining their referral system as a method of increasing interactions between primary care and behavioral health providers among their non-colocated facilities. Thirteen LIHPs reported requiring a behavioral health screening as a standard requirement in their referral system. Of these, 12 LIHPs reported having a standard referral system for primary care providers for behavioral health services, while 10 reported having a referral system for behavioral health providers (see Appendix B, Exhibit 26: Referral Methods and Systems for Non-Colocated Facilities, by LIHP).

These referrals methods are frequently through traditional forms of communication. Seven Legacy LIHPs and 3 New LIHPs make referrals through the telephone. Five Legacy LIHPs and two New LIHPs also report sending referrals via fax. Five Legacy LIHPs have the capacity to make e-referrals (Contra Costa, Orange, San Diego, San Mateo, and Ventura).

Fifteen of the 16 LIHPs surveyed had the capability to verify if a patient followed through with a referral. Some counties followed up by simply calling the referred-to provider. Those with an e-referral system have the capability to verify if the patient saw the referred-to provider, such as Contra Costa through their EPIC system.

Kern created a uniform guide to appropriately identify when a patient needs primary care or behavioral health services or a combination of both, after receiving feedback from providers who had a high volume of patients who did not need the specific services. The County developed the 4-Quadrant Model to help providers assess the type of service a patient might need and has been reviewed and approved by both providers. The screening tool places patients in one of four-quadrants depending on their physical, mental, and substance abuse needs. This helps providers identify who should be seeing the patient, appropriately refer the patient to another provider, and identify any additional support systems, such as social workers. Furthermore, the screening tool also has levels of care within each quadrant, which aids in assessing the severity of the patient's needs.

San Francisco hired a consultant to assess their behavioral health system and develop a proposal on how to integrate behavioral health services in the primary care setting. The consultant formulated the entire integration program by redefining roles and streamlining referral system with manuals. The manual described roles and responsibilities of the primary care behaviorist team, clinical activities, practice support tools, policies and procedures, performance measures, and how to administer consultation. San Francisco converted existing providers, such as social workers, into "behaviorists." This new behaviorist model is a short-term intervention program where the behaviorist will assess whether the patient will only need three or four brief interventions of whether the patient will be referred to the appropriate community behavioral health provider. The plan was launched in the fiscal year 2010-2011 and has since expanded to more behaviorists in community clinics.

Care Coordination

Promoting Provider Interaction

Two LIHPs formed committees or subcommittees to either promote interactions between primary care and behavioral health providers or to monitor progress of integration through quality improvement efforts. Kern developed and implemented a primary care and behavioral

health integration committee, which hosted “meet and greet” workshops between providers and offered a lecture series taught by participants in a medical residency program affiliated with UCLA. This was launched as a response to inclusion of behavioral health benefits in LIHP, as Kern Medical Center historically had never integrated behavioral health providers into clinics. The committee is comprised of the Kern Medical Center, Kern Medical Center Health Plan representatives for LIHP, Clinica Sierra Vista, and the National Health Services, the county’s primary care physicians, mental and substance abuse providers, a pharmacist, county administrators, and UCLA Integrated Substance Abuse Programs. The committee meets monthly, has launched a website, and posts dashboards of its activities and progress. Additionally, the committee has launched several small-scale projects, such as developing a universal screening tool that includes both mental and primary care questions that should be asked of every patient. Despite the initial resistance from both provider types, the county has succeeded in improving provider interaction over time. This committee has served as a forum for primary care and behavioral health providers to learn about both fields, understand the other’s challenges and point of view, and find effective ways to coordinate.

San Diego has established a behavioral health quality improvement (QI) subcommittee within its LIHP QI committee. The behavioral health QI team meets on an ad hoc basis, depending on the need of the current projects the team is working on. At the time San Diego’s program was interviewed, it was reviewing the outcomes of patients receiving antipsychotic medication and developing a mental health client satisfaction survey.

The long-term separation of physical and behavioral health services requires further effort to improve provider interaction and effective care coordination with primary care providers who may be less informed about the behavioral health care delivery system. Nine Legacy LIHPs and five new LIHPs reported that they provide some form of training for primary care providers and case managers on how to coordinate with the behavioral health system.

In some cases, behavioral health providers train primary care providers. Contra Costa has case managers who present to primary care groups. This is done at the executive level, between the directors of primary care, Mental Health Department, the Alcohol and Other Drugs Services (AODS) and the health plan. Additionally, behavioral health providers have conducted on-site training to various medical clinics to educate personnel on how to access behavioral health services. Contra Costa noted that collaboration at the executive level has been helpful in administering an integrated health delivery system. Leaders from its health plan, Department of Public Health, ambulatory care, mental health, and Alcohol and Other Drugs Services are coming together to discuss this form of care. Contra Costa also notes that having the right structure can facilitate this form of collaboration. Because the county has a health department

with these various components and a health plan under the same HIPAA, the health department acts as a de facto ACO, and thus the goals are the same for both.

Ventura County instituted ongoing training given by behavioral health providers and directed to the ambulatory care medical directors. San Joaquin also had behavioral health staff provide in-service training to physicians and medical residents. Riverside has its mental health team train providers on how to use their existing referral line (Community Access and Referral, Evaluation and Support [CARES] Line), which has been in existence for years.

Other forms of training include meetings or direct training of residents by care coordinators. San Diego has quarterly, ASO-administered care coordinators' meetings in which the ASO educates primary care providers on care coordination. San Francisco trains its residents on how to identify behavioral health needs in primary care settings.

Los Angeles, Santa Clara, and Ventura counties implemented different aspects of the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) model. The IMPACT model was developed in the 1990s to treat older adults with depression in the primary care setting. In Los Angeles County, more than 4,000 county staff members received training on this model, which includes problem-solving treatment. The Los Angeles Department of Mental Health (LADMH) provides this training through presentations or via webinars. LADMH also conducts follow-up sessions with providers and administrators and provides refresher courses. As part of the adoption of pieces of the IMPACT model, LADMH has instituted a new assessment policy in which all patients receive an initial assessment, but once the type of treatment is identified, LADMH administers an assessment at every session that is suited to the patient's specific condition for the purpose of monitoring progress and measuring outcomes.

Centralized Care Coordination

Centralized care coordination can standardize these efforts. Contra Costa and Kern counties have instituted this form of care coordination.

In January 2013, Contra Costa employed a new pilot in centralized case management. The county's manager of case management and behavioral health services receives a listing on a daily basis of all hospital patients from all of Contra Costa's programs, including LIHP, in order to assess whether patients have an assigned mental health case manager. The goal is to link the mental health case manager and discharge planners prior to hospital discharge to develop a joint care coordination plan.

Kern has implemented a similar strategy. In response to LIHP's offering behavioral health services as a new benefit, Kern not only developed a committee to bring both types of providers together, but also hired a behavioral health coordinator who is a medical social

worker. This behavioral health coordinator serves as a liaison and coordinates all discharge plans specifically for LIHP enrollees. Her main role is to facilitate smooth transitions from not only primary to specialty mental health but inpatient to outpatient on both sides. The behavioral health coordinator assesses the patient's condition and discusses it with the patient's primary care and mental health providers. She also developed and proposed a care plan to the care/case manager or social worker who is assigned to the patient.

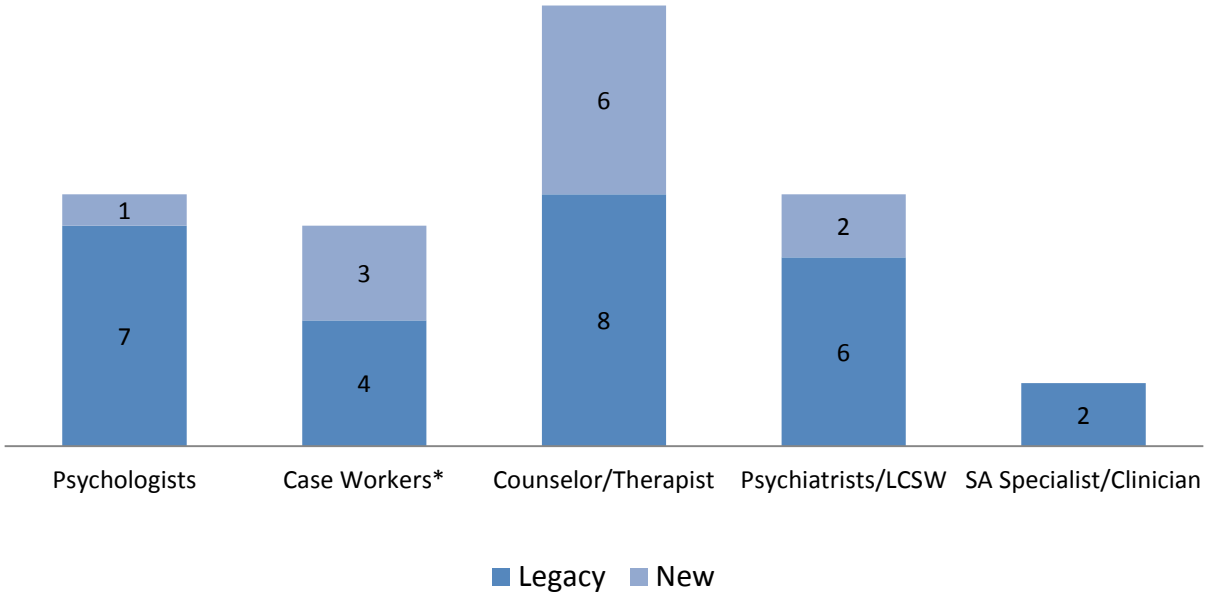
Colocation of Physical and Behavioral Health Providers

Colocation is perhaps one of the most preferred modes of integrating physical and behavioral health services. Those with colocated facilities can easily refer patients by walking them over to either type of provider or "warm hand-offs" during team-based meetings (Los Angeles and San Bernardino). Colocated facilities house both primary care providers (e.g., primary care doctors and nurse practitioners) and behavioral health providers (e.g., psychologists, psychiatrists, and licensed clinical social workers). Having both types of providers in the same or an adjacent location can increase access to these services through same-day visits, improve collaboration between providers, and reduce the perceived stigma of visiting a mental health provider.

Among the 16 local LIHPs that were surveyed, 15 had at least one colocated facility serving LIHP enrollees. Fourteen of this group had behavioral health providers colocated in a primary care setting. Three local LIHPs had only one primary care facility with a behavioral health provider (Contra Costa, Riverside, and San Joaquin), while others had multiple sites with this arrangement. Alameda, for example, has 26 primary care facilities with behavioral health providers, and San Diego County has 56. At the time data were collected for this report, Orange County was in the process of developing a plan to integrate these services.

The types of behavioral health providers in a primary care setting varied. Fourteen local LIHPs had at least a counselor or therapist (eight legacy and six new), eight had at least a psychologist (seven of these are legacy LIHPs, and one is a new LIHP), and six had a psychiatrist or a licensed clinical social worker (LCSW) (six are legacy LIHPs and two are new LIHPs; Exhibit 33). Of the LIHPs that were providing substance abuse services, one LIHP had a substance abuse (SA) specialist, and another had an SA clinician located in a primary care setting (Kern and Santa Clara, respectively). CMSP confirmed that colocated facilities existed in the consortium but could not identify the types of providers within each setting in the 35 participating counties.

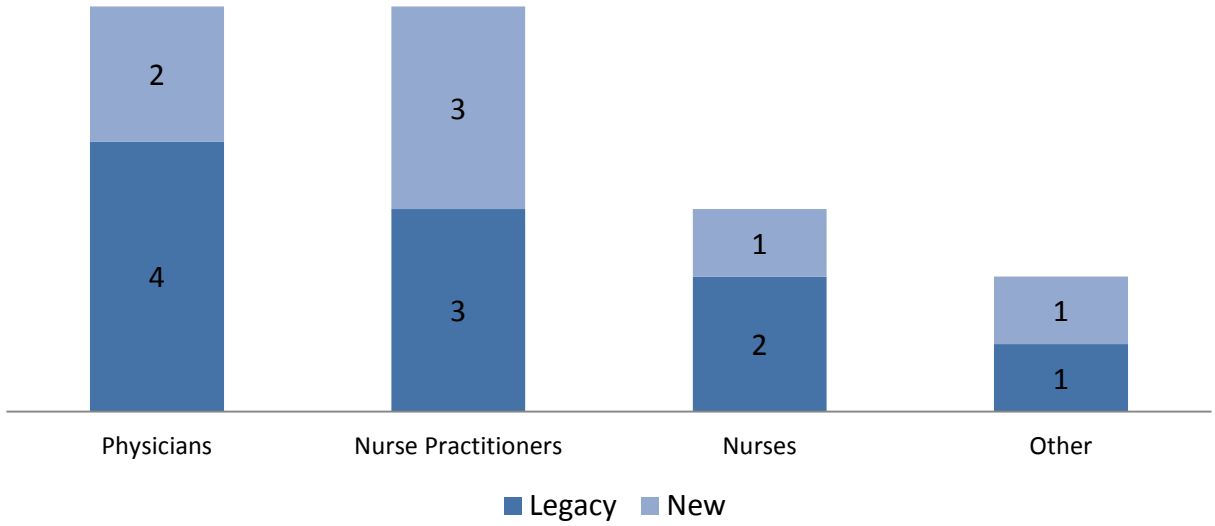
Exhibit 33: Number of LIHPs with Various Types of Behavioral Health Clinicians Colocated in Primary Care Facilities, 2013



Notes: (1) Caseworkers (*) include social workers and behavioral health coordinators. (2) "LCSW" are licensed clinical social workers. (3) "SA" refers to substance abuse. (4) Detailed information can be found in Appendix B, Exhibit 27: Types of Providers in Colocated Facilities, by Physical and Behavioral Health and LIHP.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

In some cases, local LIHPs housed primary care providers in behavioral health facilities. Six local LIHPs reported that they had on-site physicians and nurse practitioners (Exhibit 34). Of the six with physicians colocated in a behavioral health setting, four are legacy and two are new LIHPs. Those with nurse practitioners were evenly split between the legacy and new LIHPs. Contra Costa reported having certified medical assistants and care coordinators on-site, while San Bernardino housed medical residents within a behavioral health facility ("Other" in Exhibit 34).

Exhibit 34: Types of Primary Care Providers in Behavioral Health Facilities, 2013



Notes: (1) Data are for Alameda, Contra Costa, Kern, Riverside, San Bernardino, San Francisco, San Mateo counties, and CMSP. (2) "Other" includes Certified Medical Assistants (CMAs)/care coordinators and residents. (3) Detailed information can be found in Appendix B, Exhibit 27: Types of Providers in Colocated Facilities, by Physical and Behavioral Health and LIHP.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

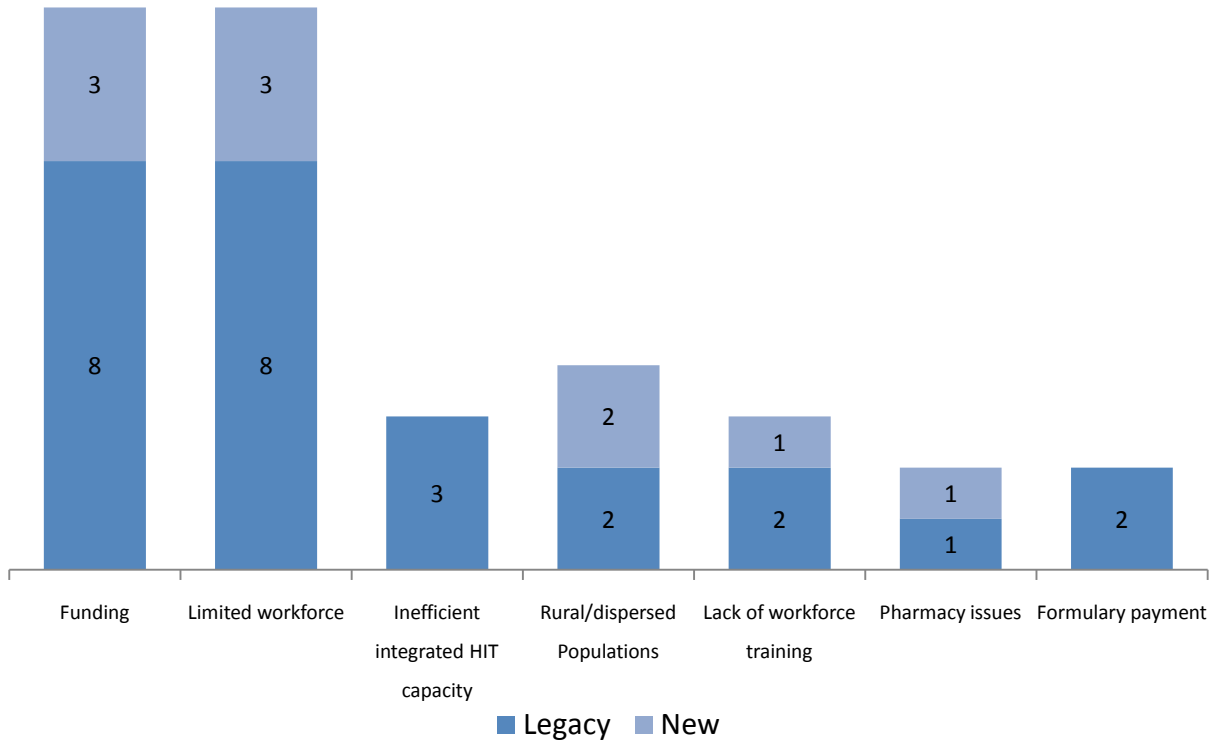
Contra Costa, San Mateo, and Ventura counties have found that having colocated facilities has improved communication and collaboration. They noted the accessibility of providers to one another and the ease of their ability to communicate. Nevertheless, housing providers in the same location does not always lead to effective communication and collaboration. For example, if a primary care clinic is on the first floor and the behavioral health clinic is on the second, practitioners would not necessarily run into each other. They suggested that building should be considered when opening colocated facilities. Additionally, regular meetings were found to aid collaboration.

Alameda County combined financial resources to primary care providers with colocation to improve integration. A two-phase initiative was implemented. The first was to provide funds for primary care providers to hire behavioral health staff, such as LCSWs or psychologists, to be located in their individual clinics. The second phase adopted a pay-for-performance type of model in which clinics need to build active caseloads and registries for their mental health patients. Clinics have to actively manage their patient panel and follow up with these patients to administer assessments such as the Patient Health Questionnaire (PHQ-9) to determine whether their conditions have improved.

Challenges and Barriers in Integrating Physical and Behavioral Health

LIHPs reported significant barriers to integration, among them funding, administrative, organizational, service delivery, and clinical issues. Many LIHPs expressed concerns about integrating care, including how such barriers detained them from moving forward with their efforts. Discussion of such barriers and challenges faced by these LIHPs helped promote a broader understanding and more cohesive structure for integration of services.

Exhibit 35: Number of LIHPs with Challenges or Barriers in Integrating Physical and Behavioral Health, by Type of Challenge, 2013



Notes: (1) Data for CMSP are not included, as CMSP could not identify the barriers/challenges faced by all of its 35 counties. (2) Detailed information can be found in Appendix B, Exhibit 28: Barriers and Challenges Related to Integrating Physical and Behavioral Health, by LIHP.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

As demonstrated in Exhibit 35, funding and a limited workforce were noted as barriers by the majority of local LIHPs. Three legacy counties also reported having an inefficient integrated HIT system. Two legacy LIHPs and two new LIHPs identified geographic disparities as problematic, while two legacy LIHPS and one new LIHP identified insufficient workforce training. Pharmacy issues were noted as a challenge for one legacy LIHP and one new LIHP. Riverside County attributed its difficulty in contracting with larger pharmacies to the LIHP's not using the computerized adjudication and billing processes to which major pharmacies are accustomed. Formulary payments were also challenging for two legacy LIHPs. One county identified the barrier of having insufficient space to offer colocated services.

Summary and Conclusions

This chapter examined the efforts of LIHPs to integrate primary care and behavioral health care, such as HIT and referral systems, care coordination, colocation of physical and behavioral health providers. The chapter also examined the challenges faced by LIHPs in their integration efforts.

- Almost all LIHPs reported some form of administrative support to increase integration between primary care and behavioral health providers. This support included streamlining the referral system and having access to a patient's medical records for both providers.
- Non-colocated facilities reported traditional forms of communication, such as the telephone and/or fax. Five legacy LIHPs reported having the capacity to make e-referrals.
- All but one of the LIHPs had the capability to verify whether a patient followed through with a referral.
- Six LIHPs reported that their behavioral health providers had access to different aspects of a patient's medical record, while only one county reported that its physical health provider had access to a patient's behavioral health data.
- Care coordination was another method of facilitating integration of services, specifically by promoting provider integration and centralizing care coordination.
- Two LIHPs formed committees or subcommittees to promote primary care and behavioral health provider interaction or to monitor the progress of integration through quality improvement efforts.
- Centralizing care coordination to facilitate integration was used by Contra Costa County in a centralized case management pilot, as well as in Kern County through a behavioral health coordinator who acted as a liaison between physical and behavioral health services.

- Colocation was one of the most preferred modes of integration of physical and behavioral health services. Fourteen LIHPs with colocated facilities had behavioral health providers in a primary care setting. Six LIHPs had physical health providers in a behavioral health clinic.
- Those with colocated facilities were able to refer patients by walking them over to the appropriate provider, provide same-day visits, improve collaboration between both types of providers, and reduce the perceived stigma of visiting a mental health provider.
- LIHPs reported significant barriers to integration, among them funding, administrative, organizational, service delivery, and clinical issues. Funding and a limited workforce were noted as barriers by the majority of local LIHPs. Three legacy counties also reported having an inefficient integrated HIT system.

Conclusions and Implications

LIHPs succeeded in implementing the program as intended but also went beyond defined program criteria to enact innovative strategies that changed care delivery in California's safety net system. The innovations and implementation methods of LIHPs are described in detail in this report. These innovations included developing robust provider networks and centralized support systems, promoting changes in provider and patient behavior, and integrating physical and behavioral health care. The success of LIHPs in system redesign through the use of these strategies and innovations will benefit many parties, including LIHP enrollees who are eligible for coverage through the Affordable Care Act (ACA), safety net providers who participated in LIHP, California counties that implemented LIHP, and managed care plans and commercial providers who will insure and provide care to LIHP enrollees through the ACA.

Enhanced Care Coordination

LIHP enrollees eligible for coverage through the ACA will benefit from receiving care in an improved setting with comprehensive benefits, enhanced and expanded infrastructure for care, and systemic improvements in care delivery. Many LIHP enrollees have received assistance in managing their chronic conditions, learned to seek care from primary care providers in their assigned medical homes, received coordinated care from teams of providers, obtained access to needed specialty and behavioral health care, received higher quality care, and received coordinated physical and behavioral health services in colocated or other integrated settings. Collectively, these changes in care delivery are expected to have addressed the needs of LIHP enrollees, improved their health outcomes, and reduced their health care costs. Further analysis is required to assess the impact of these changes in care delivery on outcomes and expenditures.

Strengthened Provider Capacity and System Support

Safety net providers who participated in LIHP and California counties that implemented LIHPs will also benefit in the long term. Safety net systems of counties that participated in LIHP will be well prepared to help LIHP enrollees transition to Medi-Cal or Covered California in 2014 because of the established relationships these enrollees have with their primary care providers. Counties and providers will benefit from network and support system expansions developed under LIHP. While significant challenges remain, investments made by LIHPs in building provider capacity and system support have transformed the delivery of care within the safety

net in California. LIHP efforts have positively impacted the delivery of care in some clinics in LIHP networks. For example, LIHPs have helped providers improve their care coordination and disease management skills. Infrastructure development, including referral and HIT systems and telemedicine capacity, will continue to improve efficiencies in patient care delivery.

Commercial providers, managed care plans, and the Medi-Cal program are also likely to benefit from the advances achieved through the LIHP program. LIHP enrollees no longer face extensive barriers to primary and specialty care and will have significantly reduced pent-up demand once they are transitioned to Medi-Cal or Covered California. The costs of providing care to LIHP enrollees are likely to be similar to those for previously insured populations, and the chronic conditions of LIHP enrollees are more likely to be controlled and managed.

Systems of Care for the Remaining Uninsured

The redesign of the safety net system under LIHP is also likely to positively impact individuals who remain uninsured upon ACA implementation. These individuals are likely to continue using the safety net system. The lessons learned by counties participating in LIHP in provider network development and systems support, the changes in provider behavior, and the model of integrated physical and behavioral health care can be used by county indigent care programs, which will face significant financial incentives upon ACA implementation to deliver more efficient and effective care.

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Appendix A: Methodology and Data Availability

Data utilized in this report were collected through surveys and follow-up interviews with LIHP administrators and surveys of LIHP providers.

UCLA conducted structured surveys with 16 LIHPs and interviews with 15 LIHP program administrators and providers from January through March 2013. The LIHP administrative survey contained three modules: medical home, network provider, and behavioral health. Because the counties in the previous demonstration had already been surveyed on their medical home implementation and provider networks, they only responded to the behavioral health module. All but one of the LIHPs participated in the follow-up interviews; Orange County declined to respond since it was at the beginning stages of integrating physical and behavioral health services.

The surveys focused on assessment of various components of LIHP implementation efforts that led to delivery system redesign. The infrastructure development module included questions on network structure, adequacy, referral management and administrative support, health information technology (HIT), telemedicine, and performance reporting. The module on changing provider and patient behavior included questions on medical home adherence, care coordination, disease management, patient self-management support, and quality improvement efforts. The behavioral health integration module included questions on colocation, care coordination, and best practices. All modules included questions on barriers and challenges that were discussed in detail in follow-up telephone interviews. Legacy LIHP data collected at the end of the original HCCI program were reviewed by LIHP administrators to ensure accuracy.

In addition to the survey of local LIHP administrators, UCLA fielded a questionnaire for clinics, private medical groups, and individual physician practices in the LIHP network. The goal of this survey was to understand the impact of LIHP on provider practice. With the exception of the largest three networks (CMSP, Los Angeles, and Orange), all identifiable clinics and private practices were surveyed. The networks in CMSP, Los Angeles, and Orange were organized by size and type of organization (clinic, medical group, or individual physician), and a random sample of half of the providers in each group was selected. We followed surveys with phone and email for providers for whom we had contact information. We did not report responses from medical groups and individual physician practices because of a very low response rate. Results from the 60 clinics that responded to the questionnaire are included throughout the

report. The basic characteristics of the clinics are shown in Appendix A, Exhibit 1. The sample includes clinic networks rather than individual sites within the same network, so the respondents represent more than 60 sites (one person responded for each network).

Appendix A, Exhibit 1: Characteristics of Participating Clinics, 2013

Number of responses per LIHP	
Alameda	3
Contra Costa	7
CMSP	15*
Kern	2
Los Angeles	8
Orange	6
Riverside	2
San Bernardino	1
San Diego	6
San Francisco	2
San Mateo	6
Santa Clara	1
Santa Cruz	--
Ventura	1
Number of providers in system/network	
1-10	22
11-25	16
26+	12
Missing	10
Percent of patient-related revenue associated with LIHP	
1-10%	25
11-40%	13
41+%	8
Missing	14
Position of survey respondent**	
Administrator (CEO, COO, CFO, practice manager)	28
Medical director	18
Physician	10
Other	6
Total	**60**

* The 15 clinics represent 13 of the 35 counties in the CMSP network.
** Total is greater than 60 because some respondents held more than one title within the clinic.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B: Supplemental Findings and Analyses

Appendix B, Exhibit 1: Assessment of Network Adequacy, by Method Type and LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Provider-to-enrollee ratio	✓	✓	✓	✓	-	-	-	✓	✓	✓	✓	-	-	-	-	✓
Distance to provider	✓	✓	✓	✓	-	-	-	✓	✓	✓	✓	✓	-	-	-	✓
Travel time to provider	✓	✓	✓	✓	-	-	-	✓	✓	✓	-	✓	-	-	-	✓
Appointment wait time	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 2: Frequency of Assessment of Provider Access, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Frequency of assessment of provider access																
Annually	-	-	✓	✓*	-	-	-	-	-	✓	-	-	-	-	-	✓
Quarterly	✓	-	-	-	-	-	✓	-	✓	-	✓	✓	-	-	✓	-
Monthly	-	-	-	✓*	-	-	-	✓	-	-	-	-	✓	✓	-	-
Ongoing basis	-	✓	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-

*San Bernardino assesses primary care monthly and specialty care annually.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 3: Types of Barriers and Challenges to Provider Network Structure, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Barriers and Challenges																
Low specialist supply	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
High demand for specialty care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
Provider willingness to participate	✓	✓	✓	✓	✓	✓	✓	-	-	-	-	✓	✓	-	✓	-
Maldistribution of specialists	✓	-	✓	✓	✓	-	✓	-	✓	✓	✓	✓	✓	-	-	-
Negotiating provider reimbursement	✓	-	-	-	✓	-	-	✓	✓	✓	-	✓	-	✓	-	-
Contracting with specialists	✓	✓	-	-	✓	-	-	-	-	-	-	✓	-	✓	-	-

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 4: Specialties in High Demand, by Specialist Type and LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Specialties in High Demand																
Gastroenterology	✓	✓	✓	✓	✓	✓	-	-	-	✓	✓	✓	✓	✓	✓	✓
Orthopedics	✓	✓	✓	-	✓	-	✓	-	✓	✓	-	✓	-	✓	✓	✓
Ophthalmology	-	✓	✓	-	-	-	✓	✓	✓	✓	-	-	✓	✓	✓	✓
Otolaryngology	-	-	-	✓	-	-	✓	✓	-	-	✓	-	-	✓	✓	-
Neurology	✓	-	-	-	✓	-	-	-	✓	✓	✓	✓	-	-	-	-
Endocrinology	-	-	-	✓	-	-	-	-	✓	-	✓	-	-	-	✓	✓
Urology	-	-	-	✓	-	✓	-	✓	-	✓	-	✓	-	-	-	-

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Cardiology	✓	✓	-	-	✓	-	-	-	✓	-	-	✓	-	✓	-	-
Dermatology	✓	-	-	✓	-	✓	-	✓	-	-	-	-	✓	-	-	-
Rheumatology	-	-	-	-	-	-	-	-	✓	-	✓	✓	-	-	-	-

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 5: Type of Administrative Support Services, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Has referral guidelines	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reviews and authorizes referrals for specialty care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Contracted with a TPA	✓	-	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
Contracted with a PBM	✓	-	-	✓	✓	✓	✓	✓	-	-	✓	✓	✓	✓	-	✓

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 6: Third-Party Administrator and Pharmacy Benefit Manager Services, by LIHP, 2013

	CMSP	Placer	Riverside	Sacramento	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Services provided by TPA																	
Claims processing and adjudication	✓	-	✓		-	✓	✓		✓	✓	✓	✓	✓	-	✓		
Member services	✓	-	✓		-	✓	✓	✓	✓	✓	-	-	✓	✓	✓		
Case management and care coordination	✓	-	-		-	-	-		✓	✓	-	-	✓	-	✓		
Provider negotiations and contracting	✓	-			-	-	✓		✓	-	-	-	✓	-	✓		
Provider credentialing	✓	-	✓		-	-	✓	✓	✓	✓	-	-	✓	-	✓		
Services provided by PBM																	
Prescription claims processing and adjudication	✓	-	-			✓	✓		✓			✓	✓	✓	-		✓
Rebate negotiations with pharmaceutical co.		-	-		✓	-	✓		✓			✓	✓	-	✓		✓
Pharmacy network management	✓	-	-		✓	✓	✓		-			✓	✓	-	✓		✓
Formulary development and management	✓	-	-		✓	-	-		-			-	✓	-	-		✓

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 7: Types of Health IT Systems, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Electronic medical record	-	✓	✓	✓	✓	✓	-	✓	✓	-	-	-	-	✓	✓	-
Electronic registries	-	-	✓	-	✓	-	-	✓	✓	✓	-	-	-	✓	✓	-

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Lifetime clinical record	-	-	-	✓	-	-	-	-	-	-	-	-	✓	✓	✓	-

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 8: Health IT System Functionality, by System Component and LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
IT System Components	-						-									
Electronic patient chart		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓
Appointment scheduling		✓	✓	✓	✓	✓		✓	✓	✓	-		✓	✓	✓	✓
Electronic prescribing		✓	-	✓	✓	✓		✓	✓	-	-		✓	✓	✓	-
Electronic referral management		✓	-	✓	-	✓		-	✓	✓	-		✓	✓	✓	-
Data Availability	-						-									
Laboratory results		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓
Patient demographics		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Radiology/imaging results		✓	✓	✓	✓	✓		✓	✓	✓	✓		-	✓	✓	✓
Medication list		✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	-
Program notes		✓	✓	✓	✓	✓		✓	✓	-	✓		✓	✓	✓	✓
Hospital discharge summaries		✓	-	✓	✓	✓		✓	✓	✓	✓		-	✓	✓	✓
Problem list		✓	✓	✓	✓	✓		✓	✓	✓	✓		-	✓	✓	-
PCP referral notes to specialist		✓	-	✓	✓	-		-	✓	✓	✓		✓	✓	✓	-

Provider Tools							-				-						
Drug formularies	✓	✓	-	✓	✓	-		✓	✓	-		✓	✓	✓	✓	✓	
Clinical guidelines and protocols	-	-	-	-	-	✓		-	✓	-		✓	✓	✓	✓	-	
Clinical decision support	-	-	✓	-	-	✓		✓	✓	-			-	✓	✓	-	
Computerized provider order entry	-	✓	-	✓	-	✓		✓	✓	✓			-	✓	-	-	
Abnormal test result alerts/flags	-	✓	-	✓	✓	✓		✓	✓	-			-	✓	-	-	
Computer reminders and prompts for medications	-	✓	-	✓	-	✓		✓	✓	-			-	✓	-	-	
Computer reminders and prompts for preventive services	-	✓	-	✓	✓	✓		-	✓	✓			-	✓	-	-	
Provider messaging	-	✓	-	-	✓	✓		-	-	-			-	-	✓	-	

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 9: Access to Telemedicine Utilization, by LIHP and Telemedicine Specialty, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County currently utilizes telemedicine for LIHP	✓	-	-	-	✓	-	✓	-	✓	✓	-	✓	✓	✓	-	✓
Telemedicine specialties that will be/are used during LIHP:																
Optometry/Ophthalmology	-				✓		✓		✓	✓		✓	✓	✓		✓
Dermatology	✓				✓		✓		-	✓		✓	✓	✓		-
Psychiatry	✓				✓		-		✓	-		✓	✓	-		-

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 10: Types of Performance Measures Collected, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County reviewed and tracked performance measures	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Utilization patterns		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient satisfaction		-	✓	✓	✓	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical outcomes		-	✓	-	✓	-	✓	✓	✓	-	-	✓	✓	✓	✓	-
Specialty referrals		-	✓	✓	✓	-	-	✓	✓	-	✓	✓	✓	✓	-	✓
HEDIS*		-	✓	-	✓	✓	-	✓	✓	✓	✓	✓	✓	-	✓	-
Adverse events		-	✓	-	-	-	-	✓	✓	-	✓	✓	✓	✓	✓	✓

* Healthcare Effectiveness Data & Information Set (HEDIS)
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 11: Types of Barriers and Challenges to LIHP Support Systems, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Specialty Referral Barriers	-						-									
Shortage of county personnel to review referrals		-	✓	✓	-	-		✓	✓	✓	-	-	-	✓	-	-
Provider adherence to referral guidelines		-	✓	-	-	✓		-	-	✓	-	✓	-	✓	-	-
Telemedicine Barriers																

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Cost		-	✓	✓	-	-		✓	✓	✓	✓	✓	-	-	-	-
County IT resources		-	-	✓	-	-		-	✓	✓	-	-	✓	✓	-	-
Quality or availability of system/equipment		-	-	-	-	-		-	✓	-	-	✓	-	✓	-	✓
Health IT Barriers																
Cost		✓	✓	✓	✓	✓		✓	✓	✓	-	✓	✓	✓	✓	✓
IT staff availability and capacity		✓	✓	✓	✓	✓		✓	✓	✓	-	-	✓	✓	✓	✓

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 12: Care Coordination Facilitation and Partnerships with Community-Based Organizations, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County trains PCPs on teamwork	-	-	✓	✓	✓	✓	✓	✓	-	-	-	-	✓	✓	✓	✓
County trains PCPs on care coordination	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
County partners with community-based organizations to facilitate availability of social services	✓	-	✓	-	✓	-	-	✓	✓	-	-	✓	-	✓	✓	✓

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 13: Health Risk Assessment Activities, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County administers health risk assessments	-	-	✓	✓	✓	-	-	✓	-	-	-	✓	✓	-	-	-
County shares information on health risk assessments with medical homes	-	-	✓	✓	✓	-		✓				✓	✓			

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 14: Disease/Case Management Services, by Condition and LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County offers disease/case management programs	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Type of program:																
Diabetes	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Asthma	-		✓	✓	-	✓	✓	✓	✓	✓	✓	-	-	✓	✓	✓
CHF	✓		✓	-	-	-	✓	✓	-	✓	✓	-	-	✓	✓	✓
Depression	-		✓	-	✓	✓	-	-	✓	-	-	-	-	-	✓	✓
Other*	-		✓	-	✓	-										

* "Other" includes HIV/AIDS, frequent ER users, and coumadin clinic clients.
Note: The shaded areas in this and subsequent exhibits indicate that the "Other" category was not included in data collection on legacy counties.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 15: Creation and Distribution of Educational Materials, by Condition and LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County creates and distributes educational materials	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	-	-	✓	✓	✓	✓
Type of material:																
Diabetes	✓	✓	✓	✓	✓		✓	✓	✓	✓			✓	✓	✓	✓
Asthma	-	✓	✓	✓	✓		✓	✓	✓	✓			✓	✓	✓	✓
CHF	✓	✓	✓	✓	-		-	✓	✓	✓			✓	✓	✓	✓
Depression	-	✓	✓	-	✓		-	✓	✓	-			✓	-	✓	✓
Other*	-	-	✓	-	✓											

* "Other" includes stroke/HTN, HIV, tuberculosis, STD, and nutrition education.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 16: Specially Trained and Designated Health Educators, by Condition and LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County provides specially trained and designated health educators for chronic conditions	✓	-	✓	✓	✓	-	✓	✓	✓	✓	-	-	✓	✓	✓	✓
Health education specialties:																
Diabetes	✓		✓	✓	✓		✓	✓	✓	✓			✓	✓	✓	✓
Asthma	-		✓	✓	✓		✓	✓	✓	-			-	✓	✓	-
CHF	✓		-	-	-		✓	✓	-	-			-	✓	✓	-
Depression	-		✓	-	✓		✓	-	✓	-			-	✓	✓	-
HIV	-		-	-	✓											

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 17: Types of Health Promotion Programs, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County offers health promotion programs	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Type of program:																
Smoking cessation	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓
Nutrition	-	-	✓	✓	✓		✓	✓	✓	-	-		✓	✓	✓	✓
Weight loss	-	-	✓	✓	-		✓	✓	-	-	-		✓	-	✓	✓
Physical activity	-	-	✓	✓	-		✓	✓	-	-	-		-	✓	✓	✓
Other*	✓	-	-	-	✓											

* "Other" includes a listening library on numerous health conditions and the Stanford Chronic Disease Self-Management Program.
Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 18: Types of Implemented Quality Improvement Initiatives, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County organized a CQI committee	-	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓
County provides evidence-based clinical practice guidelines	-	-	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓
County provides performance measure feedback to providers	-	-	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 19: Barriers and Challenges Related to County Support of Patient Self-Management, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County-reported barriers and challenges related to county support of patient self-management	-	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	-	✓	✓
Type of barrier or challenge:																
Cost		✓	✓	✓	-	✓		-	✓	✓	✓	✓	✓		✓	✓
Shortage of trained county personnel		✓	✓	✓	✓	✓		✓	✓	✓	-	-	✓		✓	✓

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 20: Barriers and Challenges Related to Quality Assurance, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
County-reported barriers and challenges related to quality assurance and improvement	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Type of barrier or challenge:																
Data availability			✓	✓	✓	-	✓	✓	-	✓	-	✓	-	✓	✓	✓
IT resources			-	✓	-	✓	✓	-	-	✓	-	✓	-	✓	✓	✓
Staff availability and capacity			✓	✓	✓	✓	✓	-	✓	-	-	✓	✓	-	✓	✓
Cost			-	✓	✓	-	-	✓	-	✓	✓	✓	-	-	✓	-
Stakeholder support			-	-	-	-	-	-	-	-	✓	-	-	-	✓	-
Other			-	-	-	-										

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 21: Additional MCE Mental Health Services Offered by New LIHPs, 2013

	CMSP	Monterey	Placer	Riverside	Sacramento	San Bernardino	Santa Cruz	Tulare
Acute inpatient hospital services: up to 10 days	CB*	CB	CB	CB	CB	CB	CB	CB
Acute inpatient hospital services >10 days	-	✓	✓	✓	-	✓	✓	✓
Case management	-	✓	✓	✓	-	✓	✓	-
Case management for frequent ER users	-	✓	✓	✓	-	✓	✓	-
Crisis hotline	-	-	✓	✓	-	✓	-	-
Crisis intervention	CB	CB	CB	CB	CB	CB	CB	CB
Crisis residential treatment	-	✓	✓	✓	-	-	✓	-
Crisis stabilization	-	✓	-	✓	-	✓	✓	-
Day rehabilitation	-	✓	-	-	-	-	-	-
Day treatment, intensive	-	✓	-	-	-	-	-	-
Dual diagnosis treatment	-	✓	✓	✓	-	-	✓	-
Family/collateral therapy	-	✓	✓	✓	-	✓	-	-
Group therapy	CB	CB	CB	CB	CB	CB	CB	CB
Hospital administrative day	-	✓		✓	-	✓	✓	-
Individual therapy	CB	CB	CB	CB	CB	CB	CB	CB
Information and referral services	-	✓	✓	✓	-	-	✓	-
Laboratory studies related to psychiatric	-	✓	-	✓	-	-	✓	-
Medication-assisted treatment	-	✓	-	-	-	-	-	-
Medication support	CB	CB	CB	CB	CB	CB	CB	CB
Mental health assessment	CB	CB	CB	CB	CB	CB	CB	CB
Mental health rehabilitation centers	-	-	✓	-	-	-	-	-
OP encounters: up to 12 OP encounters per year	CB	CB	CB	CB	CB	CB	CB	CB
OP encounters >12 days	-	✓	✓	✓	-	✓	✓	✓

	CMSP	Monterey	Placer	Riverside	Sacramento	San Bernardino	Santa Cruz	Tulare
Peer support	-	-	-	✓	-	-	-	-
Plan development	-	✓	✓	✓	-	✓	-	-
Prevention services	-	-	-	-	-	✓	-	-
Psychiatric pharmaceuticals	CB	CB	CB	CB	CB	CB	CB	CB
Self-help services	-	-	-	-	-	✓	-	-
Social rehabilitation	-	-	✓	-	-	✓	-	-
Therapeutic behavioral services	-	-	✓	-	-	✓	-	-
Transitional residential services	-	✓	✓	✓	-	-	✓	-
Treatment placement	-	-	✓	-	-	-	-	-

* "CB" = "covered benefit." The "✓" mark denotes an additional service.
Source: LIHP Contracts with the California Department of Health Care Services, Exhibit A Attachment 15.

Appendix B, Exhibit 22: Additional MCE and HCCI Mental Health Services Offered by Legacy LIHPs, 2013

	Alameda		Contra Costa		Kern		Los Angeles		Orange		San Diego		San Francisco		San Mateo		Santa Clara		Ventura	
	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI
Acute inpatient hospital services: up to 10 days	CB*	✓	CB	✓	CB		CB	✓	CB	✓	CB	✓	CB	CB	CB		CB	✓	CB	✓
Acute inpatient hospital services >10 days	✓	✓	✓	✓	-	-	✓	✓	✓	✓	-	-	✓	✓	✓	-	✓	✓	✓	✓
Case management	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Case management for frequent ED users	✓	✓	-	-	✓	-	-	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Crisis hotline	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	-	-	✓	✓	✓	✓
Crisis intervention	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	-	-	✓	✓	✓	✓
Crisis residential treatment	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	-	-	-	-	✓	-	-	-	✓	✓
Crisis stabilization	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	-	-	✓	✓	✓	-	✓	✓	✓	✓
Day rehabilitation	✓	✓	-	-	-	-	-	-	-	-	-	-	✓	✓	✓	-	-	-	✓	✓
Day treatment, intensive	✓	✓	-	-	-	-	-	-	-	-	-	-	✓	✓	✓	-	-	-	✓	✓
Dual diagnosis treatment	✓	✓	-	-	-	-	✓	✓	✓	✓	-	-	✓	✓	✓	-	✓	-	-	-
Family/collateral therapy	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	-	-	✓	✓	✓	-	✓	✓	-	-
Group therapy	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	-
Hospital administrative day	✓	✓	✓	✓	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	-	-	-

	Alameda		Contra Costa		Kern		Los Angeles		Orange		San Diego		San Francisco		San Mateo		Santa Clara		Ventura	
	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI
Individual therapy	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	-
Information and referral services	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	-	-	✓	✓		-	✓	-	-	-
Laboratory studies related to psychiatric	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	-	-	✓	-	✓	✓	-	-
Medication assisted treatment	✓	✓	✓	✓	✓	-			✓	✓	-	-	✓	✓	✓	-	✓	✓	-	-
Medication support	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Mental health assessment	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Mental health rehabilitation centers	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-
OP encounters: up to 12 OP encounters per year	CB	✓	CB	✓	CB	-	CB	✓	CB	✓	CB	✓	CB	CB	CB	-	CB	✓	CB	✓
OP encounters >12 days	✓	✓	✓	✓	-	-	✓	✓	✓	✓	-	-	✓	✓	✓	-	✓	-	✓	✓
Peer support	✓	✓	-	-	-	-	✓	✓	✓	✓	-	-	✓	✓	✓	-	✓	-	✓	✓
Plan development	✓	✓	✓	✓	-	-			✓	✓	-	-	✓	✓	✓	-	✓	-	✓	✓
Prevention services	✓	✓	-	-	-	-	✓	✓	✓	✓	-	-	✓	✓	-	-	✓	-	✓	✓
Psychiatric pharmaceuticals	CB	✓	CB	-	CB	-	CB	✓	CB	✓	CB	✓	CB	CB	CB	-	CB	✓	CB	✓
Self-help services	✓	✓	-	-	-	-	✓	✓	-	-	-	-	✓	✓	-	-	✓	-	✓	✓
Social rehabilitation	✓	✓	-	-	-	-	-	-	-	-	-	-	✓	✓	✓	-	-	-	✓	✓
Therapeutic behavioral services	✓	✓	-	-	-	-	-	-	-	-	-	-	✓	✓	-	-	-	-	✓	✓
Transitional residential services	✓	✓	✓	✓	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	✓	✓
Treatment placement	✓	✓	-	-	-	-	-	-	-	-	-	-	✓	✓	-	-	-	-	✓	✓

* "CB" = "covered benefit." The "✓" mark denotes an additional service.
Source: LIHP contracts with the California Department of Health Care Services; Exhibit A, Attachment 15.

Appendix B, Exhibit 23: Additional Substance Abuse Services Offered by LIHPs, 2013

	CMSP		Santa Cruz		Kern		San Francisco		San Mateo		Santa Clara	
	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI	MCE	HCCI
Assessment	✓		✓		✓	-	✓	✓	✓	-	✓	-
Behavioral health integration	-		✓		✓	-	✓	✓	✓	-	✓	-
Case management	-		✓		✓	-	✓	✓	✓	-	✓	-

Collateral services	-		-		-	-	✓	✓	✓	-	✓	-				
Day care rehabilitation	-		-		-	-	✓	✓	✓	-	-	-				
Detoxification	-		-		✓	-	-	-	✓	-	✓	-				
Group counseling	✓		✓		✓	-	✓	✓	✓	-	✓	-				
Individual counseling	✓		✓		✓	-	✓	✓	✓	-	✓	-				
Medication assisted treatment	-		-		-	-	✓	✓	✓	-	✓	-				
Narcotic replacement therapy	-		-		-	-	-	-	✓	-	✓	-				
Outpatient	-		-		✓	-	✓	✓	✓	-	✓	-				
Residential acute stabilization	-		-		-	-	-	-	✓	-	✓	-				
Residential perinatal treatment	-		-		-	-	-	-	✓	-	-	-				
Residential treatment including detoxification	-		-		✓	-	-	-	✓	-	✓	-				
Screening and intervention	-		✓		✓	-	✓	✓	✓	-	✓	-				
Sober living environment	-		-		-	-	-	-	-	-	✓	-				
Treatment placement	-		✓		✓	-	✓	✓	-	-	-	-				

Source: LIHP contracts with California Department of Health Care Services; Exhibit A, Attachment 15.

Appendix B, Exhibit 24: Methods LIHPs Use to Support Interaction Between Physical and Behavioral Health Providers, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Methods LIHPs use to support interaction between physical and behavioral health providers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referral system	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Financial incentives/ resources	-	-	-	-	-	-	-	-	✓	-	-	-	-	✓	-	-
HIT	-	-	-	-	✓	-	-	✓	-	-	-	-	-	✓	✓	-

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 25: Access to Primary Care Records Among Behavioral Health Providers, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
LIHPs in which the behavioral health IT system has access to medical records	NA	✓	-	-	-	✓	-	✓	✓	-	-	-	-	✓	✓	✓
Data to which behavioral health providers have access:																
Patient demographics		✓	-	-	-	✓	-	✓	✓	-	-	-	-		✓	✓
Diagnoses		✓	-	-	-	✓	-	✓	✓	-	-	-	-	✓	-	-
Treatment plans		✓	-	-	-	✓	-	✓	✓	-	-	-	-	✓	-	-
Medication prescribing and management		✓	-	-	-	✓	-	✓	✓	-	-	-	-	-	-	-
Patient registries		✓	-	-	-		-	-	✓	-	-	-	-	-	-	-
Assessments		✓	-	-	-	✓	-	-	✓	-	-	-	-	✓	-	-
Progress notes		✓	-	-	-	✓	-	✓	✓	-	-	-	-	✓	-	-
Lab results tracking		✓	-	-	-	✓	-	✓	✓	-	-	-	-	✓	-	✓
Health outcomes		✓	-	-	-	✓	-	✓	✓	-	-	-	-	-	-	-
Other		-	-	-	-	-	-	-	✓	-	-	-	-	-	✓	✓
Documentation required to access data		-	-	-	-	-	-	✓	✓	-	-	-	-	✓	-	-

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 26: Referral Methods and Systems for Non-Colocated Facilities, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura

Standard referral guidelines for non-colocated facilities	**NA**	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓
Primary care providers to refer for behavioral health services		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		-	✓
Behavioral health providers to refer for primary care services		✓		✓	✓	✓	-	✓	✓	-	✓	✓	✓		✓	-
Referral methods in non-colocated facilities	**NA**	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**NA**	✓
E-referral				-	-	-	-	✓	-	-	✓	✓	-	✓	-	✓
Fax				-	✓	✓	✓	-	✓	✓	-	✓	✓	-	-	✓
Phone				✓	✓	✓	-	✓	✓	-	✓	✓	✓	✓	-	✓
Provider can verify whether patient followed through with referral	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 27: Types of Providers in Colocated Facilities, by Physical and Behavioral Health and LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Physical and behavioral health services are colocated	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**NA**	✓	✓	✓	✓	✓
Types of behavioral health clinicians colocated at physical health facilities:	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**NA**	✓	✓	✓	✓	✓
Psychologist	✓	-	-	-	-	-	✓	✓	✓	-		✓	-	✓	✓	✓
Caseworker*	-	✓	✓	✓	-	-	✓	✓	-	-		✓	✓	-	-	-
Counselor/ therapist	✓	✓	✓	✓	✓	✓	✓	✓	✓	-		✓	✓	✓	✓	✓
Psychiatrist/LCSW	-	-	✓	-	-	✓	✓	✓	✓	✓		-	✓	-	✓	-
Substance Abuse Specialist/Clinician	-	-	-	-	-	-	-	-	✓	-		-	-	-	✓	-
Types of primary care providers colocated at behavioral health facilities:	✓	-	✓	✓	-	-	✓	✓	✓	-	**NA**	-	✓	✓	-	-
Physician	✓	-	-	✓	-	-	✓	✓	-	-		-	✓	✓	-	-

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Resident	-	-	-	✓	-	-	-	-	-	-		-	-	-	-	-
Nurse practitioner	✓	-	✓	✓	-	-	-	✓	✓	-		-	-	✓	-	-
Nurse	-	-	-	✓	-	-	✓	✓	-	-		-	-	-	-	-
CMA/Care Coordinator	-	-	-	-	-	-	-	✓	-	-		-	-	-	-	-
Pharmacy on-site	✓	✓	-	✓	✓	✓	-	-	✓	✓	NA	✓	-	✓	✓	-

* Caseworkers include social workers and behavioral health coordinators.

Source: UCLA Center for Health Policy Research surveys of LIHP administration.

Appendix B, Exhibit 28: Barriers and Challenges Related to Integrating Physical and Behavioral Health, by LIHP, 2013

	CMSP	Placer	Riverside	San Bernardino	San Joaquin	Santa Cruz	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Barriers LIHPs face that prevent full integration	N/A															
Funding		-	✓	-	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	-	✓
Limited workforce		-	✓	-	✓	✓	✓	✓	✓	-	✓	✓	✓	-	✓	✓
Lack of efficient integrated HIT capacity		-	-	-	-	-	-	-	✓	-	-	-	✓	-	✓	-
Rural/ dispersed populations		-	✓	✓	-	-	-	-	-	✓	-	✓	-	-	-	-
Lack of workforce training		-	-	-	-	✓	-	✓	-	-	-	✓	-	-	-	-
Pharmacy issues		-	✓	-	-	-	-	-	-	-	-	✓	-	-	-	-
Formulary payment		-	-	-	-	-	-	-	-	-	-	✓	-	✓	-	-

Source: UCLA Center for Health Policy Research surveys of LIHP administration.