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THE HEALTH ALLIANCE OF NORTHERN CALIFORNIA

North Coast Clinics Network

ARCH Alliance for Rural Community Health

Community Health Centers and Partnership HealthPlan Collaboration Improves the Medicaid Health Delivery Landscape in Rural California

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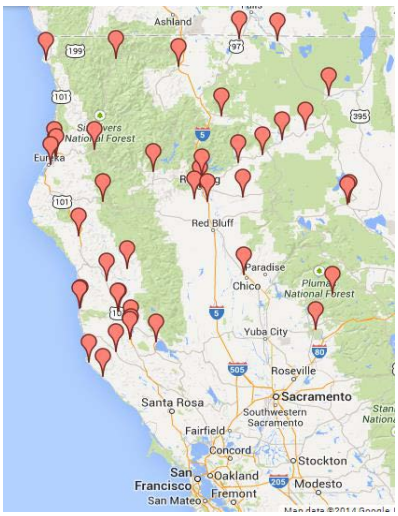
Introduction

As the health care landscape continues to evolve, rural northern California health centers are primed to explore innovative solutions and implement necessary changes that will achieve the triple aim of improved health outcomes, enhanced patient experience and controlled healthcare costs. Over the past four years, rural health care leaders in northern California have focused on opportunities brought by the Affordable Care Act (ACA) in order to achieve systems change that results in expanded access to health care services and improved health outcomes for rural communities. During this period of significant change in the health care environment, three health center controlled networks (HCCNs) and their health center members partnered in order to garner bi-partisan support and successfully expand a County Organized Health System (COHS) model of California's Medicaid (Medi-Cal) Managed Care to their region. Throughout this time, these members also developed unique collaborations that allowed for timely sharing of information, data-driven decision making, and strengthened advocacy opportunities to ensure that rural California residents are able to benefit from the opportunities brought by the ACA.

Northern California Health Center Controlled Network Collaborative



The Northern California HCCN Collaborative spans 40,000 square miles, or 24% of California's northernmost landmass. This region includes 13 rural and frontier counties with 772,436[1] people. The rural and frontier regions are rugged and mountainous with the majority of residents living in scattered, remote communities where transportation is limited and often disrupted by extreme weather conditions.

The Northern California HCCN Collaborative includes three non-profit networks: Alliance for Rural Community Health, North Coast Clinics Network, and Health Alliance of Northern California. Together, these three networks represent 17 Federally Qualified Health Center (FQHC) corporations.

Member health center organizations operate 46 individual FQHC sites. Members provide high quality, affordable medical, dental, and behavioral health care services to nearly 1/3 of the rural and frontier regions' total population[2].

The service area ranks well above the state average in the percentage of residents living below the federal poverty level (FPL) with 20% below FPL verses California's 15.9%[3]. In addition to those living

[1] U.S. Census Bureau (2014 population). State & County QuickFacts
[2] Uniform Data Systems 2014
[3] U.S. Census Bureau (2009-2013). State & County QuickFacts: Humboldt County

below FPL, the region ranks above the national and state averages for unemployment at 9.9%[4]. The HCCN service area also face several challenges that impact the social determinants of health and likely contribute to the poor health outcomes described below. Patients in the region demonstrate poorer health outcomes. According to County Health Status Profiles, the majority of counties in the Tri-Consortia region rate higher for suicide, chronic liver disease, coronary heart disease, and cancer than both the state average as well as the goals set by Healthy People 2020[5].

Social Determinants of Health[6]	Mortality
Compared to California, the HCCN service area has: • **89%** have a higher percentage of seniors aged 65+ • **100%** have more children living in poverty • **100%** have lower median household incomes • **78%** have higher unemployment rates • **15-23%** of population is uninsured	*Compared to California, the HCCN service area has:* • **100%** have higher rates of overall/premature death • **78%** are ranked higher in child mortality • **89%** have higher cancer death rates with colorectal, lung, and female breast cancer being the highest • **100%** have higher suicide death rates • **89%** report higher drug-induced death rates

In an effort to address the health disparities in rural Northern California, the HCCN Collaborative prioritized partnership and collaboration as a means to make change in the community and positively affect the residents therein. Many times rural health centers are the only providers of comprehensive primary care in their communities or struggle with significantly limited access. This environment has driven HCCNs and their member organizations to develop strong, long-standing relationships with private providers, specialists, tertiary care, and county governments. These partnerships have resulted in a coordinated, patient-centered health care and human service delivery system that provides quality health care services for hard-to-reach populations in rural areas.

HCCN Collaborative Leads Medicaid Managed Care Expansion in Rural Northern California

Health centers in the Tri-Consortia region recognized that rural providers needed a more integrated system as they looked to meet the demands of the ACA, including health coverage expansion, electronic medical record implementation , and Patient Centered Medical Home (PCMH) recognition. They looked to the HCCN due to their demonstrated history of success assisting disparate providers in achieving collective goals and creating forums for collaboration across the region through community initiatives, roundtables, and peer networking.

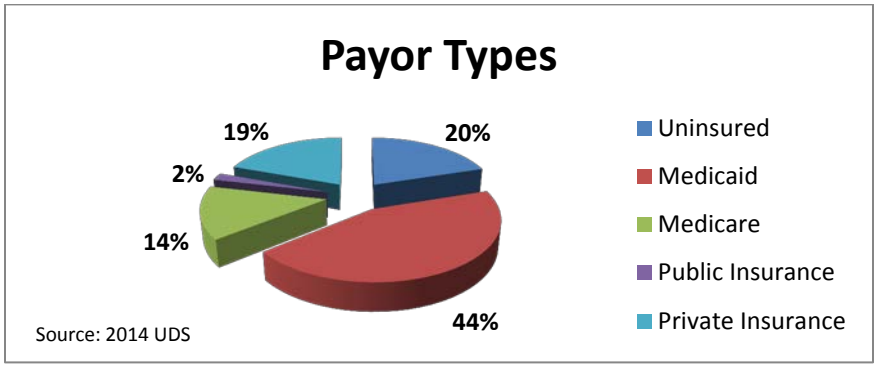
One of the first significant changes that arose out of the ACA came in September of 2013, when California's Medicaid program (Medi-Cal) expanded managed care into 28 primarily rural counties, including 9 of the 13 Northern California HCCN coalition counties. The HCCN collaborative played a vital role in successfully securing the managed care model best suited for its rural landscape and population through effective education, advocacy, and partnership building.

For rural Northern California, the journey toward Medi-Cal managed care started a year earlier. California's FY2012-2013 state budget, as set forth in Assembly Bill 1467, authorized the Department of

[4] U.S. Dept. of Labor. Bureau of Labor Statistics. Local Area Unemployment Statistics Map: CA-Humboldt (2013)
[5] County Health Status Profiles 2014
[6] United States Census Bureau, 2009-2014

Health Care Services (DHCS) to implement Medi-Cal managed care in the rural expansion counties. Up until 2012, Medi-Cal managed care had mostly been implemented in larger counties with little to no rural areas with the exception of Mendocino County, which had successfully transitioned to managed care using a COHS model the year before.

As such, the HCCNs wanted to ensure that the rural counties of Northern California implemented a managed care plan that best fit the health needs of its residents. It was of critical importance that health center leaders remain at the forefront of Medi-Cal managed care expansion in their counties as patients with Medi-Cal made up 44% of their patient population; moreover, with the expansion of Medi-Cal eligibility to <138% FPL in California, the health centers were estimating at least a 5-15% increase in their Medi-Cal population as residents would now qualify for the program.



For the first part of 2012, the HANC, NCCN and the California Hospital Council coordinated several stakeholder meetings of health center and hospital leadership and educational forums for Network membership to understand the various health plan models, how they were functioning in other regions, and discuss the best fit for the rural service area. The HCCNs also utilized their well-established Rural Roundtable forum as one such venue. Together, ARCH, NCCN, and HANC convene executive leadership teams and health center Board representatives from member corporations at Rural Roundtable meetings three times a year. These two-day roundtable meetings consist of an education session on the first day followed by a networking dinner, at which point the group sets the agenda for the following day. The roundtable format provides opportunities for executive teams to discuss policy updates, education needs, operational changes, and managed care/behavioral health challenges impacting all health centers in the region.

While the state intended to implement a geographic managed care model throughout the 28 counties, the HCCN organizations determined through stakeholder discussions and forums that a regional County Organized Health System (COHS) model would best address the needs of the local health care system and support providers and county government working to improve health outcomes through a coordinated system of care. The COHS would support patient-centered health homes throughout the region wherein clinical care and social determinants of health are addressed while improving care coordination and producing cost savings that would be reinvested back into the local communities.

Upon examination of the Medi-Cal managed care expansion regulations outlined in the law, policy leads at the HCCNs learned that in California the state cannot move forward with implementation without receiving support from local counties' Board of Supervisors. Thus, over the next 18 months, HANC and NCCN, along with the Hospital Council of California, led a coordinated advocacy and education effort that involved a bipartisan coalition of health leaders and legislators from each of the expansion counties to ensure a COHS model via Partnership HealthPlan of California (PHC). The HCCN engaged local Boards

of Supervisors and state legislators, educating them about the law and health plan models and securing letters of support for the COHS model. Regional health leaders also submitted letters to legislators, to Department of Health Care Services (DHCS), and to the Secretary of the California Health and Human Services Agency requesting exclusion from the formal bid process in order to be allowed to join PHC's COHS region. Lastly, the Northern California HCCNs coordinated efforts to obtain health center provider non-binding letters of intent to work with PHC to demonstrate the region's support of a COHS and PHC in particular.

In February of 2013, HCCN leadership succeeded in providing rural-specific language to the State's Budget Trailer Bill addressing the Medi-Cal Managed Care Rural Expansion, securing the COHS model with PHC for 8 of the 11 Northern California counties. For the remaining rural counties, the State contracted with Anthem Blue Cross and California Health & Wellness.

The successful efforts in achieving a COHS model resulted in several benefits for the health centers, county governments, and the patients in the HCCN communities.

- **All Medi-Cal patients in the PHC COHS counties have access to a primary care health home:** The dedicated outreach and enrollment efforts of the consortia, their member health centers, local DHHS, and PHC resulted in an increase of Medicaid patients served by CHCs from 36% in 2013 to 44% in 2014,[7] a total of 111,169 Medi-Cal Managed Care lives assigned to the HCCN network members.[8] Through the health home model, patients are linked to a primary care provider whereby care can be successfully coordinated, reducing medically inappropriate emergency room usage; providing an appropriate level of inpatient care; and expanding case management programs and adding essential services locally.
- **The Northern California rural region has a system to support and sustain PCMH efforts:** PHC utilizes a primary care medical home model in their coverage of Medi-Cal patients, which allows patients to receive preventive care, provides referrals for specialists, coordinates treatment plans, and supports social determinant interventions. This focus on prevention advances upstream and proactive treatments and shifts the practice of medicine from illness to wellness, prioritizing patient experience and producing cost savings and control.
- **"Payment reform" opportunities begin to be explored through the COHS model:** PHC employs a payment methodology that aligns incentives to support prevention-oriented health services and supports linkages to other elements of a health home that are not currently funded. PHC reinvests cost-savings achieved from properly managing patients' care back into the communities they serve as reimbursement, quality incentives, and additional services to patients.
- **Population health opportunities are available to improve health outcomes in the region:** The regional COHS supports health providers, patients, and county governments to work together to improve health outcomes using a local/regional system of care. PHC coordinates numerous networking, training, strategic planning, and focus group opportunities for health care entities and patients to influence the development of the local health system and services.
- **Northern California has an enhanced local and regional information technology infrastructure:** The regional COHS is helping to support the exchange of information between continuums of services, tracks and monitors health status changes at individual and population levels, and informs ongoing quality improvement efforts. PHC's data warehouse supplies providers with actionable

[7] 2013/2014 Uniform Data System
[8] PHC Active Enrollees By Site Report (01.15.16)

information that allows for data-driven decision making and allows for preventive and chronic care outreach to patients.

- **Resources are available for counties through Inter-Governmental Transfer (IGT) of funds:** The IGT process is a funding strategy under Section 1903(w)(a) of the Social Security Act that states and/or local governments utilize to increase federal matching dollars for Medicaid programs. Counties can receive additional federal Medicaid matching funds under agreements with DHCS and PHC. These funds provide counties with the flexibility to create services and programs that are specific to the unique needs of the communities they serve.

- **Hundreds of jobs have been created in the region:** The expansion of PHC into the additional 8 rural communities of Northern California has resulted in job creation opportunities directly, by employing local community members to provide support on behalf of the health plan. It has also resulted in CHC job creation as centers are able to invest in non-billable positions, such as population health managers, health coaches, and promotoras.

HCCNs and PHC Collaborate to Increase Access and Improve Health Outcomes

In response to a health care environment shifting from volume to value, both member CHC's and PHC are focused on population health management, patient experience, and cost control. Guided by these strategic priorities, the partnership between the Northern California HCCNs and PHC is a natural fit. With support from PHC, the Consortia have been able to enhance their existing peer networks, build new ones, and maintain efficient modes of communication, action, and spread of programs, services, and initiatives. Through both the peer networks and the Rural Roundtables, the Tri-Consortia are creating opportunities for key health care and PHC staff to develop relationships with their peers, strategize and share best practices, expertise, and resources to ensure greater impact in the communities they serve.

- **Chief Executive Officer Peer Group (CEO)** – Health center CEOs discuss implications of new federal or state policies that impact local service delivery systems. Strategies are developed for working with local legislators to ensure that rural access is prioritized at the state and federal levels, allowing patients to receive timely and appropriate care with their providers of choice. These meetings also provide a forum to discuss workforce related issues and large-scale operational challenges and opportunities to help health centers meet the evolving demands in each community.

- **Chief Finance Officer Peer Group (CFO)** – Health center finance leaders conduct information sharing and exchange best practices on a variety of pertinent topics relating to financial health, including managed care billing, changes in payor mixes and services, changes in HRSA and UDS reporting, opportunities and challenges related to electronic health records, and strategies for health center sustainability.

- **Chief Operating Officer Peer Group (COO)** – COO meetings focus on opportunities and challenges within their health centers as new policies come down from the federal or state agencies that impact health center operations. Discussion topics include HRSA FQHC Program changes, HIPAA, staff training and career advancement, and regulatory compliance issues related to confidentiality and patient information sharing.

- **Quality Improvement Peer Group** – QI leads from each CHC organization focus on maximizing opportunities available within health plan quality incentive programs, HEDIS, Meaningful Use, patient centered medical home (PCMH), UDS, Population Health, and local/regional data analytics projects. Network facilitators also collect clinical and operational data from each health center to measure trends regionally and in turn provide targeted training and technical assistance. Through the use of dashboards and other graphical displays, CHC staff is more educated about their relative position compared to other health providers and can then share best and/or promising practices that have proven effective in improving the health outcomes of their respective patient populations.

- **Outreach/Enrollment Peer Group** – Staff who lead outreach and enrollment efforts for their health centers are brought together to provide feedback to the State regarding the Insurance Exchange (Covered California) and Medi-Cal enrollment and retention processes/systems. Participants also share operational methods for outreach, enrollment, retention, and reporting. Covered California staff joins these meetings to directly engage and receive feedback from CHCs related to the unique rural issues of network adequacy, marketing, and barriers to the enrollment process.

By facilitating meetings with diverse levels of health center staff, the networks are able to stay abreast of the myriad of issues facing rural health centers in a shifting environment. These venues also effectively drive regional initiatives on behalf of health center members and patients and serve as a platform to monitor access and health trends throughout northern rural California. Through thoughtful partnership building and collaboration with PHC, the Consortia and its health center members have been able to co-create and reshape programs, services, and systems that meet the needs of the patient population, ensure clinical quality and effectiveness, and integrate appropriately with local community culture.

Lessons Learned

Each of the three consortia earned the trust of their membership as well as the broader health care community in order to effectively lead cross-regional information and data sharing, facilitate peer groups, and drive advocacy efforts on behalf of health centers. Working collaboratively across regions in rural northern California in partnership with PHC has resulted in a unique and sophisticated primary care delivery system that provides access to underserved, hard-to-reach populations and meets the needs of rural and frontier communities. Lessons learned include:

- Education and transparency are critical for success: In order to successfully advocate for rural health centers, HCCN leaders must dedicate sufficient time to educating members, as well as community stakeholders and political representatives, on the topic at hand in order to progress in a collaborative fashion and achieve success. The success of implementing a COHS model for Medi-Cal Managed Care expansion in northern California counties was achieved by creating an environment of transparency. The HCCNs achieved transparency through ongoing, open forums driven by members and stakeholders in which feedback, discussion, and debate are encouraged in order to achieve consensus on advocacy priorities and decisions.

- Consistent communication is essential: By effectively harnessing technology, the Northern CA HCCNs are able to maintain relationships to collectively address issues across the 40,000 square miles of

collective service area. HCCNs use a combination of phone, webinar, video, and in-person meetings to continuously engage the geographically diverse community of health center leaders across the region and provide multiple forums to pose questions, gain clarifications, and discuss challenges and opportunities. Meanwhile, HCCN staff communicates weekly and utilizes a shared tracking system so that they can meet their targets to support the membership.

- Relationships drive progress: Rural and frontier health centers are able to provide high quality health care services in large part due to their collaborative relationship building with other local health care providers and community based organizations in order to maximize the capacity that exists in smaller communities. The regions' successful initiatives have relied on bipartisan partnerships with a variety of stakeholders and policy makers across 13 counties. Additionally, the strong relationships that have been built with PHC have allowed swift progress to improve patient access and health outcomes in these new service areas.

Looking Ahead

Health centers in the rural north enjoy a long history of working creatively to implement innovative solutions that will meet the needs of their communities. This experience has reinforced for rural health care leaders the critical impact that can be gained through intentional collaboration and proactive partnerships. The bi-partisan success that was achieved to expand the COHS Medi-Cal managed care plan to 8 rural counties was an important step to improving access and health care outcomes in the rural north. It has been through continued trust, data-driven communication, and peer engagement that health centers are able to continue to strengthen their networks and capitalize on opportunities to achieve the triple aim framework. As health centers look towards the future, several significant initiatives remain as essential priorities for our rural health care system, including workforce strategies to ensure that there are sufficient, diverse, and well qualified health care providers in addition to well-trained support staff to serve all of the newly insured patients for their medical, dental, and behavioral health needs; quality improvement efforts across the region that will allow providers to test innovative and evidence-based interventions and track and measure their progress in improving a number of patient health outcomes; and finally payment reform efforts that will revolutionize the way that providers are reimbursed for the care that they provide to low-income patients.

The North Coast Clinics Network, Health Alliance of Northern California, and Alliance for Rural Community Health look forward to continuing to lead efforts in our regions that foster collaboration and strategic partnerships in order to tackle these exciting opportunities ahead and ultimately improve the health and wellbeing of our rural communities.

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