



California Health Care Foundation

PRIMED

Medicaid Pilots Open Door for Innovation in California

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Safety-net health care providers and plans are under extraordinary pressure to transform how they deliver care — an effort that technology and entrepreneurs can support and accelerate.

Introduction

Since the implementation of the Affordable Care Act (ACA) in 2014, Medi-Cal has grown to cover almost one in three Californians — over 13.5 million people — and remains the largest state Medicaid program in the nation. In addition to expanding the number of Medi-Cal recipients, the ACA catalyzed two other key trends, both of which will persist even if the ACA undergoes changes at the federal level.

First, the ACA set in motion payment reforms that hold health care providers and payers more accountable for their patients' care. Second, it accelerated the growth of managed care plans, through which a state provides a monthly capitation payment for the care of each Medicaid patient. In 2010, these plans were available only in 25 of California's 58 counties, and covered 55% of Medi-Cal enrollees.¹ By January 2017, they were available in all 58 counties and covered 80% of Medi-Cal enrollees. Now that they bear a larger share of the risk for sicker and costlier patients, Medi-Cal health plans and providers are incentivized to operate in a fundamentally new way.

Together, the growing use of managed care in Medicaid and the payment incentives put in place by the ACA are catalyzing a shift toward value-based care. Rather than maximizing the *volume* of care delivered, regardless of outcome, safety-net payers and providers must now optimize *value*, which couples improved health with manageable costs. At the same time, they must still grapple with limited resources and complex patient populations. Delivering value despite those challenges will require unprecedented efficiency and ingenuity — the safety net is primed for technology-driven innovation.

California's Health Policy Pilots Reveal Broader Trends

The 1% of Medi-Cal enrollees with the highest costs continues to account for more than 25% of Medi-Cal spending.² Regardless of how the federal debate on health care financing is resolved, the Medi-Cal delivery system needs to find new ways to keep its costs under control. Legislatures in California and in many other states are committed to maintaining the ACA's Medicaid expansion to address the needs of lower-income Americans no matter what.³

To meet the needs of the evolving Medi-Cal managed care system, California is piloting new policy initiatives to encourage payers and providers in the safety net to adapt their models of care.

Examining these pilots and initiatives allows for tracking broader trends, the changes they require from providers and health plans, and the opportunities they present for impactful innovation. To explore these trends, six pilots and initiatives were identified that tackle the most important challenges facing California's safety net (see the appendix for more information about each):

- ▶ Coordinated Care Initiative
- ▶ Drug Medi-Cal Organized Delivery System
- ▶ Federally Qualified Health Centers Alternative Payment Methodology Pilot
- ▶ Health Homes for Patients with Complex Needs
- ▶ Public Hospital Redesign and Incentives in Medi-Cal
- ▶ Whole-Person Care Program

To carry out these pilots, safety-net providers and plans need high-value innovation that engages patients outside of the clinical setting, makes data accessible and usable for all health system staff, and enhances coordination between the health system and its external partners. Innovators need to consider how their products fit in with provider and payer workflows, and how they link with existing technology and infrastructure.

How Are California's Policy Shifts Affecting Safety-Net Providers and Health Plans?

Broadly, many of the pilots and initiatives illustrate two trends related to the shift toward value-based care: the redesign of payment methods and incentives, and the need for increased coordination and integration across the broader health ecosystem, including social service organizations that support non-health care needs.

Redesigning Payment Models and Incentives Across the Delivery System

Nationwide, states are exploring ways to improve quality and reduce the cost of care in an environment with tremendous variation between providers and plans. California has focused its efforts on realigning payment around performance, which it assesses using a comprehensive set of measures relating to quality, enrollment, and usage, among other criteria. As a result, many of the state's pilots focus on encouraging health systems to develop the capabilities required to track and improve these new performance measures. All of the pilots necessitate a sophisticated ability to capture data to monitor patient services and health outcomes, and many organizations are implementing more than one of them.

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Pilots

Public Hospital Redesign and Incentives in Medi-Cal (PRIME). PRIME is a program in California's Medi-Cal 2020 Waiver that provides funding for designated public hospitals (DPHs) and district/municipal public hospitals (DMPHs) throughout California.

The goals of the program are to:

- ▶ Increase the system's capacity to provide patient-centered, data-driven, team-based care to high-cost patients and those at risk of becoming high-cost patients.
- ▶ Strengthen data analysis capacity to improve point-of-care services, complex care management, and population health management.
- ▶ Improve population health outcomes for Medi-Cal beneficiaries, as demonstrated by the achievement of performance goals related to clinical improvements, preventive interventions, and patient experience metrics.
- ▶ Improve the integration of physical and behavioral health care and coordination among participating PRIME entities.⁴

Also, PRIME requires robust data collection and year-over-year performance improvement across three core domains:

- ▶ Outpatient delivery system transformation and prevention
- ▶ Data gathering in high-risk or high-cost populations
- ▶ Resource use efficiency

In addition to selecting optional projects, DPHs are required to participate in a standardized set of six projects across the three domains. The type and number of metrics varies by project, but most of the 54 hospitals participating in PRIME are now required to collect more than 50 new metrics to report progress.⁵ To implement PRIME, DPHs and DMPHs in California need to become proficient in delivering a new type of integrated care while being able to report on their progress.

Federally Qualified Health Centers Alternative Payment Methodology pilot. In 2015, California's legislature authorized a three-year pilot program to encourage Federally Qualified Health Centers (FQHCs) to implement a new Alternative Payment Methodology (APM).

Under the plan, Medi-Cal managed care plans are provided with a capitated rate that includes each participating FQHC's prospective payment system rate. FQHCs then receive their own clinic-specific per-member

per-month (PMPM) capitation payment for each patient assigned to their primary care practice.^{6,7} The pilot allows for greater flexibility in providing patient-centric innovations, such as same-day primary care visits, in addition to behavioral health, group, email, and phone visits.⁸ While some clinics have already developed the technology, workflows, and internal processes needed to do email, telephone, and video visits, many have not. Through their participation in the pilot, these FQHCs are not only developing the capacity to deliver different types of care, but are building systems to capture, integrate, and use this information about the care they are providing.

Incentivizing Care Coordination and Integration Across the Safety Net

Health plans urgently need to work with providers, county agencies, and social support services to understand patient needs and to prevent and manage health issues related to a person's environment. While working in this new way is ultimately better for individual and population-level health, it can create enormous coordination challenges. The following policy pilots and initiatives encourage providers to develop systems that enable and enhance coordination between different groups:

- ▶ **Whole-Person Care (WPC).** Part of the Medi-Cal 2020 waiver, WPC is designed to integrate clinical health, behavioral health, and social services to create better outcomes for beneficiaries. WPC pilot teams include Medi-Cal managed care health plans, clinical and mental health providers, public agencies and departments, and community partners that work together to integrate and improve care for high-risk Medi-Cal beneficiaries.

Among the 25 participating counties in California, WPC is anticipated to reach over 331,000 of Medi-Cal's most frequent users in the first five years.⁹ Participating entities identify populations of focus, share data between actors and systems, coordinate care in real time, and evaluate individual and population progress.¹⁰ Target populations frequently include patients who have high rates of avoidable emergency department visits, hospital admissions and nursing facility placements, and those who are homeless or at risk of homelessness.¹¹

To best support these populations, health systems need to integrate an awareness of patients' social

determinants of health into the clinical setting. Integration and coordination among actors with different data systems and legal data-sharing restrictions presents significant challenges, but offers enormous potential for innovation to solve these complexities and better serve patients and populations. [Read more](#) about the role of emerging technology in helping the health care system address these unmet social needs.

- ▶ **Health Homes for Patients with Complex Needs.** The Health Home Program (HHP), authorized by the ACA, integrates primary, acute, and behavioral health across providers, plans, and social services for Medi-Cal's highest users. The six required categories of services include comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and the use of health information technology to link services.¹² Like Whole-Person Care, HHP addresses patient's social determinants of health, and will require providers to solve coordination challenges beyond the health system.

Implications of the Policy Pilots

With these pilots, California has formalized a cost incentive and business rationale for clinics, hospitals, and health plans to provide care in a new way, with increased urgency for organizational transformation. It is often imperative for safety-net organizations to succeed in these types of incentive programs if they are to maintain financial solvency. These pilots are relevant to the safety net more broadly, as they provide additional attention, resources, and buy-in, which accelerate the evolution of both health and community services.

"We're a small organization. These policy pilots represent tens of millions of dollars to us. PRIME is \$20-30 million, and Whole-Person Care is at least as much. For our total budget of \$250 million, that's a big chunk, so we're focused on improving care to secure funding. Leadership is bought into that."

— Health plan CEO

What New or Improved Capabilities Does the Safety Net Need?

The current trends in Medi-Cal require providers and health plans to develop new ways to deliver care. These developments fall into three broad categories, as shown in Table 1.

Challenges and Solutions

Proactively Identify and Engage with Patients

INSIGHT: Providers and health plans are seeking to effectively change patient behavior outside of the clinical setting.


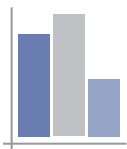

In a value-based care system, providers and plans need to develop a different kind of relationship with their patients. Rather than waiting for patients to seek care, they now need to reach out to patients and promote health beyond the clinical setting. Also, as patient engagement gains importance, providers and plans are

becoming more focused on customer satisfaction. This transition requires providers to engage patients in their care differently and to develop ways for patients to easily book appointments, communicate with their providers, view laboratory or radiology results, and see notes about their care. Patients feeling connected to their care not only increases satisfaction but contributes to more effective self-management and improved health outcomes.

Safety-net providers and plans face many challenges when engaging with patients in this way. For instance, one provider emphasized the importance of the patient portal being accessible by smartphone, as 75% of members have smartphones but fewer have regular access to desktop computers.

Additionally, sharing clinical notes with patients may open opportunities for patients to have the information they need to manage their health, but provider notes are written in English and often not at a literacy level appropriate for patients. One provider aims to have all patient communication written at a third-grade reading level but is unsure of how to give patients access to provider notes at this level of accessibility. Finally, because Medi-Cal

Table 1. Key Capabilities and Innovations Needed to Respond to Medi-Cal Trends

<p>1. Proactively identify and engage with patients</p>	<ul style="list-style-type: none"> ▶ Identify individual patients and connect with them outside of clinical encounter. ▶ Develop effective patient engagement strategies that meet patients' language, literacy, and technology needs. ▶ Improve the organization's ability to consistently and accurately capture patient data — including data on mental health, substance use, and social determinants — and use it to understand individual and population-level needs.
	
<p>2. Use data to inform decisionmaking and workflows</p>	<ul style="list-style-type: none"> ▶ Report data to better understand performance and to comply with regulatory requirements. ▶ Understand costs of various processes and interventions to improve care (i.e., improved cost accounting). ▶ Use data analysis to predict which patients have the highest risk of poor health outcomes, to more effectively target outreach and interventions. ▶ Deploy data visualization tools to enable staff to take meaning from vast quantities of data.
	
<p>3. Coordinate across safety-net providers, plans, and social services</p>	<ul style="list-style-type: none"> ▶ Identify common patients and share data to support coordinated care across various clinical providers. ▶ Collect and use data to understand patients' social needs. ▶ Target, analyze, and match clinical, behavioral, and social needs, and provide facilitated handoffs to relevant providers. ▶ Ensure community-wide connectivity, relationships, and partnerships between clinical care and social service settings.
	

enrollees are increasingly covered under managed care contracts, plans are being asked to comply with more regulatory requirements. This makes it increasingly important for plans to connect effectively with patients.

Several technological capabilities are required to establish and maintain this type of patient relationship. For instance, providers need an Enterprise Master Patient Index, which uses a series of algorithms to identify duplicative records and match patients across various settings. Providers also need to promote use of patient portals and telehealth technologies that allow patients to interact with providers when and where it is convenient for them.

“We are required to inform patients by mail who their primary care doctor is, but due to frequent moves, patients often don’t receive this information and end up going wherever care is most accessible to them. Then we must send an updated card with the new primary care physician listed, sometimes three times in one month, which creates an additional administrative burden.”

— Health plan CEO



OPPORTUNITIES FOR INNOVATION

These challenges raise a number of important opportunities for innovation:

- ▶ Enhance patient engagement in their health management through multichannel communication.
- ▶ Develop the ability to efficiently identify individual patients as they move in and out of various systems.
- ▶ Increase patient access to medical information and plans for self-management (e.g., literacy and language translation).

SPOTLIGHT

Partnership Between Clinic and Innovators to Develop CareMessage

In preparation for its participation in the FQHC alternative payment model, Northeast Valley Health Corporation (NEVHC) needed to enhance its ability to effectively reach patients for initial enrollment and ongoing engagement in ways appropriate to patients’ language, literacy, and technology needs. To do this, NEVHC had to be able to text its members in real time. NEVHC began to develop the technology internally, but early in the project CareMessage offered it the chance to test CareMessage products in clinics without an initial investment. Once NEVHC tested out CareMessage, it became clear that the product could deliver results beyond what NEVHC could build independently. By offering a pilot, CareMessage allowed NEVHC to be certain about the product’s ability to work in their unique setting before adoption.

One of NEVHC’s first projects with CareMessage was a goal-setting program. NEVHC is recognized as a Primary Care Medical Home (PCHM) through the Joint Commission, and one of the core components to this model of care is developing self-management goals with patients. Patients who used CareMessage for the goal-setting program reported that the text messages helped them change their identified behavior, and almost all agreed that the text messages made them feel more connected to their provider. Although it did not show initial improved outcomes with some patients, NEVHC decided to continue the contract because patient satisfaction was markedly improved. As one of NEVHC leaders said, “They do it better than we can. It’s more seamless to the users but complex to the developers. With CareMessage, it felt like someone was actually texting you.”

However, CareMessage was unable to integrate with NEVHC’s electronic health record (EHR) system, so clinicians and care teams couldn’t see the content of each patient’s self-management goals or any progress toward these goals in the system. Unless a patient mentioned their participation or progress during the visit, clinicians weren’t able to reinforce and realign the self-management goals with the clinical care plan. Integration with EHR systems is crucial to gaining long-term benefits from collecting additional patient data.

Use Data to Inform Decisionmaking and Workflows

INSIGHT: Providers and plans often have plenty of data, but lack tools to ensure that data are used to inform decisions effectively.

Providers and plans are being challenged to more effectively target health care interventions toward the populations that need care most. This means that they need a variety of tools and technologies that enable them to stratify patients, better understand the costs of care, and collect and report information that demonstrates how their interventions contribute to improved patient health outcomes. However, many providers and plans in the safety net lack basic data functionalities, such as cost accounting tools that would help them understand the total costs of care for various interventions. Other providers have noted that few risk-stratification models consider patients' changing social circumstances, which is critical to predicting needs among the Medi-Cal population. Thus, plans and providers are left relying primarily on an individual's past health history as the best predictor of future needs, which is of limited use.

Another challenge is that the health care industry captures large quantities of data without sufficient capacity, staffing, or workflow to effectively analyze and apply it. Thus, for organizations to effectively use these data, they need the data analysis capacity to make meaning of data, data visualization to translate that to end users, and trained staff who have the time to interpret and use the information. Providers and plans are more cautious than ever about ensuring they have these vital prerequisites in place.

Organizations often have to significantly change the way they operate to accommodate incoming data. To implement the Whole-Person Care pilot in Contra Costa County, the health system hired an additional 100 community health workers to conduct patient outreach. The data collection process included a time-consuming multistep process: performing patient phone screening to assess unmet needs, documenting screening information in the patient EHR, consulting a community resource directory to find available resources (provided by Health Leads), making necessary referrals, and then capturing the resulting action plans in the EHR.

Patient registries are a key tool that allow providers to report on metrics for a specific set of patients over time. These registries ideally pull information from individual patients' records and compile a snapshot for a particular group.



OPPORTUNITIES FOR INNOVATION

These challenges raise several important opportunities:

- ▶ Make data accessible and usable for all health system staff to generate insights, regardless of position or educational background.
- ▶ Improve ability to effectively assess and prioritize care for patients in the safety net using appropriate models that account for social factors.
- ▶ Help providers and plans effectively use the data that currently exist in their systems.

“There is no validated risk-stratification model in the safety net. We look at patients that are currently high utilizers and focus on them, rather than focus on individuals who are likely to be high utilizers in the future. In the Medicaid population, a lot of risk factors are social — homelessness, food insecurity, high rates of violence in your community. Until you can have those data streams work together, you won't know where to do proactive outreach.”

— Public hospital COO

SPOTLIGHT

West County Health Centers' Health Care for the Homeless Initiative

West County Health Centers (WCHC), an FQHC located in West Sonoma, has taken a sophisticated approach to leveraging technology to better understand risks and to target interventions among homeless people and opioid users. For its Health Care for the Homeless Initiative, WCHC partners with the county to receive data from the Homeless Management Information System (HMIS), which is matched to the health centers' EHR system. To use the data, WCHC uses a collection of tools from Unifi, ArcGIS, and Tableau.

WCHC first implemented Unifi software to catalog and prepare the vast amount of data being added. WCHC used this platform to match the health centers' EHR information, HMIS data, and claims data from their health plan and Centers for Medicare & Medicaid Services (CMS). (WCHC is also preparing to add county morbidity data, education data, and criminal justice data to the same platform.) Next, WCHC layered Tableau onto the platform to allow advanced, self-service data visualization. This piece allows the end user to make meaning of the data and easily manipulate them to generate insights about the patient population. As the final piece, WCHC used ArcGIS to compile geographic data onto a map of the county.

WCHC staff are piloting a variety of creative ways to leverage this rich data set to engage with homeless people in the community. One such pilot aims to tag the specific coordinates of each homeless outreach encounter. Eventually, those tags will be aggregated to create maps and identify living patterns of the homeless population throughout the county, enabling WCHC to direct additional services to high-risk encampment areas.

In another initiative, WCHC employed technology to combat the opioid crisis. Using the same tools described above, WCHC highlighted patients who were prescribed high-dose opioids and mapped this population within their service area. The map revealed a hot spot within a particular neighborhood. With this precise information, WCHC began working with officials and social service agencies to target intervention efforts.

While Sonoma County is only beginning to implement the Whole-Person Care pilot, it will be able to leverage WCHC's systems to better understand needs and target resources among the homeless population and people with substance use disorders. WCHC's next step is to make its database multi-tenancy and to explore how other providers and community organizations can use the system. Equipped with advanced technology, WCHC now plays a convener role in its community, and is encouraging county agencies and social services to join it in preventing unnecessary care and improving health outcomes.

Coordinate Across Safety-Net Providers, Plans, and Social Services

INSIGHT: *There is a need to enhance communication and relationships among clinical care and social service providers to provide high-quality and low-cost care.*

The patients in the safety net are among California's most vulnerable people. To get support for their health and social needs, they are required to navigate some of the most complex and disconnected systems in the state. Because of poverty and housing instability, many low-income people seek care and social services in different places. Each time someone enters a new care setting, the provider teams start from the beginning. Even if tests and procedures have already been conducted in another care setting, there is usually no way to efficiently obtain that information. Thus, providers will either order duplicate

The patients in the safety net are among California's most vulnerable people. To get support for their health and social needs, they are required to navigate some of the most complex and disconnected systems in the state.

tests and procedures, leading to increased cost, or delay the evaluation for a subsequent visit to wait for prior records, leading to delayed or even missed diagnoses. Either way, this inefficiency brings substantial health, economic, personal, and societal costs.

To avoid delivering poor-quality care, providers need to be able to communicate and coordinate care in different settings. This requires health information exchanges and case management systems that allow providers to share data about patients and pick up care where another provider left off. Due to privacy concerns, particularly related to substance use disorders and mental health conditions, data-sharing platforms need to allow users to view the platform with differing levels of access and privacy, ensuring sensitive information is available only to appropriate users.

Finally, care providers have learned that executing policy pilots and adopting value-based care more broadly requires a reliance on community assets and people with lived experience. Community health workers and peer supports contribute to weaving the fabric of coordination necessary to meaningfully shift the model of care. So technology will need to be used effectively by many different kinds of users and in different settings.



OPPORTUNITIES FOR INNOVATION

These challenges raise several important opportunities:

- ▶ Build and expand health information exchanges that provide complete information and enable “mutable or consumable” functionality that withholds certain sensitive information from particular audiences.
- ▶ Develop a case management platform that allows providers to share data about patients and assume care where another provider left off.
- ▶ Create collaboration platforms that are both accessible and easy to use for new types of health workers, such as community health workers and peer support specialists.

SPOTLIGHT

ACA Encouraging Collaboration in Los Angeles

The expansion of Medicaid under the Affordable Care Act marked the inclusion of a new population in our health care system: low-income adults involved in the justice system. The L.A. Department of Health Services (LADHS) is exploring how to support them in reentry to the L.A. community through the Whole-Person Care pilot. During reentry, people with behavioral, substance use, or chronic medical conditions are at high risk of rapid health deterioration. To better support their transition, LADHS is focusing on improving information sharing and care management capabilities to facilitate collaboration between providers and social service agencies.

In doing so, LADHS faces three challenges. First, it has to build a care management platform tool. Next, it must implement change management that enables it to scale the adoption, uptake, and utilization of new systems. Finally, LADHS must gain an understanding of the legality and regulations around sharing information on conditions like substance use disorder.

LEARN MORE

Dive deeper into the opportunity that exists for technology to help identify and meet the social needs of patients in the safety net. Read *Addressing Social Factors in the Health Care Safety Net*, another report in the PRIMED collection.

Implications for Innovators: What Does High-Value Innovation Look Like?

The principles described below will help ensure that solutions are designed for successful implementation and use specifically within the safety net.

PRINCIPLES OF HIGH-VALUE INNOVATION

RATIONALE

Optimal Fit with Patient Context



Innovative tools must meet the unique circumstances of patients in the safety net, which can include a wide array of needs, including those related to language, literacy, culture, and technology. Patients may also struggle with a variety of social needs outside of the health care setting, such as a lack of reliable transportation or access to computers or phones, that can affect their ability to get care.

Optimal Fit with Provider Context



Solutions must fit the unique circumstances of safety-net providers who have a strong mission orientation and deep connections within the communities they serve. Their care teams often include a variety of nonmedical staff, such as community health workers and peer support specialists, some of whom may have language and literacy needs unique to their environment.

Linkages and Interoperability



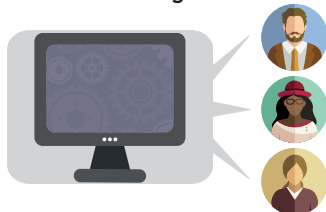
Solutions must be designed to complement and integrate with existing technology, particularly EHR systems. Innovators should build on existing systems, workflows, and staff expertise whenever possible. Requiring providers to switch between interfaces or duplicate work can create significant barriers to adoption, especially for under-resourced clinics and hospitals.

Accessible, Actionable Data



Solutions that collect or produce data should ensure that those data can be efficiently accessed, analyzed, and ultimately applied to improve care, workflows, or costs. Innovators must consider who will use the data and how they'll access it, as well as how they can maintain and ensure its accuracy and validity.

Tailored Design



Solutions should be rigorously prototyped to demonstrate value in a variety of safety-net settings. Codesigning or modifying products with input from safety-net partners cannot only increase their applicability to this market, but also serve as proof of concept in other markets.

Facilitated Purchasing and Implementation



Pilots and demonstrations can help prove a product's value to risk-averse and resource-constrained safety-net customers. Innovators should be aware of the dynamics surrounding purchasing decisions, which are growing increasingly complex as providers become more interconnected.

The Greatest Opportunities for Innovation

Innovation that addresses the needs of safety-net providers and plans described in this primer would help contribute to increased quality, accessibility, and affordability of health care in these settings. Specifically, there are several particularly promising opportunities for such innovation:

- ▶ **How might patients be more meaningfully engaged in providing data about their health in ways that inform provider interactions and ultimately increase patients' control of their health management?** In addition to the data collected by providers, patients themselves are cataloging considerable amounts of data on their behaviors through fitness trackers, pedometers, and other consumer tools. If integrated seamlessly and securely into existing workflows, these data could help providers more effectively manage and support patients outside of the clinic.
- ▶ **How can the extensive data collected by payers, providers, and social service agencies better support effective preventive care?** Health care organizations need innovative ways to leverage the vast amounts of data being collected across care settings in order to predict which patients would benefit most from targeted prevention efforts. The most valuable analytical tools would comprehensively assess patients' life circumstances, including changes in their social determinants of health, and be usable by many different types of providers.
- ▶ **How can different health system actors access and effectively apply relevant information collected by other providers about a patient to provide seamless, coordinated, and nonduplicated care?** Regardless of which door a patient uses to enter the health system, continuity of care is essential. Innovative case management platforms and similar tools should allow providers to view relevant prior records, log their care delivery, and share information with others, including social service providers.

- ▶ **How might innovation empower providers to continue to evolve without having to replace existing technology infrastructure?** There is ample opportunity for innovators to focus on improving the efficiency, interoperability, and utility of existing products. Many resource-limited safety-net providers are overwhelmed by the cost and time associated with replacing legacy systems, so this area of opportunity will persist.

Conclusion

Health care systems in California and the nation are undergoing a major transition to value-based care. California's health care pilots and initiatives offer financial incentives to accelerate this transition to better serve the nearly 14 million safety-net patients in California. There are many opportunities for innovation to play a transformative role in this transition. Beyond the potential to capture a large market opportunity, there is enormous potential for deep social impact that comes from supporting improved health outcomes for the one-third of California's population with the greatest need. Also, the safety net is a willing partner in prototyping, refining, and furthering innovation while testing the capacity of new tools. As one health system chief medical information officer shared, "I always tell entrepreneurs, 'If you can make your solution work in the safety net, you can probably make it work anywhere.' We have so many challenges here, so starting in the safety net would open a great market."

TALK TO US

If your company has developed an innovative solution that is addressing any of the opportunities outlined here, we want to hear from you. Email us at InnovationFund@chcf.org or tweet at us [@chcfinnovations](https://twitter.com/chcfinnovations).

Appendix: California's Health Policy Pilots

Note: The details of these pilots are subject to change. Visit dhcs.ca.gov for the most up-to-date information.

Whole-Person Care (WPC)^{13,14}

- Summary** The Medi-Cal 2020 Section 1115 waiver authorized the creation of a five-year, up to \$1.5 billion federally funded pilot program to test county-based initiatives that coordinate health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and have poor outcomes.
- Participants** Health systems including county agencies, health plans, hospitals, clinics, and social service providers.
- Timeline** WPC was approved for the five-year window through December 31, 2020. It will be implemented throughout this time frame with two rounds of applicants.
- Target populations** The Medi-Cal 2020 waiver listed populations that WPC pilots could target, but permitted applicants to identify additional populations. Fifteen of the 18 approved first-round pilots will target high utilizers with repeated incidents of avoidable emergency department use, hospital admissions, or nursing facility placement. Fourteen of the 18 approved first-round pilots will target people who are homeless or at risk of homelessness.
- Funding** Funded by the Medi-Cal Section 1115 waiver: \$1.5 billion of federal Medicaid matching funds and \$1.5 billion from local funds provided through intergovernmental transfers.
- Scope** Between the first and second round, 25 of California's 58 counties will participate, reaching over 331,000 Medi-Cal beneficiaries over the first five years.
- Strategies**
- ▶ Increase integration between county agencies, health plans, providers, and other entities
 - ▶ Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries
 - ▶ Reduce inappropriate emergency department and inpatient services
 - ▶ Improve data collection and sharing among local entities to support sustainable ongoing case management, monitoring, and strategic program improvements
 - ▶ Increase access to housing and support services

Public Hospital Redesign and Incentives in Medi-Cal (PRIME)^{15,16}

- Summary** A five-year initiative under the Medi-Cal 2020 Section 1115 waiver that builds on the Delivery System Reform Incentive Payments program established under the Bridge to Reform waiver. The goal of PRIME is to continue significant improvement in the way care is delivered through California's safety-net hospital system to maximize health care value and to move toward alternative payment models such as capitation and other risk-sharing arrangements.
- Participants** Seventeen designated public hospitals (DPHs) and 37 district/municipal public hospitals (DMPHs) in California.
- Timeline** PRIME was approved for the five-year window from December 30, 2015, through December 31, 2020. It will be implemented throughout this time frame.
- Target populations** For DPHs the target population includes:
- ▶ All Medi-Cal managed care primary care cases assigned to the DPH as listed by the Department of Health Care Services (DHCS) at the end of each measurement period.
 - ▶ People with at least two encounters by DPH for an eligible primary care service during the measurement period.
- For DMPHs, the target population includes Medi-Cal beneficiaries with at least two encounters by the participating entity.
- Funding** PRIME entities may receive up to \$3.7 billion in federal Medicaid funding over five years, which must be matched by the state share.
- Scope** PRIME is being implemented in 17 DPHs and 37 DMPHs in the state of California.
- Strategies** PRIME provides incentive payments for quality improvement. Hospitals select projects to implement across three domains:
- ▶ Outpatient Delivery System Transformation, including a major focus on prevention.
 - ▶ Improving care for targeted high-risk or high-cost populations.
 - ▶ Reducing overuse and misuse of identified high-cost services, eliminating use of ineffective or harmful services, and addressing inappropriate underuse of effective services.
- DPHs must implement at least nine projects, including a specified number from each domain. DMPHs must implement at least one project across the three domains.

Health Homes for Patients with Complex Needs^{17,18}

- Summary** An ongoing initiative authorized by Section 2703 of the Affordable Care Act to develop a network of providers that will integrate and coordinate primary, acute, and behavioral health services for the highest-risk Medi-Cal enrollees.
- Participants** Medi-Cal managed care plans (MCPs) will organize the payment and delivery of services. Plans certify and contract with Community-Based Care Management Entities (CB-CMEs), which may include hospitals, clinics, physicians, local health departments, community mental health centers, and substance use disorder treatment providers. County mental health plans and county substance use disorder agencies that participate in the Drug Medi-Cal waiver have the option to serve in the MCP or CB-CME role for Health Homes Program beneficiaries with conditions that are appropriate for specialty behavioral health treatment.
- Timeline** DHCS announced that the implementation of the state's Health Homes Program will begin July 1, 2018, and be phased in through three groups every six months.
- Target populations** The HHP is intended to be an intensive set of services for a small subset of members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk 3% to 5% of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both a select group of disease classification codes for each eligible chronic condition, and a high level of complexity.
- Funding** Ninety percent federal matching funds are available for the first eight quarters of the HHP, and are subsequently reduced to 50% federal match for the population that was Medicaid eligible before 2014. People eligible through the Medicaid optional expansion will continue to receive 100% Federal Medical Assistance Percentage for health home services, with the match gradually decreasing to 90% in 2020.
- Scope** HHP will be implemented between January 2018 and January 2019, and will be rolled out in three different groups. These three groups are intended to include 29 of California's 58 counties.¹⁹
- Strategies** HHP will provide reimbursement for care coordination services and benefits. There are six categories of required services:
- ▶ Comprehensive care management
 - ▶ Care coordination and health promotion
 - ▶ Comprehensive transitional care
 - ▶ Patient and family support
 - ▶ Referral to community and social support services
 - ▶ Use of health information technology to link services, as feasible and appropriate

Federally Qualified Health Centers (FQHCs) Alternative Payment Methodology (APM) Pilot^{20,21}

- Summary** California State Senate Bill (SB) 147 (Chapter 760, Statutes of 2015) authorized a three-year APM pilot program for county and community-based FQHCs willing to participate in the pilot program. The purpose of the FQHC APM Pilot is to incentivize delivery system and practice transformation at FQHCs. This would be achieved through new flexibilities available under a capitated model that would move clinics away from traditional volume-based services to a payment method that better aligns with the evolution of health service delivery and financing. The proposed APM structure provides participating FQHCs with the flexibility to deliver care most effectively, without having to worry about the more restrictive traditional billing structure. With this new system in place, FQHCs will begin to expand upon the innovative forms of care that are not reimbursed under traditional volume-based systems.
- Participants** Federally Qualified Health Centers.
- Timeline** TBD
- Target populations** The APM pilot transitions children, nondisabled adults, seniors and persons with disabilities, and expansion adults to PMPM payments.
- Funding** No additional funding outside regular Medi-Cal.
- Scope** While there is no predetermined number of FQHCs that can participate in the pilot, health center associations have indicated that 75 health center sites in 14 counties have expressed strong interest in participating.²²
- Strategies** Examples of nontraditional services could include but are not limited to:
- ▶ Integrated primary and behavioral health visits on the same day
 - ▶ Group visits
 - ▶ Email visits
 - ▶ Phone visits
 - ▶ Community health worker contacts
 - ▶ Case management

Drug Medi-Cal Organized Delivery System (DMC-ODS)²³

Summary	The DMC-ODS is a voluntary pilot program that offers California counties the opportunity to expand access to high-quality care for Medi-Cal enrollees with substance use disorders (SUD). The goal of the DMC-ODS is to demonstrate how organized SUD care improves beneficiary health outcomes while decreasing system-wide health care costs. Counties that choose to participate in the DMC-ODS are required to provide access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria. This approach is expected to provide eligible enrollees with access to the care and services they need for a sustainable and successful recovery.
Participants	Participants in the effort count various county agencies including county SUD and behavioral health agencies, public health officials, and probation officers, and providers, including FQHCs and drug treatment service providers, as well as health plans and other community social services. Three counties have executed a contract with DHCS, 12 counties across the state have approved implementation plans, and six others are in the process of developing implementation plans.
Timeline	Pilot approved in August 2015 and will run through 2020.
Target populations	Medi-Cal beneficiaries with diagnosed SUDs.
Funding	Cost of waiver services shared between federal government, state government, and counties. ²⁴
Scope	DHCS has approved implementation plans from 19 counties in California, and another 6 counties have implementation plans in draft form. Overall, 95% of all eligible Medi-Cal beneficiaries reside in counties that have submitted DMC-ODS implementation plans. ²⁵
Strategies	Counties that participate in the DMC-ODS are required to provide to all eligible beneficiaries a continuum of services modeled after the ASAM Criteria. Services required to participate in the DMC-ODS include: <ul style="list-style-type: none">▶ Early intervention (overseen through the managed care system)▶ Outpatient services▶ Intensive outpatient services▶ Short-term residential services (up to 90 days with no facility bed limit)▶ Withdrawal management▶ Opioid/narcotic treatment program services▶ Recovery services▶ Case management▶ Physician consultation

Coordinated Care Initiative (CCI)²⁶

Summary	An ongoing initiative to promote coordinated care to seniors and persons with disabilities who are eligible for both Medi-Cal and Medicare in seven California counties through Cal MediConnect (CMC) managed care plans.
Participants	Cal MediConnect plans in seven counties and their contracted providers, as well as MCPs in the seven CCI counties. CMC plans must sign an agreement with county mental health agencies agreeing to coordinate services, though the services are carved out and are not included in the capitation rate.
Timeline	Phased-in enrollment into Cal MediConnect plans on a county-by-county basis began in April 2014. The three-year program budget continued through the end of 2017 and was not extended.
Target populations	Targets those who are dually eligible for Medi-Cal and Medicare and live in one of the seven participating counties. Seventy percent are age 65 and older. Approximately 30% are younger people living with disabilities.
Funding	Federal funding for CCI is available through California's renewed Section 1115 Medicaid waiver at California's traditional 50% federal financing participation.
Scope	CCI was piloted in seven counties in California.
Strategies	The CCI provides a PMPM for the beneficiary's Medicare and Medicaid services. CMC plans coordinate a beneficiary's benefits, including medical, behavioral health (other than the county carve-out), and long-term services and supports (including institutional, home, and community-based services). CMC plans offer: <ul style="list-style-type: none">▶ All a patient's Medi-Cal and Medicare benefits, including prescription drugs▶ A health risk assessment▶ Care coordination through a care coordinator, an interdisciplinary care team, and an individualized care plan▶ Additional transportation and vision benefits▶ Care plan option services not traditionally reimbursed under Medicare and Medi-Cal, including ramps, grab bars, and similar items, to keep people safe in their homes

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