

HRSA 95-164

6205

**A TEST OF LOCAL LEVEL  
HEALTH CARE REFORM STRATEGIES  
IN SELECTED CALIFORNIA COUNTIES**

**FINAL REPORT**

Contract Number: HRSA 40-95-0024

Submitted to:

Karen Thiel Raykovich, PhD  
Office of Planning, Evaluation, and Legislation  
Health Resources and Services Administration  
Parklawn Building, Room 14-36  
5600 Fishers Lane  
Rockville, Maryland 20857

Submitted by:

Fresno Regional Foundation on behalf of the Institute for Health Futures  
Birch & Davis Associates, Inc., Subcontractor

May 24, 1996

# Institute for Health Futures

## *Fresno Regional Community Foundation*

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1999 Tuolumne Street  
Fresno, California 93721  
Telephone: (209) 281-0808  
Fax: (209) 2284926

Washington, DC Office  
Telephone: (301) 5896760  
Fax: (301) 650-0398

**Bruce Bronzan**  
*Executive Director*

May 24, 1996

Karen Thiel Raykovich, PhD  
Office of Planning, Evaluation, and Legislation  
Health Resources and Services Administration  
Parklawn Building, Room 14-36  
5600 Fishers Lane  
Rockville, MD 20857

RE: Contract No.: HRSA 40-95-0024, Items 2, 3, and 4 (Final Report)

Dear Dr. Raykovich:

The Institute for Health Futures is pleased to submit 10 copies of the final report on the Testing of Local Level Health Care Reform Strategies in Selected California Counties. It contains Item 2: County Profile, Item 3: Implementation Plans for the Selected Strategies, and Item 4: Project Journal for the above-referenced contract between the Health Resources and Services Administration and the Fresno Regional Foundation.

The document contains an executive summary, four chapters, and an appendix, each contributing a different perspective on the story of a local level reform initiative that is taking place in Alameda County, California:

- **Executive Summary**—A overview of the concepts, principles, and activities that guided the development and execution of this project.
- **Chapter I**-The conceptual framework for local level reform that lies behind the Alameda County effort.
- **Chapter II-A** profile of the health system in Alameda County, set against the background of Federal and State health care reform efforts

Karen Thiel Raykovich, PhD

May 24, 1996

Page 2

- **Chapter III**—The implementation plan for the Alameda County Value Purchasing Cooperative
- **Chapter IV**-The implementation plan for the Alameda County Health Information Network
- **Appendix A**-Federal waiver options for consideration in future reform efforts in Alameda County

If you have any questions, please feel free to contact me at (209) 224-3235 or Veronica Elliott, Project Manager, at (301) 650-0236.

Sincerely,

A handwritten signature in black ink that reads "Bruce Bronzan". The signature is written in a cursive, flowing style.

Bruce Bronzan  
Executive Director

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## CONTENTS

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	<b>Page</b>
<i>EXHIBITS</i>	v
<i>EXECUTIVE SUMMARY</i>	vii
<b>CHAPTER I: DESCRIPTION OF THE PROJECT CONCEPT AND PROCESS</b>	I-1
<b>CHAPTER II: ALAMEDA COUNTY PROFILE</b>	II-1
<b>CHAPTER III: IMPLEMENTATION PLAN FOR THE ALAMEDA COUNTY VALUE PURCHASING COOPERATIVE</b>	III-1
<b>CHAPTER IV: IMPLEMENTATION PLAN FOR THE ALAMEDA COUNTY HEALTH INFORMATION NETWORK</b>	IV-1
<i>APPENDIX A: FEDERAL WAIVER OPTIONS FOR ALAMEDA COUNTY</i>	

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## EXHIBITS

---

<b>Exhibit Number</b>		<b>Following Page</b>
1	LOCAL REFORM PROTOTYPE	viii
2	ALAMEDA COUNTY REFORM PROTOTYPE PROVIDER NETWORK	viii
3	ALAMEDA COUNTY REFORM PROTOTYPE VALUE PURCHASING COOPERATIVE	ix
4	ALAMEDA COUNTY REFORM PROTOTYPE HEALTH INFORMATION NETWORK	ix
5	ALAMEDA COUNTY REFORM PROTOTYPE	ix
I-1	LOCAL REFORM PROTOTYPE	I-3
I-2	ALAMEDA COUNTY REFORM PROTOTYPE PROVIDER NETWORK	I-6
I-3	ALAMEDA COUNTY REFORM PROTOTYPE VALUE PURCHASING COOPERATIVE	I-6
I-4	ALAMEDA COUNTY REFORM PROTOTYPE HEALTH INFORMATION NETWORK	I-h
I-5	ALAMEDA COUNTY REFORM PROTOTYPE	1-7
II-i	ALAMEDA COUNTY REFORM PROTOTYPE PROVIDER NETWORK	II-1
II-2	HEALTH SPENDING IN CALIFORNIA BY SOURCE OF FUNDS IN 1994	II-3
II-3	PROJECTED CALIFORNIA STATE AND LOCAL GOVERNMENT HEALTH FUNDING 1996-2000	II-4
II-4	PERCENT OF POPULATION ENROLLED IN MANAGED CARE	II-5
II-5	MAP OF ALAMEDA COUNTY	II-11
II-6	ALAMEDA COUNTY HEALTH CARE BUDGET	II- I?
II-7	COLLABORATIVE INITIATIVES IN ALAMEDA COUNTY	II- 17
II-X	ALAMEDA HEALTH CONSORTIUM MEMBERSHIP	II-27

---

EXHIBITS (Continued)

---

<b>Exhibit Number</b>		<b>Following Page</b>
n-9	HEALTH MAINTENANCE ORGANIZATIONS SERVING ALAMEDA COUNTY	ii-28
II-10	HOSPITALS LOCATED IN ALAMEDA COUNTY	ii-38
III-1	ALAMEDA COUNTY REFORM PROTOTYPE VALUE PURCHASING COOPERATIVE	III-5
Iv-1	CHMIS GENERAL AREAS OF OPERATIONS	IV-6
IV-2	CHMIS ARCHITECTURE	IV-6
IV-3	CHMIS DATABASE	IV-7
IV-4	NETWORK INTERFACE ENGINE FUNCTIONS	IV-7
IV-5	CHMIS DATA EXCHANGE	IV-8
IV-6	INTERCONNECTION OF HEALTH CARE PROVIDERS	IV-10
IV-7	ALAMEDA COUNTY REFORM PROTOTYPE HEALTH INFORMATION NETWORK	IV-15
IV-8	CONVERSION DATA	IV-17
IV-9	ANSI RECORDS AND COMMUNICATIONS STANDARDS MATRIX	IV-19
A-1	COMPARISON OF SECTION 1115 AND SECTION 1915(b) WAIVERS	A-2
A-2	POTENTIAL BENEFITS OF A SECTION 1115 WAIVER	A-5
A-3	APPROVED SECTION 1115 WAIVERS	A-5
A-4	PENDING SECTION 1115 WAIVERS	A-5
A-5	HEALTH AND SOCIAL SERVICE HUB	A-14
A-6	ALAMEDA COUNTY SYSTEM INTEGRATION PROGRAM	A-16

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**EXECUTIVE SUMMARY**

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## EXECUTIVE SUMMARY

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This project demonstrates that a well-coordinated and locally determined approach to health system reform **will** enhance the availability of needed services at a lower cost, benefiting all community members and, especially, the most vulnerable **families**. It shows how Federal support can facilitate innovation at the community level, leading to improvements in programs that are essential to **low**-income people. Further, it contributes to the redefinition of the public health function.

A core idea behind this project had been developed some time ago by Bruce Bronzan of the Institute for Health Futures (II-IF) and Herb Birch of Birch and Davis Associates, Inc. (B&D). It is the realization that health care reform at the **local** level can do as much as, and maybe more than, national health care reform to improve access to high quality health services at an affordable cost. This realization gathers strength from the fact that a significant proportion of the money spent on health care in any **community** is public money, whether it **be** money used to finance health services for those groups within the population for which the government accepts responsibility (military families, veterans, the very poor), or money used to purchase health insurance for public employees. Given this commitment of public funds — which may be as high as 75 percent of the health dollars spent in some communities — public policy at the local level can be quite effective in bringing about health system changes. The project, therefore, provides a model that can assist a local community (in this case, a county) to develop and then implement a local health care reform initiative.

The project also offers a replicable example of what can be done with a creative blend of Federal, State, and local action and support. The documentation in this volume describes background information, activities undertaken, and lessons learned, and this case study material can be used as a backdrop against which to review policy alternatives in general and evaluate other local situations in particular.

The IHF team reviewed several counties in California that were candidates for the model project. Fresno County had originally been seen as ideal but, because of recent events, was no longer so when the project got underway. Contra Costa was also a strong candidate, but the resignation of its innovative health director to take on the crisis in Los Angeles made it less desirable. With the advice of a stellar project advisory council, Alameda County, with its well advanced integrated provider system and visionary leadership, was selected to serve as the site for the development of this local health care reform strategy.

Alameda County covers an area of about 737,500 square miles and includes 14 cities. The total population was 1,307,572 in 1992, making it the sixth most populous county in California. This population is 53 percent white, 17 percent black, 14 percent Asian, and 14 percent Hispanic. Approximately 16 percent or 203,000 Alameda County residents are Medicaid-eligible, and about 25 percent of these do not have English as their primary language. Another 300,000 or so are indigent

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and uninsured. About 100,000 county residents work in the public sector: 53 percent in Federal, State, county or city government; 29 percent in the schools; and 18 percent in colleges or universities.

The county has a budget of about \$455 million for health. The largest allocation goes to support the hospitals associated with the county medical center. A further \$84 million is for mental health and \$17 **million** for alcohol and drug abuse programs.

Alameda County is the first of the 12 approved in **California** to have a local initiative in operation under the State's 1915(b) waiver program. The county's Knox-Keene license was granted in September 1995, the Alameda Alliance for Health **opened** its doors on January 1, 1996, and **13,000** members were enrolled as of April 1.

The county has a history of innovation. For example, Alameda County is the **first** site selected for a Federal waiver under the Clinton Administration's Empowerment Zone/Enterprise Community initiative, one of 22 Healthy Start demonstration programs, and one of nine demonstrations under the RWJ-HUD funded Homeless Family Program. The county also has a history of successful collaborative ventures, and 24 networks of between 3 and 25 participating agencies are currently in place.

As with many innovative communities, county leaders are visionary, energetic, and eager to seize an opportunity to try something new. Many of the ideas brought to the county by the IHF project team had already been thought about in the Alameda context, and key people were brought on board quickly. The fact that county business, political, and administrative interests have a history of working closely together **meant** that the county supervisors could rapidly establish a county working group to take the lead on reviewing the local health care reform strategy being proposed by the **IHF** team. As the project moves into more detailed planning and then implementation, these community stakeholders will be critical to its success.

The generic local health care reform prototype that had been developed by Bronzan and Birch is illustrated in Exhibit 1. Using information gathered through the review of documentation and through interviews, the IHF team determined that the provider network in Alameda County was **highly** developed already. It is depicted in Exhibit 2. The IHF **team** concluded that the strategic options of greatest promise in the context of Alameda County were the development of a value purchasing cooperative and a countywide health information network.

It took little persuasion for the IHF team to convince key decision-makers in the county that value purchasing and an information network were important next steps along the road to local health care reform, and a county working group was put in place to provide formal interaction and collaboration with the IHF team. Elements of each strategy had been considered in the past and/or were already in place. An important contribution of the **IHF** team was to emphasize the interrelationship and mutual dependency of these two approaches and to show how they fit within the broader goal of improving health care outcomes.

**EXHIBIT I**  
**LOCAL REFORM PROTOTYPE**

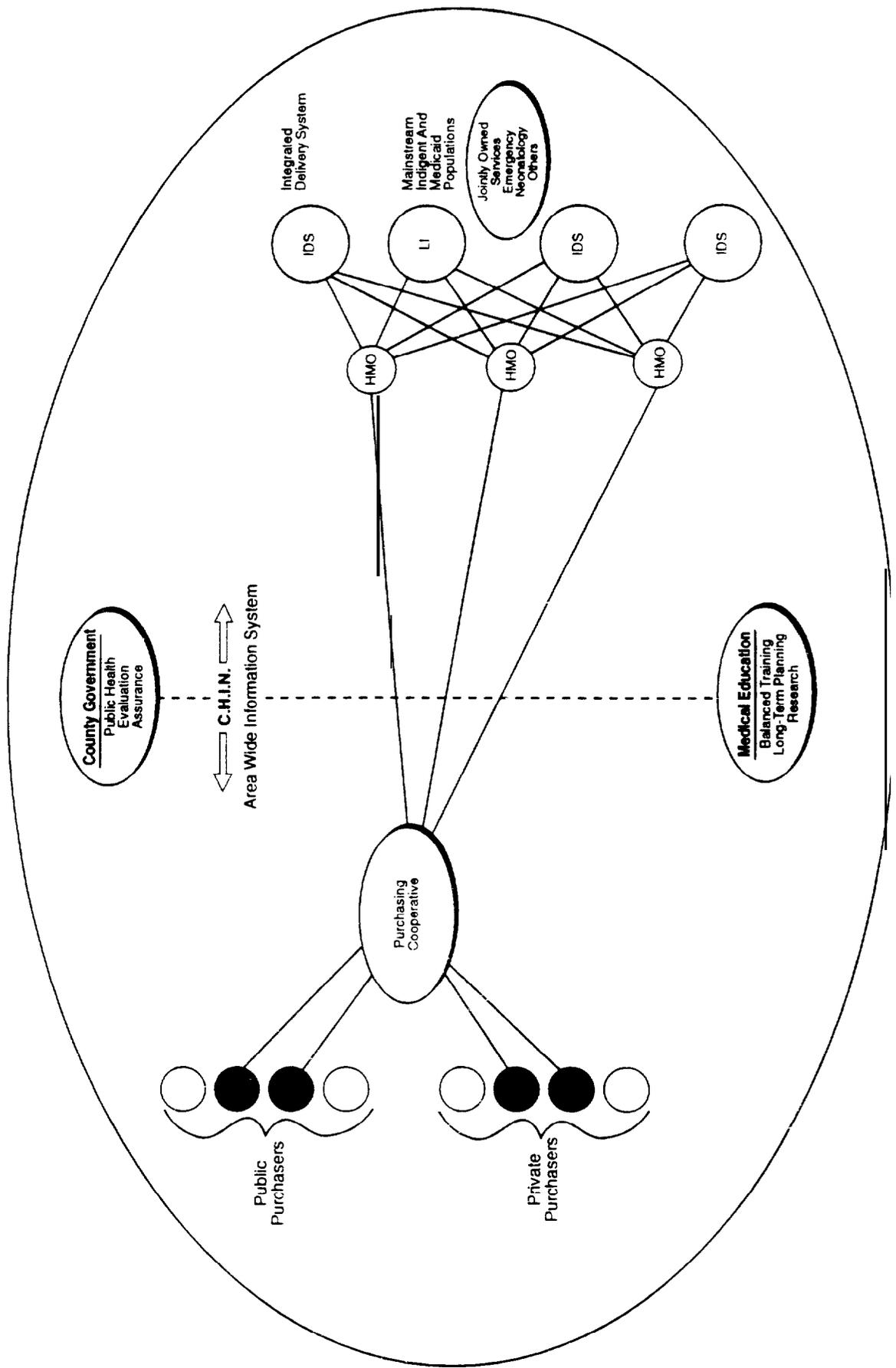
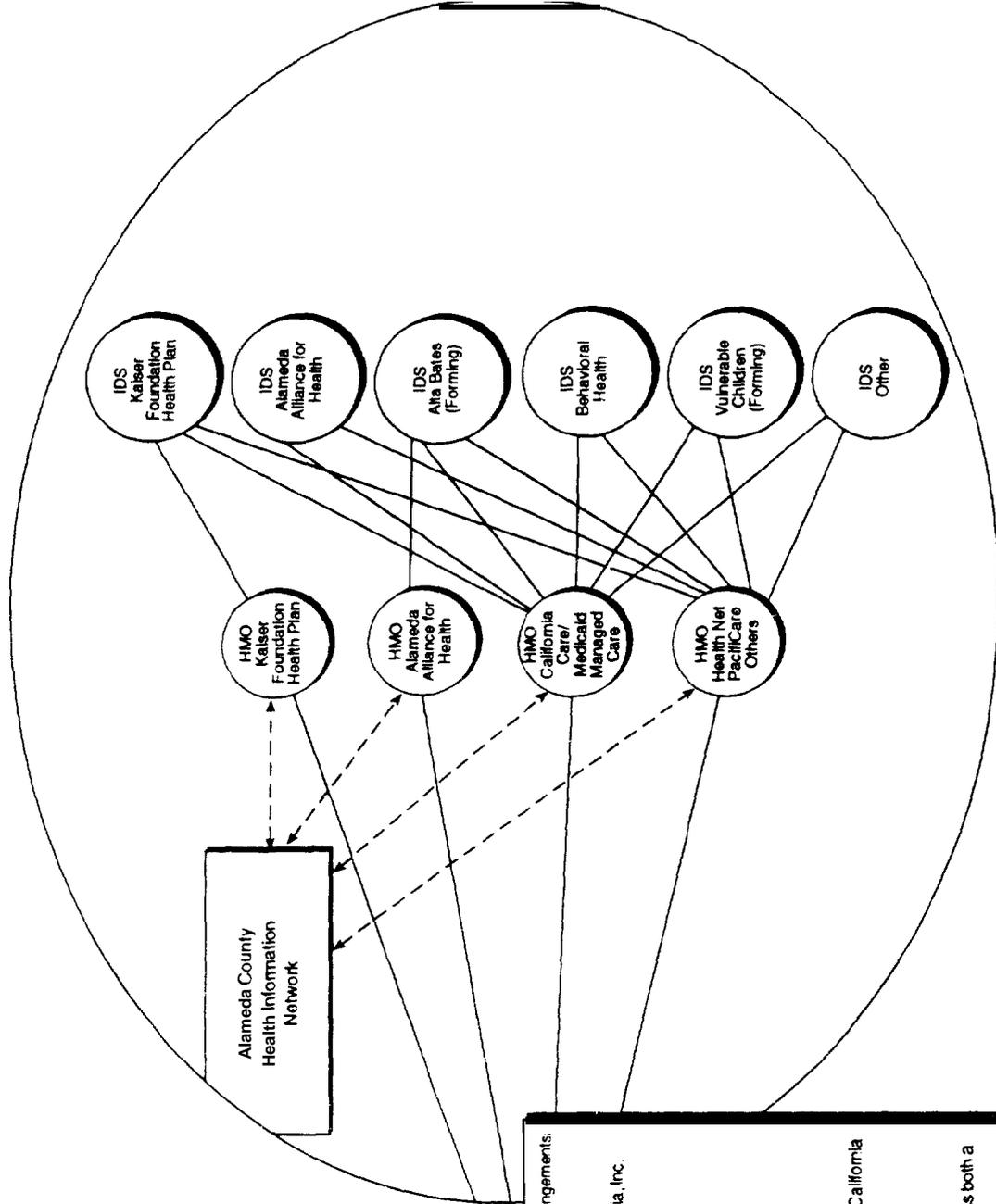


EXHIBIT 2

ALAMEDA COUNTY REFORM PROTOTYPE  
THE PROVIDER NETWORK



Some HMOs have exclusivity arrangements with the IDS

- Other HMOs include:
  - Aetna Health Plans of California, Inc.
  - Blue Shield of California
  - Cigna Health Care of Northern California
  - FHP, Inc
  - Foundation Health
  - Health Net
  - Lifeguard, Inc.
  - Maxicare
  - MetLife Healthcare Network of California
  - National HMO
  - PacificCare of California
  - PruCare of California
- The Alameda Alliance for Health is both a HMO and an IDS
- Kaiser Foundation Health Plan has a closed panel of physicians

———— Purchasing of services  
----- F b w o d a t a

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**Specialists** on the **IHF** project team then developed an implementation plan for the Alameda County Value Purchasing Cooperative, and another for the Alameda County Health Information Network. These plans lay out the principles behind these approaches, the steps that need to **be** taken to implement them, and the resources that will be required. Members of the advisory council and the county working group reviewed and approved these plans. Exhibits 3 and 4 illustrate the scope and purposes of the cooperative and the network, and Exhibit 5 takes the generic model health care reform prototype and places it in the context of Alameda County.

The implementation of the community-based strategy that was developed during this planning phase is feasible. The next step for the **IHF** team is to fine-tune the implementation approach by working with the local working group and Alameda County **officials** to finalize an agreement among all the key **community** players that the purchasing alliance and information network are the logical next steps toward health care reform in the county. At the same time, more analysis needs to be done to ascertain how best to organize, structure, and locate the alliance and information network and then to facilitate the development of consensus among essential community stakeholders about these matters. The **IHF project** team stands ready to take these next steps once funds are available for this purpose, as do the political and administrative arms of the Alameda County government.

One of the reasons funds were made available to support this project was to ascertain whether or not the project process **could** be usefully replicated in other locations and, if so, how. The **IHF** team will have more suggestions about this once the more detailed planning is completed, and probably more once implementation is under way.

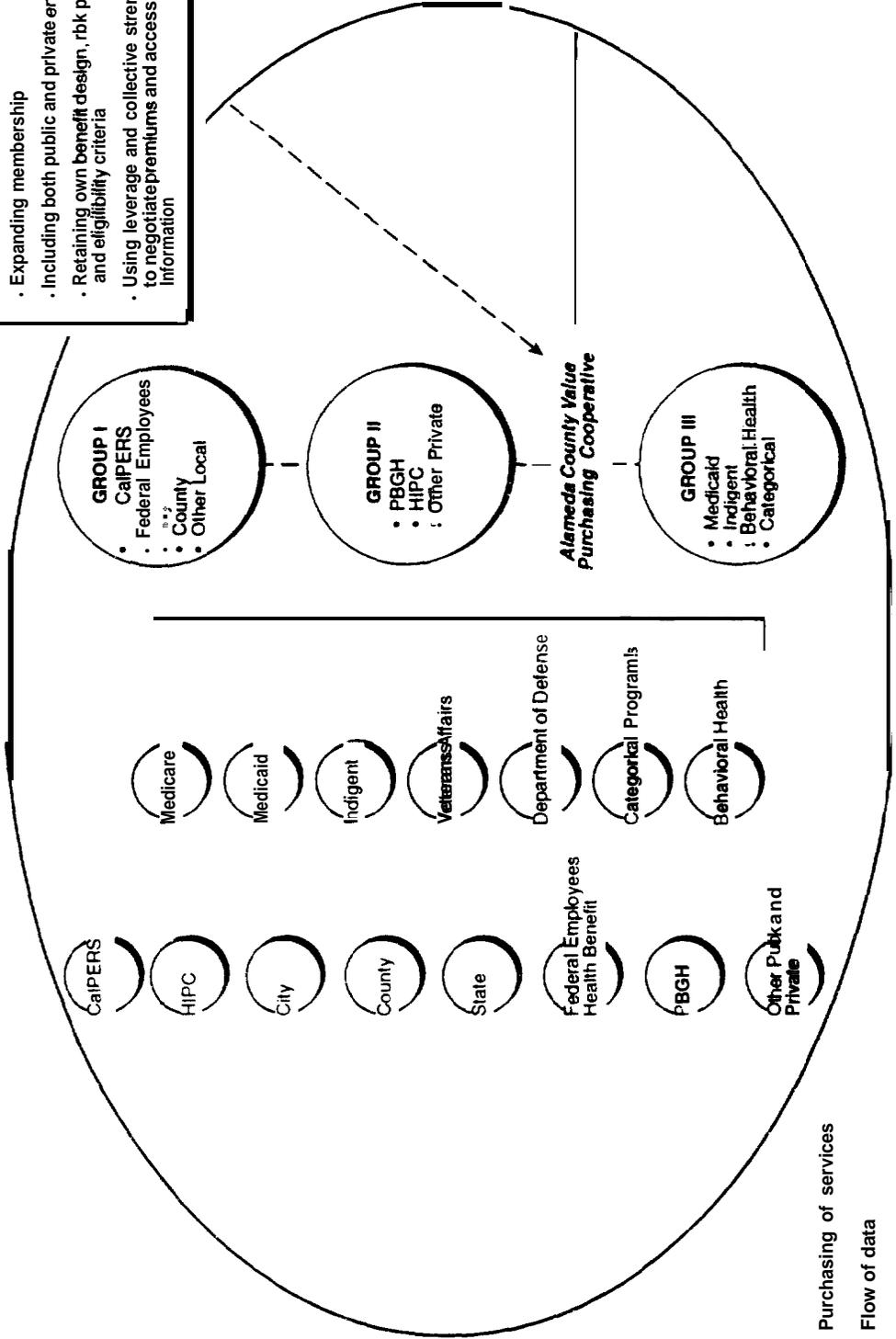
More work needs to be done to identify the legislative and regulatory incentives'and barriers that affect local health care reform. Many key elements seem to be dependent on being able to offer flexibility at the local level, and the authority under which local flexibility might be possible needs to be more clearly articulated. It is important that decision-makers in counties considering local health care reform are aware of the latest pertinent information about waivers and other candidate mechanisms and their implications.

Like toll roads, the elements of local health care reform (an integrated delivery system, a **value** purchasing cooperative, and a community health information network) require investments in the beginning and then they pay for themselves. To provide a stimulus to local health care reform, a program design well worth considering is the one adopted in the early days of the health maintenance organization (HMO). Under the Federal HMO program, grant funds were made available for feasibility, planning, and initial development of **HMOs**, and loans and loan guarantees were made available for initial operating deficits. This amounted to the equivalent of venture capital for local innovation.

EXHIBIT 3

ALAMEDA COUNTY REFORM PROTOTYPE  
THE ALAMEDA COUNTY VALUE PURCHASING COOPERATIVE

- Acting as driving force behind the Alameda County Health Information Network
- Consolidating purchasing power and effectively uses information and data to intelligently buy goods and services from HMOs
- Expanding membership
- Including both public and private entities
- Retaining own benefit design, risk pools, and eligibility criteria
- Using leverage and collective strength to negotiate premiums and access information



— Purchasing of services  
- - - Flow of data

EXHIBIT 4

ALAMEDA COUNTY PROTOTYPE  
THE HEALTH INFORMATION NETWORK

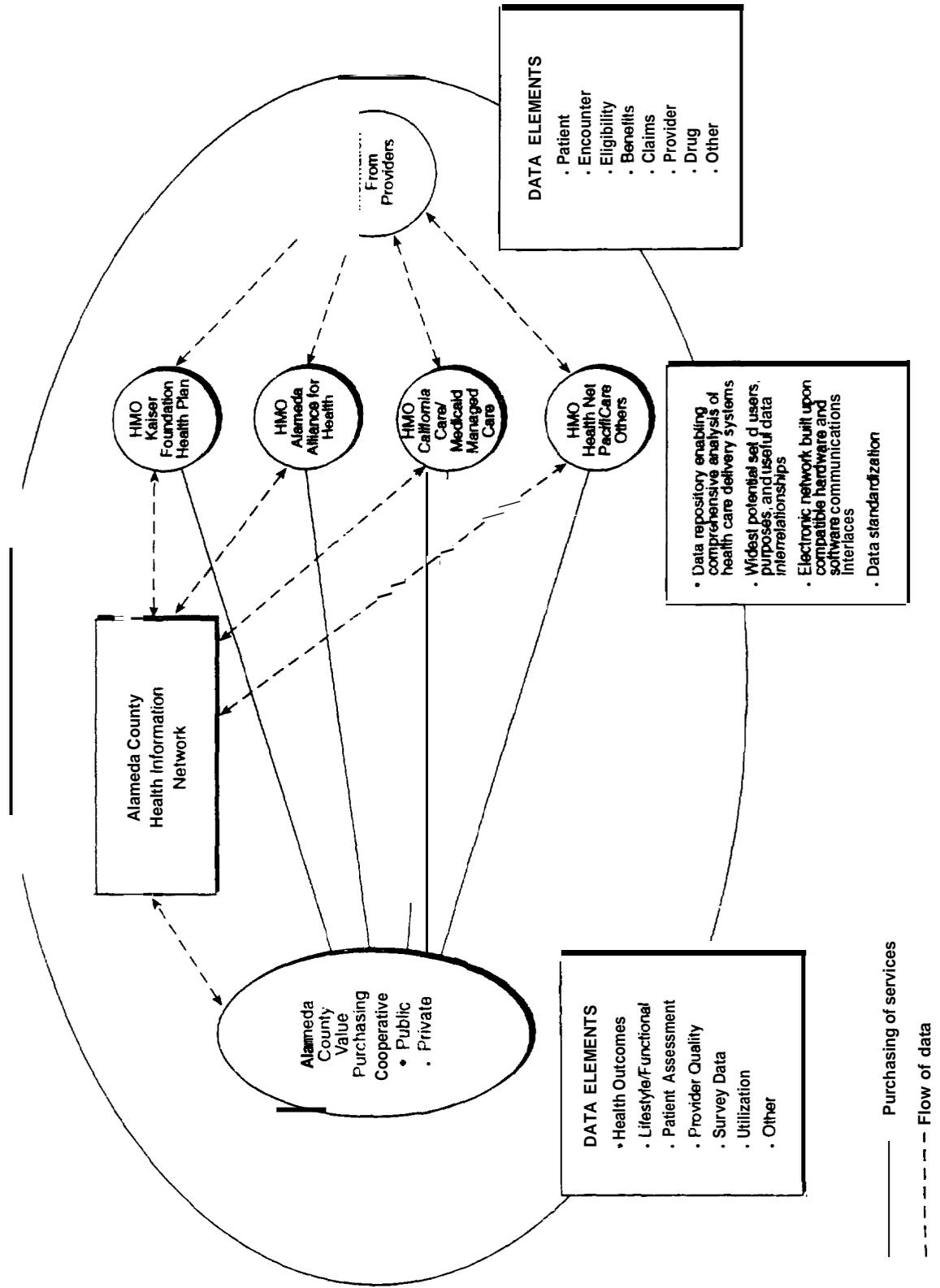
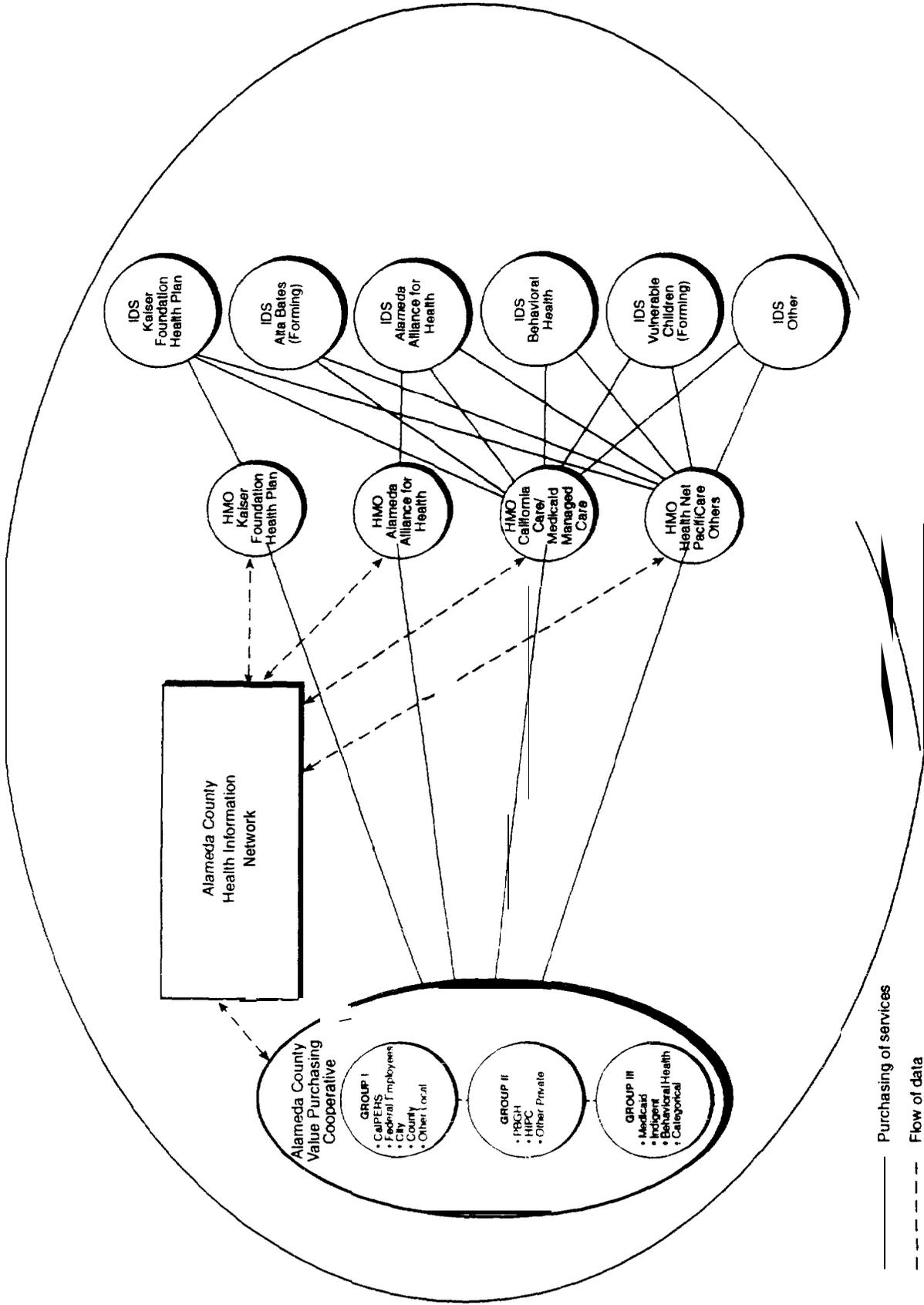


EXHIBIT 5

ALAMEDA COUNTY REFORM PROTOTYPE



*Developing Innovative Strategies to Propel the County Forward!*

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The Federal Government can play other invaluable roles in local health care reform. For example, it can stimulate interest in the idea, network among people and organizations with something to offer, voice **concerns** about the effects on vulnerable populations, share information about lessons **learned**, and affirm the essential parochial character of viable health care reform efforts.

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**CHAPTER I**

**DESCRIPTION OF THE PROJECT CONCEPT AND PROCESS**

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## CHAPTER I

### DESCRIPTION OF THE PROJECT CONCEPT AND PROCESS

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#### 1. INTRODUCTION

This project demonstrates that a well-coordinated and locally determined approach to health system reform will enhance the availability of needed services at a lower cost, benefiting all community members, and, especially, its most vulnerable families. It shows how Federal support can facilitate innovation at the community level, leading to improvements in programs that are essential to **low**-income people. Further, it contributes to the redefinition of the public health function.

The project is taking place at a time of great change in many aspects of the American health system. American insurance companies and large employers, both public and private, are driving down the cost of health insurance by bringing the pressure of the market to bear on providers of health care services. Through well-informed and shrewd negotiating, these purchasers are pressuring providers to deliver a better package of services at a more competitive price. Providers are responding by making more effective services available in a more **efficient** way, by joining forces with other providers through consolidation or integrated systems, by restructuring incentives to promote the least costly medically indicated services, and by closely managing the care provided. As these changes occur, Government is reexamining its own role and redefining how Government protects the public's health through such means as provider incentives, regulation, surveillance, information, and the provision of services.

Concurrently, public policy-makers are engaged in a wide-ranging examination of how Government could better serve its purpose. This process is resulting in an emphasis on performance and outcomes, greater acceptance of funding flexibility, and shifting responsibilities among Federal, State, regional, and local levels of authority. For those responsible for implementing legislation concerned with services for vulnerable families, this reengineering offers hope that unnecessary bureaucratic barriers to the coordinated provision of health, economic, and social services can be reduced, leading to improved family outcomes.

A core idea behind this project had been developed some time ago by Bruce Bronzan of the Institute for Health Futures (IHF) and Herb Birch of Birch and Davis Associates, Inc. (B&D). It is **the** realization that health care reform at the local level can do as much as, and maybe more than, national health care reform to improve access to high-quality health services at an affordable cost. This realization gathers strength from the fact that a significant proportion of the money spent on health care in any community is public money, whether it be money used to finance health services for those groups within the population for which the government accepts responsibility (military families, veterans, the very poor) or money used to purchase health insurance for public employees. Given this

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**commitment** of public funds — which may be as high as 75 percent of the health dollars spent in some **communities** — public **policy** at the local level can be quite effective in bringing about health system changes. The project, therefore, provides a model that can assist a local community (in this case, a county) to develop and then implement a local health **care** reform initiative.

The project also offers a replicable example of what can be done with a creative blend of Federal, State, and local action and support. The documentation in this volume describes background information, activities undertaken, and lessons learned, and this case-study material can be used as a backdrop against which to review policy alternatives in general and evaluate other local situations in particular.

Further, members of the **IHF** project team, including key senior staff of B&D, are convinced that support for the further refinement and subsequent implementation of the strategies developed so far will be an attractive proposition to both government and nongovernment organizations. **This** document, therefore, is a valuable stepping stone to this next phase and will be used as a basis for discussion and to develop proposals.

## 2. THE CONCEPTUAL MODEL BEHIND **THIS** PROJECT EMBRACES COMPREHENSIVE, LOCAL LEVEL HEALTH CARE REFORM

The analysts who comprise the **IHF** project team believe that sensible responses to the critical, current issues of health sector reform must take into account that the delivery of health care services is, and must be, a local endeavor. Regional, State, and even national organizations may have a role to play, but local responses must be formed around delivery systems that respond specifically to local needs, preferences, and constraints.

This recognition of the essentially parochial character of health care reform is all the more important when it comes to meeting the needs of vulnerable segments of the population because, for these families, accessibility is the key issue. To be addressed, accessibility has to be defined broadly to include location, convenience, affordability, and cultural appropriateness; and each of these attributes is locally **determined**.

As stated in the **IHF** concept paper that shaped the project, several principles are fundamental to the project concept:

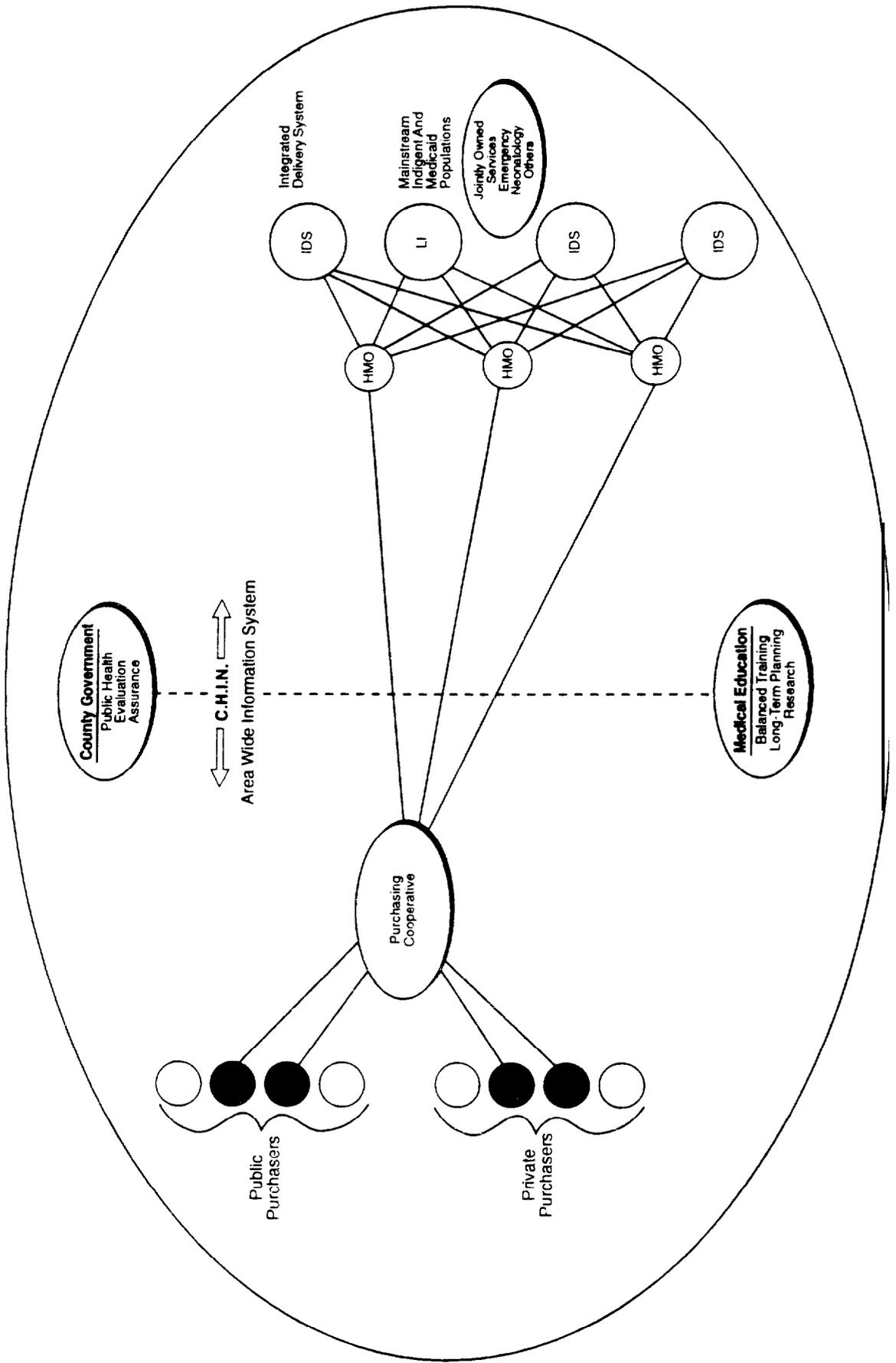
- Comprehensive, area wide reform is needed if changes are to respond to local needs.
- Preserving and strengthening the involvement of the existing network of community-based programs for which the Public Health Service (PHS) provides funding and other support is a priority because these resources are essential to the provision of culturally appropriate health and social services for low-income families.

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- **Medicaid** is viewed as a vital funding source for publicly funded county hospitals and State medical schools; the potential loss of Federal disproportionate-share hospital **dollars** will impact negatively on both State and local governments unless the indigent health **care system is redesigned**.
  - The success of locally based health care reform projects **depends** a great **deal on** ground-up involvement, participation, and commitment from the local leadership, together with substantial technical **and** other assistance from State and Federal program officials.
  - New systems are needed for restructuring both the **delivery** and financing of the State **and** county indigent care system that will place patients squarely in the mainstream of the rapidly changing health care system. Special provision may still need to be **made** for related services such as transportation and interpretation.
  - Reforming the health care system at the local level can be accomplished successfully in incremental ways by using constructively the full weight of the **wide range of** programs controlled by the Federal **and** State governments. Characteristics of these programs may need to be adapted in order to **contribute** most effectively to the reform effort.
  - The collective purchasing power of programs providing services to State and local employees and of programs providing services to the medically indigent is a strong inducement to health care system change.
  - For any health care reform options, managed care offers the right approach for accessing and providing community-based services, and managed competition offers the right approach for purchasing and patient choice decisions.

Exhibit I- 1. shown on the next page. depicts the conceptual model of local health care reform that **had been** previously developed **by** IHF and B&D and that was used to structure the project. Starting with the right-hand side **of the** page, the various components are:

- **Health Maintenance Organizations and Integrated Delivery Systems-These** related components of the health care reform model encompass the provider side in a managed care environment. **HMOs act as** payers and gatekeepers to individual providers, groups, and facilities. The model shows these providers organized into integrated **delivery** systems that are specifically contracted to one or more **HMOs**. Of special interest is the fact that community health centers, migrant health **centers**, mental health and substance **abuse** centers, family planning clinics, and other PHS-supported programs might operate as part of an integrated delivery system. **In**

**EXHIBIT I-1**  
**LOCAL REFORM PROTOTYPE**



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California, specifically, the State's local initiative experiment is an important component of this model.

- **Jointly Owned Services--Joint** ownership of costly services could be a part of a local health care reform initiative. Various specialty services--trauma, perinatology, neonatology, imaging--are clearly among those that **would** benefit from jointly owned and managed assets. Major issues of provider cooperation, coordination mechanisms to **minimize** delays in receiving needed services, duplication of effort, and inappropriate treatment would need to be resolved.
- **County Government--County** governments are central to the **health** care reform process, given that they often own important community health care resources and always manage health system funds. These resources and funds are critical to the provision of health care services to vulnerable populations.
- **Medical Education--Local** health care reform offers the opportunity to revisit the design and financing of medical education. Issues include comprehensive coordination of medical **workforce** training, community-driven master planning, and a greater emphasis on primary care and ambulatory training sites within the managed care environment. Local health care reform initiatives could also demonstrate how research might be designed and implemented in a manner consistent with the values of a managed care system.
- **Community Health Information Network--Local** health care reform requires comprehensive, accurate, and timely information in order to be effective. The Community Health Information Network model is valuable to review in view of local circumstances.
- **Purchasing Cooperatives--The** private sector contains examples of purchasing cooperatives that have been developed to strengthen the negotiating position of purchasers of health care services. In the public sector, several States have established mechanisms for pooling groups to improve their purchasing power or expand access to health care. In fact, **CalPERS's** success in California in bringing down prices and increasing consumer access to information is probably the most powerful example of purchasing cooperatives for the country. No jurisdiction has yet implemented a program, however, that pools Federal, State, and local government health care beneficiaries in some form of voluntary purchasing cooperative.

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### 3. CALIFORNIA IS AN IDEAL STATE IN WHICH TO EXAMINE THIS CONCEPT

This conceptual model lies at the heart of the **IHF** project. Before exploring how the model was applied, adapted, and built upon as the project progressed, it is important to highlight characteristics of the State of California that made it a particularly attractive place to pursue this concept:

- The strategic plan of the California Department of Health Services clearly recognizes the importance of serving the needs of those people who are the PHS constituents, and it is committed to ensuring the provision of **culturally** competent primary health care to the medically underserved.
- California appears to have at least as many people in Federal- and State-supported programs as most States, and quite possibly more. The percentage may be as high as 75 percent in some California counties.
- It has a rich infrastructure of community health centers, other government-supported ambulatory care programs, VA hospitals, **DoD facilities**, medical schools, and **school-based** health programs.
- In many large urban communities in California, more than 70 percent of employed, insured workers belong to managed care plans. Medicare eligibles are enrolling in Medicare risk plans in record numbers, and Medicaid agencies are moving large numbers of their Medicaid populations into managed care plans.
- As the large, well-managed **HMOs** in California enjoy increased popularity, their size and power have enabled them to exert an influence over the provider community that has been unknown in the fee-for-service model. **HMOs** are able to bring the purchasing power of hundreds of employers to the negotiating table when they meet with hospitals, medical groups, and individual clinicians. Their ability to extract price concessions from providers is unprecedented.
- While large portions of the health care market have been consolidated into a few very large **HMOs** in California, except for a few purchasing cooperatives, most employers have not consolidated their purchasing power. They have little or no leverage to influence the large plans and are without power to insist on adequate data to help them manage their programs.
- Prepayment in community health centers and migrant health centers represents some 29 percent of all nationwide prepaid enrollment in these types of centers. This enrollment is also quite concentrated, with 15 percent of all California's prepaid enrollees being served by five community and migrant health centers.

- 
- California's legislature and executive branch are receptive to innovation, as evidenced most concretely by its local initiative plan.
  - It has several counties, such as Alameda and Fresno, that have reputations for trailblazing and embracing innovative reform measures.

As discussed in greater detail in the following section of this chapter, the project team had planned originally to implement local health care reform in Fresno County. As the project proposal was being reviewed, activities already under way in Fresno County suggested that this would be an ideal site. However, changing policies and priorities within the county proved otherwise. As a result, the IHF team spent quite a bit of time and effort investigating alternative counties in California in which to undertake the project.

With guidance from the Project Advisory Council, made up of health care system experts with a broad variety of State experience, the project team came to the conclusion that Alameda County offered the best chance of success. Specific information about Alameda County, its population, and its health care system may be found in Chapter II, the Alameda County profile.

The Institute for Health Futures team was charged with using the conceptual model developed earlier to identify the priority health care reform strategies that would carry Alameda County forward, while protecting the health of the most vulnerable segments of its population. The project process, its phases and specific activities, is described in the section that follows.

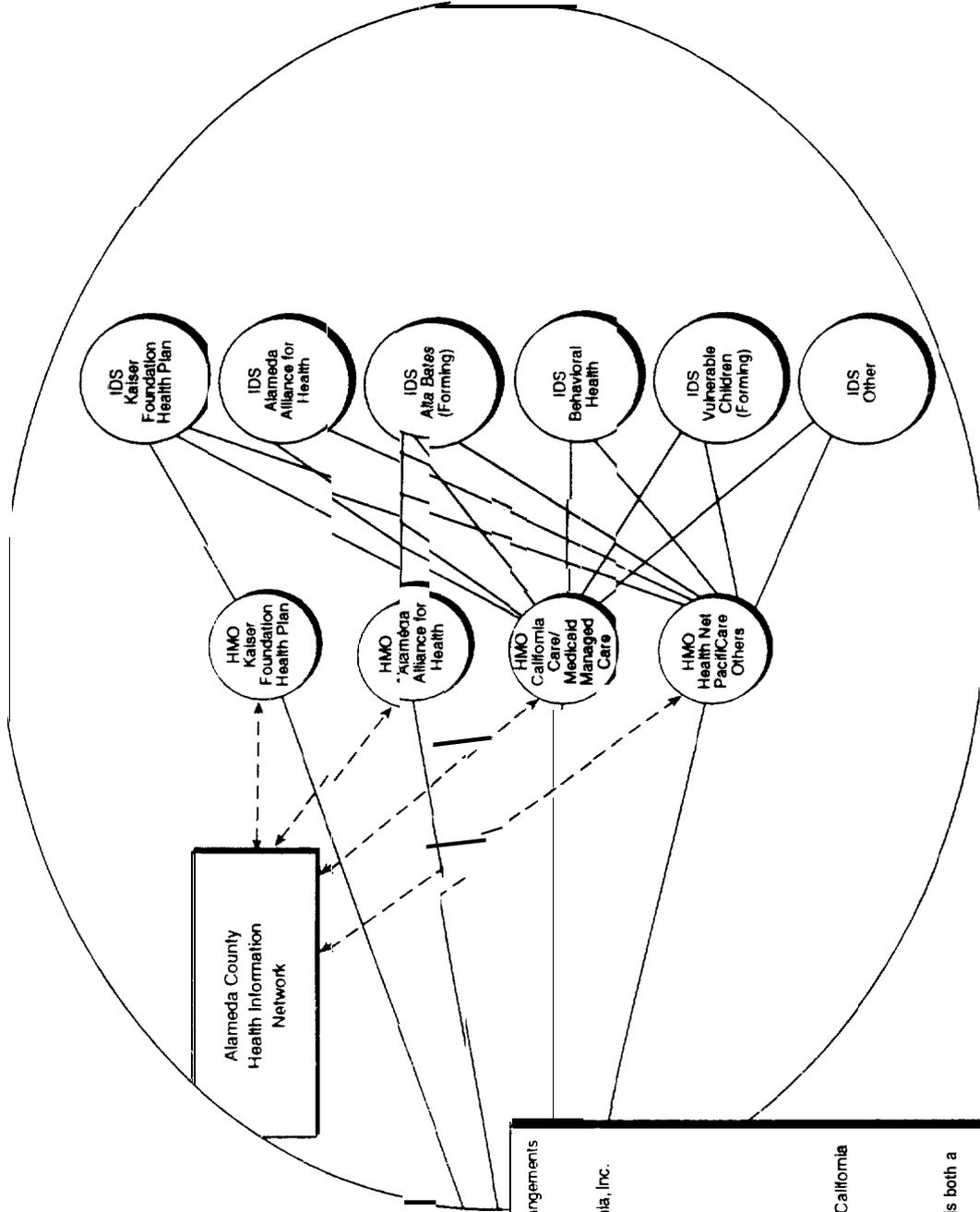
Exhibit I-2 illustrates that the provider side of the model was already well organized in this county. A number of **HMOs** have been active in the county for some time, and their presence has encouraged the formation of integrated delivery systems. Further, as one of the 12 counties selected by the State to implement the Local Initiative policy for **Medi-Cal**, the Alameda County Health Agency has moved ahead rapidly to establish the Alameda Alliance for Health as the local alternative. The integrated delivery system that makes up the Alliance **includes** most of the essential community providers that traditionally serve vulnerable families.

Exhibit I-3 presents one of two central health care reform strategies being proposed by the **Institute** for Health Futures. Under this strategy, purchasers of health care services in the county will come together to form the Alameda County Value Purchasing Cooperative (ACVPC). The ACVPC will consolidate purchasing power and use its leverage and collective strength to negotiate favorable premium rates for members, as well as to require the collection of information that will guide health system decision-making. An implementation plan for the development of the ACVPC is presented in Chapter III.

Exhibit 1-4 presents the other strategy that is central to reform in Alameda County. This is the creation of a health information network (**HIN**) that supports and guides health care reform activities.

EXHIBIT I-2

ALAMEDA COUNTY REFORM PROTOTYPE  
THE PROVIDER NETWORK



Some HMOs have exclusivity arrangements with the IDS

- Other HMOs include:
  - Aetna Health Plans of California, Inc.
  - Blue Shield of California
  - Cigna Health Care of Northern California
  - FHP, Inc.
  - Foundation Health
  - Health Net
  - Lifeguard, Inc
  - Mexicare
  - Melife Healthcare Network of California
  - National HMO
  - PacificCare of California
  - PruCare of California
- The Alameda Alliance for Health is both a HMO and an IDS
- Kaiser Foundation Health Plan has a closed panel of physicians

EXHIBIT I-3

ALAMEDA COUNTY REFORM PROTOTYPE  
THE ALAMEDA COUNTY VALUE PURCHASING COOPERATIVE

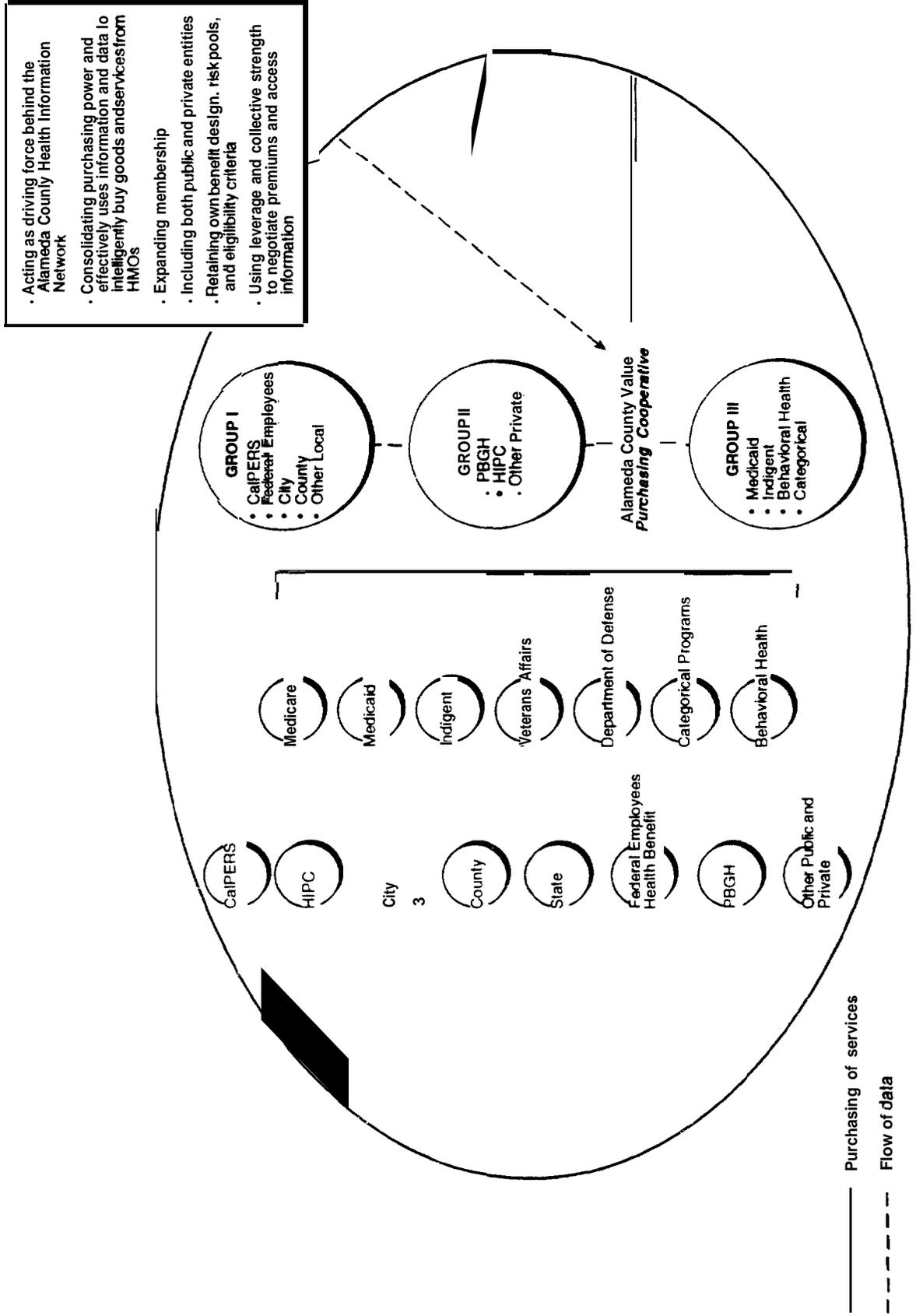
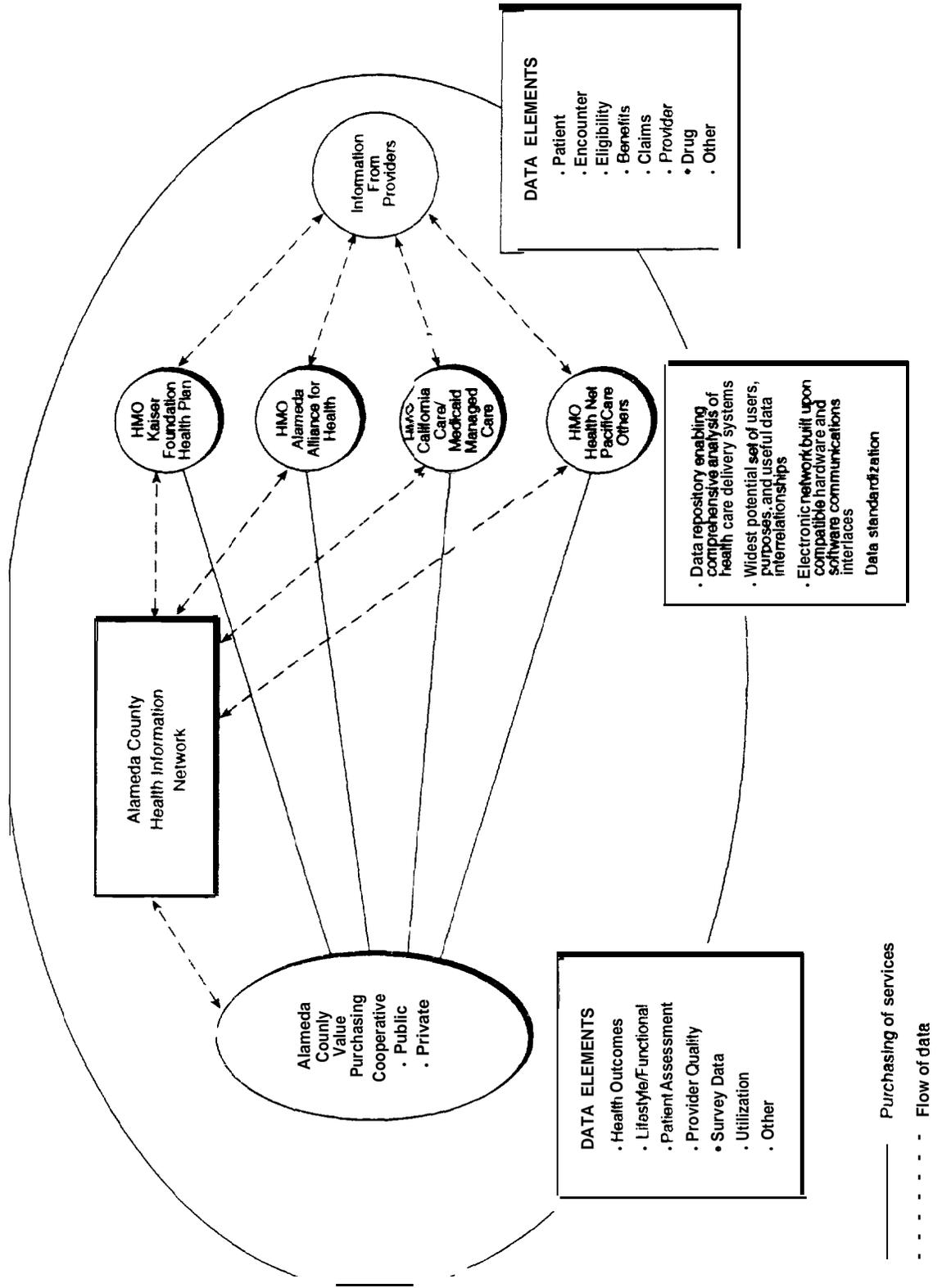


EXHIBIT I-4

ALAMEDA COUNTY PROTOTYPE  
THE HEALTH INFORMATION NETWORK



**DATA ELEMENTS**

- Patient
- Encounter
- Eligibility
- Benefits
- Claims
- Provider
- Drug
- Other

• Data repository enabling comprehensive analysis of health care delivery systems

• Widest potential set of users, purposes, and useful data interrelationships

• Electronic network built upon compatible hardware and software communications interfaces

Data standardization

**DATA ELEMENTS**

- Health Outcomes
- Lifestyle/Functional
- Patient Assessment
- Provider Quality
- Survey Data
- Utilization
- Other

———— Purchasing of services

- - - - - Flow of data

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The concept of the **HIN** is discussed in Chapter **IV**, along with a plan for its development and implementation.

It is critical to appreciate that these two **strategies**—the ACWC and the HIN—are interrelated and interdependent. Implementing one without the other is counterproductive in the Alameda County context. The strategies are presented as separate chapters of this document for reasons of convenience: The strategies are closely tied to each other.

Exhibit I-5 puts the picture together again and illustrates how **local** health care reform looks in Alameda County. The Institute for Health Futures, B&D, and Alameda County are anxious to continue their collaboration and move ahead with the implementation of this model approach to local health care reform.

#### **4. THE PROJECT PROCESS SERVES AS A CASE STUDY**

There are four phases to the overall project. The HRSA-supported activities reported in detail here comprise the middle two phases.

- Phase 1: Conceptualizing the local health care reform model, sharing the model with Federal officials and others, and securing funds.
- Phase 2: Determining the county in which to undertake the project.
- Phase 3: Strategic community planning for local health care reform.
- Phase 4: Implementing the local health care reform initiative.

Phase 1 began in January 1994 and was not completed until August 1995; Phase 2 took place in September and October 1995; Phase 3 began in November 1995 and ended in April 1996; and Phase 4 **has** yet to begin.

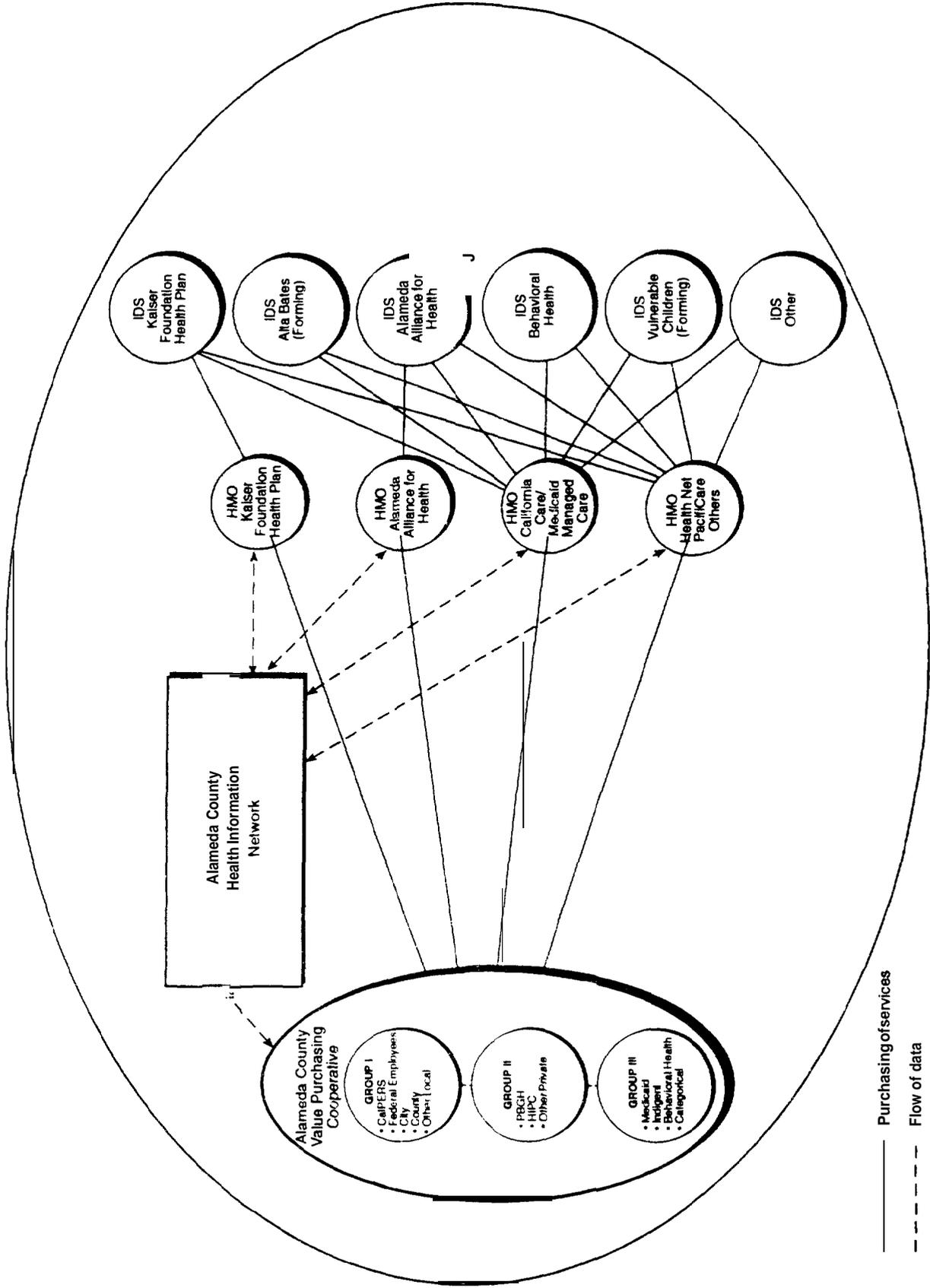
The section below describes the key elements of each phase, the people involved, and lessons learned.

##### **4.1 Phase 1: Depicting Local Health Care Reform and Seeking a Sponsor**

This project builds upon two documents that were submitted to DHSS early in 1995:

- *Managed Care Developments in California and their **Effect** on Community and Migrant Health Centers and Title X Family Planning Providers*, submitted by Birch & Davis Associates, **Inc.** (B&D), to the Office of the **Assistant** Secretary for Health in draft on September 16, 1994, and in final on January 23, 1995; and

EXHIBIT I-5  
ALAMEDA COUNTY REFORM PROTOTYPE



*Developing Innovative Strategies to Propel the County Forward!*

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- *A Test of Local-Level Health Care Reform Strategies in Selected California Counties, A Concept Paper*, prepared by the Institute for Health Futures (IHF) and submitted to the Health Resources and Services Administration (HRSA) on March 24, 1995.

The first of these documents examines in a broad sense the efforts being made in California to shift a large part of its Medicaid program, known as Medi-Cal, to managed care and describes the major issues surrounding the provision of services to vulnerable populations that are facing both the State of California and the United States as a whole. This leads into a discussion of strategies that the Public Health Service (PHS) might consider in response to these issues.

The concept paper submitted by IHF in collaboration with B&D points out that selected counties in California are beginning a strategic planning exercise and that this has profound implications not only for these local areas, but also for the State and the nation. The paper calls for the design and testing of models that obtain the best health care **services** at the least cost through involving the broadest possible range of providers in local markets. The paper included the model of local health care reform that was used to shape the project reported on in this document.

The concept paper in draft form was taken by the **IHF** team into discussions with a variety of potential sponsors before striking a responsive chord within HRSA. The paper was formally submitted to HRSA on March 24, 1995. On June 6, 1995, a Request for Proposal (**RFP**) was issued by HRSA, with responses due on July 7.

In this RFP, HRSA stated that the proposed project fits well into HRSA's Mission Statement, which calls for the agency to strive to achieve "increased access to high quality health care for populations which are disadvantaged, underserved, or have special needs." Further, HRSA's role in promoting innovative and supportive partnerships to promote effective, integrated systems of care was cited, as was the fact that the project's findings can increase HRSA's capacity to provide training and technical assistance to localities as they develop health care systems which are more responsive to the needs of these populations.

IHF submitted a proposal with B&D as its subcontractor, revised it a little based on the Government's review, and received an award in the amount of \$150,000 in mid-August. The proposal. and subsequent contract. stated the overall program objective as:

- Document a process for developing strategies for collaboration at the local level among government health care programs.

The project's specific objectives are listed as the following:

- Develop strategies for collaboration at the local level among government health care programs;

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- Develop a **detailed** plan for implementing at least one different approach to collaboration among government-supported health care **programs**; and
  - A written report documenting the planning and development experience.

Work on the project began in earnest with a kickoff meeting on September 14, 1995.

#### **4.2 Phase 2: Determining the County**

This phase of project activity was originally seen as unnecessary because, due to the strong association of Mr. **Bronzan** and Mr. Birch with the Fresno Regional Medical Network project, it had been assumed that Fresno was the county of choice. In fact, the pilot project proposal submitted to HRSA was sometimes referred to as “the Fresno project.”

#### **When It Came Time To Implement the Project, Fresno County Was No Longer the Ideal Site**

During the six months that the concept paper and subsequent proposal were being submitted and reviewed by HRSA, activities in Fresno County continued to evolve rapidly. The Regional Medical Network effort had successfully pulled together a broad community steering committee referred to as a “development board.” This development board included participants from a wide cross-section of the **medical provider community**, the university, federally qualified clinics, the medical society, the county government, and local business leaders. As the concept emerged, and as the local marketplace continued to evolve, certain stress lines developed:

- The federally qualified health centers, which jealously guarded their long histories of independence, were extremely skeptical of becoming part of an integrated **delivery** system.
- Private physicians at the community hospital became nervous about the implications of bringing over indigents, as well as the teaching program.
- Faculty in the university teaching program became nervous about changing from their familiar environment to a private setting.
- Other hospitals became concerned about the potential competitive strength of a new and integrated delivery system.
- The churning within the hospital physician community relative to the formulation of independent physician associations (**IPAs**) and their affiliation with hospitals became an increasingly contentious and competitive issue of its own.

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- The county government became extremely resistant to any change in its status as a provider.

Tensions in the Fresno County government reached a point in which the county withdrew from the Regional Medical Network development board for an indeterminate “review of its options.” An examination of the Fresno county government’s reaction to this shifting ground is important, given that reactions like these are likely to be repeated all across the United States as local market reform efforts take hold:

- There was an automatic if not intrinsic resistance and inertia on the part of county staff, whose bureaucracies and jobs were threatened by any change.
- Organized labor (public employee unions) had a similar immediate reaction to any reorganization of the health care delivery system, regardless of the deteriorating conditions in the county or the potential for improved conditions with reorganization.
- The attitude of several county supervisors was, “Who are they to tell us what to do?”
- Most important, the county’s overall general budget depended on health care funds.
  - A variety of departments, such as computer services, personnel, purchasing, auditor-controller, and others, shifted costs over to the hospital budget far in excess of the hospital’s demands on their services.
  - The county had used the relatively recent disproportionate-share hospital (DSH) funds to back out its general fund contribution to the hospital. In other words, in an indirect but real way, the county was using DSH funds to pay for non-health-related county services.
  - With the Medicaid program going into a managed care format, Medicaid patients would most certainly choose private-sector hospitals in large numbers.

The county’s **overall** response to these items was to attempt to control managed care Medi-Cal as a referral base to itself **and** to fight all efforts at integrating the delivery system of essential community providers. In so doing, the county alienated virtually the entire rest of the provider community.

When it was clear that the county no longer wished to participate in the Regional Medical Network, the rest of the members of the development **board chose** to go ahead without the county, believing

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that ultimately they needed the integration, and the county would ultimately have no other choice. Their reasons were significant:

- The health centers, which had a long, difficult, and distrustful relationship with the county, came to the conclusion that they **would** rather refer their patients for inpatient services to a private setting than to the county.
- The university, aided by pressure from the legislature to convert to primary care, saw the Regional Medical Network as an opportunity not only to improve the physical venue of the physician training program but also to modernize the program in which physicians **could** be training in an integrated system and a managed care format with an emphasis on primary care.
- Individual practicing physicians (traditional Medicaid providers) began to realize the importance of being part of a system as opposed to being “left out.”

Perhaps most critical, however, was the State’s managed care Medi-Cal local initiative program. The clear implications of putting the Medicaid population into managed care were: 1) that Medicaid eligibles would be sought after by the overbedded private sector; 2) that it was a natural fit into the regional medical network **concept**—an integrated network of providers; and 3) that it was imminently threatening to the county because, given a choice, Medicaid patients would vote with their feet and leave the county hospital for the private hospital.

Thus, in September 1995 as the project was beginning, the health system in Fresno county was still a long way from being organized in an integrated, efficient way. Further, many of the key players in the county’s health system were taking opposing positions and having difficulty collaborating among themselves. Therefore, the decision was made to keep Fresno as an option, but to look for another California county where the IHF project might have a greater chance of succeeding.

### **Identifying Other Candidate Counties Required Considerable Information Gathering and Discussions with Potential Collaborators**

During the September 14, 1995, project kickoff meeting between the responsible Federal officials and the IHF team, it **was** decided that **IHF** would look beyond Fresno County alone and develop selection criteria for evaluating alternative California counties. A county topology that had been developed by Bruce **Bronzan** was used as a starting point for these criteria. **In** this topology, counties are divided into three broad types: 1) confused and ill-prepared to deal with the changes; 2) in sudden and dramatic **fiscal** crisis; or 3) planning their way out of health care delivery. It was agreed that the project could best be conducted using the third type.

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Following this decision, the **IHF** team began reviewing information about a number of California counties. Members of the project team then visited several of the leading contenders and discussed local health care reform ideas and the **IHF** model with a variety of potential collaborators, including:

- Tom **Elkin**, President, **Elkin** Consulting
- Mark Finucane, then Health Director, **Contra** Costa County
- David Kears, Director, Alameda County Health Care Services Agency
- Sharon Levy, Chair, Fresno County Board of Supervisors
- Burt Margolin, Health Crisis Manager, Los Angeles County
- William Randolph, Chief Administrative Officer, Fresno County
- Sharyn **Renna**, Chief of Staff to Fresno County Supervisor Stan **Oken**

### **The First Meeting of the Project's Advisory Council Provided a Valuable Format for Selecting The County**

At the same time as identifying candidate counties, the **IHF** team began the process of inviting key people to join the project advisory council. The strategy for selecting members included three principal criteria: 1) individuals with a strong background and experience in health policy, 2) individuals with statewide credibility, and 3) individuals who could affect the support and assistance that the project would ultimately need. Those who agreed to serve on the council were:

- S. Kimberly **Belshé**  
Director, California Department of Health Services
- Willie L. Brown, Jr.  
Mayor of San Francisco
- Tom J. **Elkin**  
Health Consultant  
Former Assistant Executive Officer, Health Benefit Services,  
California Public Employees Retirement System
- Molly Joel Coye, MD  
Former Senior Vice President, Clinical Operations  
Good Samaritan Health System  
Former Director, California Department of Health Services
- Kenneth L. Maddy  
Senator, State of California
- Emery B. Dowell  
Member, Managed Risk Medical Insurance Board

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- Jack C. **Lewin**, MD  
Chief Executive Officer, California Medical Association  
Former Director of Health, State of Hawaii
  - David J. **Kears**  
Director, Health Care Services Agency, Alameda County  
Chief Executive **Officer**, Alameda Alliance for Health
  - William B. Kerr  
Director, Medical Center at University of California, San Francisco
  - David Werdegar, MD  
Director, Office of Statewide Health Planning and Development.  
California Department of Health and Welfare Agency
  - Marjorie Sue Wolf  
Director, Sierra Pacific Veterans Integrated Service Network,  
Department of Veterans Affairs
  - Ronald **Carlson** (*ex officio*)  
Associate Administrator for Planning, Evaluation, and Legislation,  
Health Resources and Services Administration

The first project advisory council meeting was **held** on October 12, 1995, in San Francisco to discuss: 1) The history of the project, its goals, timetables, etc.; 2) Council members' views on the project concept and priorities; and 3) the selection of the county.

The IHF team established for advisory council members that the project was founded on a set of principles:

- Comprehensive. **areawide** reform is needed if changes are to respond to **local** needs, with the success of locally based health care reform projects depending a great deal on ground-up involvement, participation, and commitment from the local leadership, together with substantial technical and other assistance from State and Federal program officials.
- The collective purchasing power of programs providing services to State and local employees and of programs providing services to the medically indigent is a strong inducement to health care system change. This reinforces the importance of health care reform at the local level!.

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- New systems are needed for **restructuring** both the delivery and financing of the State and county indigent care system that will place patients squarely in the mainstream of the rapidly changing health care system. Special provision may still need to be made for related services such as transportation and interpretation.
  - Preserving and strengthening the involvement of the existing network of **community-**based programs for which the PHS provides funding and other support is a priority because these resources are essential to the provision of culturally appropriate health **and** social services for low-income families,
  - Medicaid is a vital funding source for publicly funded county hospitals and State **medical** schools, the potential loss of Federal disproportionate-share hospital dollars will impact negatively on both State and local governments unless the indigent health care system is redesigned.
  - For any health care reform options, managed care offers the right approach for accessing and providing community-based services, and managed competition offers the right approach for purchasing and patient choice decisions.

The project advisory council agreed with these principles and they were incorporated into the discussion of the project concept and the county selection process.

After the council members had endorsed the overall local health care reform model, the principles behind it, and the specific project concept, they turned their attention to the selection of a county. Three important recommendations emerged from the group:

- Given the scope of this project and the short time available, it was very strongly and unanimously felt that the county that was farthest along in its health care program development would be the best county to choose. Advisory group members argued that it was important that this pilot project **succeed** and that success would be more likely in a county with creative leadership and a history of innovation.
- Of the six or seven counties under consideration, the advisory council members agreed with the **IHF** team that the most promising were Contra Costa, Alameda, and Fresno.
- It was felt that the development of the **managed** care Medi-Cal program in the chosen county would be extremely important to its **success** in that it is highly desirable to have the purchasing cooperative component **link** with the managed care Medi-Cal program.

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In discussions following the advisory council meeting, both Alameda County and Fresno County representatives indicated a strong desire for their counties to be selected. However during the following week, the California Department of Health Services rejected Fresno County's application for local initiative participation in Medicaid managed care, leaving Fresno County as the only county of the 12 in the program with two private mainstreams and no local initiative. Fresno County's reaction was to prepare to sue the State over the **rejection** of its plan. These actions ruled out Fresno County as a candidate site for the pilot local health care reform project.

Meanwhile, the public hospital financing crisis that emerged in Los Angeles had evolved to the point that the Los Angeles Board of Supervisors was recruiting a new health director. Mark Finucane, Contra Costa County's long-time Health Director, was the leading candidate. This left Contra Costa County as a less than ideal site for the **IHF** project.

After several conference calls with advisory board members, the recommendation was **made** that Alameda County be the pilot project county because of its highly evolved local initiative plan and stable leadership. HRSA officials approved this recommendation. Specifically, the county offered:

- Strong and supportive leadership
- A history of innovation and collaboration
- An ideal geographic and demographic mix
- A start on key local health care reform initiatives
- Characteristics that make the project a good learning environment

#### **4.3. Phase 3: Strategic Community Planning for Local Health Care Reform**

From November 1995 through April 1996, the **IHF** project team concentrated on strategic community-based planning in Alameda County. This planning process was intended to apply the local health care reform model developed **by the IHF** project team to the particular circumstances in Alameda County, and to develop the steps needed to carry the reform process forward into implementation. As previously discussed, the reform strategies central to success in Alameda County had been identified as the **formation** of a value purchasing cooperative to strengthen the negotiating power of public sector purchasers, and the development of a countywide health care information network to support purchasing decisions and improve health care system management and public health.

The planning effort was constrained by the fact that Fresno County was not chosen, resulting in the consumption of considerable project resources in the unanticipated necessity of selecting an alternative county. Therefore, the number of days available for the **IHF** team to spend in the county were fewer than had been planned in the original project design. Further, the **IHF** team had to expend more effort than expected in establishing relationships with a number of **key** people in Alameda County, people whose counterparts in Fresno County **already** had a relationship with **IHF** team leader Bruce **Bronzan**. This necessity further **limited the** level of **effort available** for the

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community planning activities of the project.

The planning phase can be divided into three segments:

- A period of concentrated information gathering and analysis
- A period of little project activity due to non-project causes
- A period of intense planning

### **Interviews, Information Gathering, and Relationship Building Were Important**

Early in this period of strategy development, the focus was on developing a deeper understanding of **Alameda** County and soliciting support from a variety of leaders within the county. Research on the county profile (presented in Chapter II) provided a good starting point for a better understanding of the current political, social, and health services delivery system infrastructure in the county.

In addition to developing a county profile to gain insight into the county, several days were spent early in this phase introducing the project to individuals with a wide variety of perspectives:

- Wilma Chan, Alameda County Supervisor, Third District, and Susan Rosenthal, Supervisor's Assistant
- Mary King, Alameda County Supervisor, Fourth District
- Elihu M. Harris, Mayor of Oakland
- Susan Muranishi, Alameda County Administrator
- David Kears, Director, Alameda County Health Care Services Agency
- Don Perata, former Alameda County Supervisor
- Gregory Roth, Chief Deputy Director, and Mark Legnini, Deputy Director of Health Policy and Planning, both of Dr. David Werdegar's office-Office of Statewide Health Planning and Development
- John Ranney, Executive Director, and Emory "Soap" Dowell, Chairman of the Board of the Health Insurance Plan of California (HIPC)

Gathering information for the county profile became a concentrated effort. Considerable time was spent reading and conducting over 30 interviews with local-level stakeholders. Chapter II contains a list of contacts who provided information for the county profile. It became clear that information for some basic inquiries (e.g., the number of primary care physicians, the number of medical school

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residency **affiliation** programs, the number of community clinics) was unavailable or not centralized in one source.

During this same period, the II-IF team began to fill in the elements of the local health care reform model (Exhibit I-1) with information specific to Alameda County. This process **confirmed** that the service provider component is already well integrated and efficiently organized in Alameda County and that the traditional providers of services to vulnerable families are a central part of the Alameda Alliance for Health. This led the team to conclude that a value purchasing cooperative and associated community health information network were the important missing elements. This conclusion shaped the subsequent activities of the **IHF** team.

### **Various Factors External to the Project Led to a Period of Inactivity**

During late November and December 1995 and most of January 1996 activity came to a virtual standstill on the project because of: 1) Federal Government furloughs, 2) the holiday season, 3) the weather on the East Coast, and 4) time spent on the submission, review, and eventual rejection of a proposal to add more funds to the project effort to compensate for the resources expended on the county selection process and add specialized expertise to the IHF team.

### **Project Activities Started up Again in Earnest**

Once these various obstacles had been overcome, a period of intense II-IF team effort began toward the end of January and continued through mid-March. This period was characterized by highly focused work by the project team members, including contact, by telephone and in person, with a broad variety of Alameda County stakeholders.

### **The Project Advisory Council Continued to Provide a Sounding Board**

The second project advisory council meeting took place on January 23, during which Alameda County Health Care Services Agency Director David Kears made a presentation on the Alameda County Alliance, the local managed care **Medi-Cal** initiative that was the first local initiative to go on-line in the State. At the time of the meeting, the Alliance had over 4,000 enrollees and was rapidly expanding.

Additionally, Mr. Kears explained the efforts to move county inpatient facilities into a separate county health authority. Both the local initiative and the effort to set up an authority were being resisted by the public employee unions. The county supervisors remained **firm**, however, in their support of the effort, and Mr. Kears also expressed his strong support for the development of a purchasing alliance and area wide information system. Finally, he explained the county's preliminary effort to integrate certain social services and health care services,

Members of the advisory council then engaged in a spirited discussion about the Alliance and II-IF's

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underlying model of local health care reform. It was agreed that the progress already made by Alameda County to develop integrated provider networks resulted in the project's priorities resting on a purchasing cooperative and community information network. The value purchasing concept was explained in detail by Tom **Elkin**, and Mark Legnini talked about the role of information in managed care and public health.

A third and final meeting of the advisory council was scheduled for April 11, with the agenda of reviewing a draft project report. This turned out to be an inconvenient day, with most members preferring to pass along any comments **by** telephone.

### **The County Working Group Was a Useful Forum for Garnering Support and Identifying Local Concerns and Constraints**

At the request of the **IHF** team, county district supervisors Mary King **and** Wilma Chan convened a meeting with members of the project's county working group on January 24. The agenda was to review the project concept and status, identify additional interests that needed to be represented in the working group, and arrange for follow-up discussions on an individual basis.

The project's county working group met on March 19, and this meeting was a positive step **toward** involving a broader range of individuals in the project. A presentation of the project was made, with emphasis on the recommended strategies of a value purchasing cooperative and a community health information network. Of particular value was the fact that the Alameda/Contra Costa Medical Association director, a hospital administrator, and the Alameda County Superintendent of Schools participated in this discussion. The Superintendent was especially supportive of the project's emphasis on purchasing and information and was anxious to be part of it.

Membership of the **county** working group (chosen **by the two county** supervisors) includes:

- Wilma Chan (Co-Chair)  
Member, Alameda County Board of Supervisors
- Mary King (Co-Chair)  
Member, Alameda County Board of Supervisors
- b-win Hanson  
Chief Executive Officer, Summit Medical Center
- Susan Muranishi  
County Administrator
- Antonie H. Paap  
Chief Executive Officer, Children's Hospital

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- August **Scornaienchi**  
Superintendent of Schools
  - Lila Saks  
Chief Executive Officer, Diversified Services
  - Lyle Yates, MD  
Director, Alameda/Contra Costa Medical Society
  - David Kears  
Director, Health Care Services Agency  
Chief Executive **Officer**, Alameda Alliance for Health

Members of the **IHF** project team made no attempt to influence the criteria for membership of the county working group, believing that this was the province of the county supervisors. As the project moves closer to implementation, however, it may be necessary to add to the working group to make it more broadly representative of the community.

Members of the county working group met again on April 11 to provide feedback on the **IHF** draft report. Generally, their reaction was positive and they were eager to move ahead with implementation of the value purchasing alliance and the health information network.

### **Introducing Potential Collaborating Organizations and Other Community Stakeholders to the Local Health Care Reform Project Was Essential**

During their visits to the Bay area, team members met with a number of individuals who worked for organizations that **would** likely collaborate in any local health care reform efforts, represented relevant special interests, and/or had special knowledge of value purchasing or health information systems. These meetings were for the purpose of introducing the project, building support, and gathering information. The paragraphs below contain highlights of some of these discussions.

Patricia Powers is Executive Director of Pacific Business Group on Health (**PBGH**), a very successful purchasing cooperative that serves clients mostly in the private sector. Ms. Powers was interested to **learn** of the purchasing initiative being considered by the **IHF** team and was eager to collaborate when appropriate. The areas of information and outcome measurement were identified as being most conducive to collaboration.

The benefits administrator for the City of Oakland, **Leanne** Marshall, and the benefits coordinator for Alameda County, Helen Wright, indicated strong interest in exploring a-purchasing cooperative to include public employees once the concept was explained to them. They also indicated the need for a uniform and practical information system.

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Mildred Thompson, of the county's Healthy Start program, emphasized the desirability of integrating health and social services in the county. Such a move would not only be more administratively efficient, but also would reduce the burden on the county's most vulnerable families, some of whom receive services from several programs and therefore have five or six case workers. Further, Ms. Thompson discussed the desirability of bundling of categorical funding streams to reduce barriers to needed services and to reduce administrative costs.

Rita Boyle, Coordinator of the Interagency Children's Policy Council, is in charge of a large-scale county effort to integrate a variety of children's services in health, welfare, mental health, foster care, and criminal justice. This was an exciting addition to the emerging integration of services to better meet the needs of vulnerable families in the county. Ms. Boyle is eager to find ways to collaborate with the project's implementation.

**Ralph Silber**, Executive Director of the Alameda Health Consortium, represents many of the federally **qualified** health centers in the county. He felt that the health centers were in "pretty good shape" as a result of their relationship with the **Alliance**, but a number of details still had to be worked out. Mr. **Silber** was concerned that the purchasing cooperative could not reduce rates to the providers much lower than they are, that there was a great need for more primary care doctors, and that medical education was not well coordinated.

To get a better sense of how labor leaders might react to the local health care reforms being proposed, a meeting was **held** with Pat Ford, Executive Director of United Service Employees Local 616, who is considered one of the key public employee union leaders. Ms. Ford acknowledged that, in general, the emphasis of this project **would** benefit union membership directly and that any negative effects of downsizing, **if it** occurred, would be indirect, years later, and probably due to other forces beyond the purchasing cooperative. She agreed to meet with the project team on a regular basis to exchange information and advice on the project.

Marjorie Wolf, Director of the newly created **VISN** for the Department of Veterans Affairs described the reorganization and goals of the VA in the area. Ms. Wolf sits on the project advisory council and is therefore quite familiar with the project and the potential for future collaboration.

Meetings with State officials confirmed that the prospect of block grants from the Federal Government had motivated State officials to entertain the notion of a statewide information system. In turn, the Department of Health Resources found the Alameda County project concept potentially valuable in that it might serve as the prototype for a "ground-up" information system the State is seeking.

IHF team members also **discussed** with various Federal officials and State and local leaders the concept of integrating social services and other discretionary programs with health care services through the purchasing cooperative, and **including** information about these programs in the information system. These discussions **focussed** on the need, **during** the project implementation stage,

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to **recommend specific** ways that the Federal **Government could** assist in supporting the local delivery system, including waivers.

### **Strategic Plans on the Purchasing Cooperative and the Information Network Were Drafted by Experts on the II-IF Team**

Early versions of the project design had envisioned that implementation plans would be developed by members of the local community and the **IHF** team working in concert. Funding and timing constraints prevented this from being practical.

In early March, members of the **IHF** team spent several days in Alameda County working closely together to develop further the strategic concepts of the value purchasing cooperative and the community- information network. During this period, the team interacted with a number of key county officials for the purposes of clarification, coordination, and consensus building. They also spent a long time working through the interdependence between the cooperative and information network, the likely timing of developing these innovations, and the resource requirements of each.

Chapters III and **IV** contain implementation plans for the cooperative and the information network. These have been reviewed by members of the advisory council and the county working group, as well as by the appropriate officials of Alameda County.

#### **4.4 Phase 4: Implementing the Local Health Care Reform Initiative**

The implementation of the community-based strategy that was developed during this project is not only feasible but also stands an excellent chance of meeting the objective of improving outcomes for vulnerable families.

An early implementation step is for the **IHF** team to work with Alameda County officials to inventory the various inputs into the county's health care system, such as State and federally funded programs, related **programs** such as the Empowerment Zone/Enterprise Community initiative, and other health and social services that impact on Alameda County residents, especially its most vulnerable families. The inventory of **programs** will include identification of funds over which the county has control, as these can most readily and quickly become part of local health care reform. It will also be important early in implementation for the managed care organizations operating in the county to be brought into the process.

The **IHF** team also needs to fine-tune the implementation approach by working with the local working group and Alameda County officials to finalize an agreement among all the key community players that the purchasing alliance and information network are the logical next steps toward health care reform in the county. At the same time, more analysis needs to be done to ascertain how best to organize. structure, and locate the alliance and information network and then to facilitate the development of consensus among essential community stakeholders on these matters. The **IHF**

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project team stands ready to take these next steps, as do the political and administrative **arms** of the Alameda County government.

The **strategic** plans in Chapters **III** and IV will be refined as a result of the planning and analysis work described above. Once the implementation plans are more **definitive**, **IHF** and the county will be in a position to move ahead with implementation. **The** IHF team feel confident that foundations, venture capitalists, and corporations can be brought in to support start-up aspects of implementation. Once the value purchasing cooperative is established, it will pay for itself quite quickly. The community health information network will also become self-sustaining, and even profitable. within a fairly short time.

## 5. SEVERAL LESSONS CAN BE LEARNED FROM THE PROJECT TO DATE

### 5.1 **Lessons about Counties and Health Care Reform**

- Counties are being profoundly affected by the changing relationships among DHSS at the Federal level, State Governments, and the DHSS Regional Offices, and they must be prepared for dramatic changes in the scope of their health care responsibilities.
- County governments are going to be forced to make hard economic choices about whether to raise local taxes and/or whether to disband some programs.
- County governments need to redefine their public health role and seize the opportunity to take on a central role in a locally reformed health care system.
- While some county government officials are innovative and visionary, others are defensive, isolated, and prone to fight any change in their status.
- Counties currently provide much of the health and social services needed by vulnerable families. but county health and social services are often the least well funded among various community providers,
- Families that are poor or otherwise disadvantaged often receive services from a number of providers and support agencies: rationalizing this situation will require cooperation at Federal, State, and local levels.
- County health care services are particularly vulnerable in a managed care environment because they are not competitive with the private sector.
- Counties all over the United States seemed to be experiencing the same set of dynamics with many of the same reactions. The vision of reform reflected in the

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concept paper and used to shape the Alameda County project began to emerge not only as a model but also a path for a variety of communities to follow.

## 5.2 Lessons about the Project Concept and Process

- Going into the county with a proposed local health care reform model quickly leads to interest **and** commitment on the part of key players.
- Having a competent and respected **statewide** advisory council is quite valuable. Their thoughtfulness, insight, and early participation, as well as their individual influence and reputation, added instant credibility to the project.
- An outside team can serve as catalysts and facilitators for local health reform.
- The selection of a county that is already advanced in health care reform is useful as it **minimizes** conflict, **maximizes** the efficiency and focus of the work, and increases the likelihood of success.
- The **stability** of the health care delivery component is **determined** primarily **by the** local market **dynamics**, the personalities of local leaders, and the relationship with larger **statewide** dynamics, such as Medicaid financing mechanisms.
- Early support **from** inside the county's power circle is essential for introductions, endorsements, and information gathering.
- Planning for a transition for the critical components of indigent care, Medicaid, medical education, and special services is absolutely crucial if a community is going to make the transition smoothly and avoid crisis environments.
- The concept of value purchasing was **quickly** and enthusiastically endorsed **by those** responsible for **buying** health insurance for public employees. The next steps in this regard **would** be to: 1) systematically discuss the idea with each public employee purchasing entity, and 2) involve them as an advisory committee in the concept development.
- A purchasing alliance is the specific engine necessary to develop the information **system network**. **The network, in turn, becomes the necessary** fuel for the purchasing alliance.

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## 6. MORE DETAILED PLANNING IS REQUIRED TO DETERMINE THE REPLICABILITY OF THE ALAMEDA COUNTY PROJECT ELSEWHERE

One of the reasons why DHSS provided IHF with funds to support this project was to **ascertain** whether or not the project process **could** be replicated usefully in other locations, and, if so, how. The IHF team will have more suggestions about this once the more **detailed** planning is completed, and probably more once implementation is under way.

More work needs to be done to identify the legislative and regulatory **incentives** and barriers that affect **local** health care reform. Many **key** elements seem to be dependent on being able to offer flexibility at the local level, and the authority under which local flexibility might be possible needs to be more clearly articulated. The Appendix to this report contains a discussion of Federal waiver options for Alameda County. However, the terms under which this mechanism for stimulating change are permitted are subject to review and are reconsidered quite frequently. It is important that decision-makers in counties considering local health care reform are aware of the latest pertinent information about waivers and other candidate mechanisms **and** their implications.

Like toll roads, the elements of local health care reform (an integrated **delivery system**, a **value** purchasing cooperative, and a community health information network) require investments in the beginning; once they are up and running, they pay for themselves. To provide a stimulus to local health care reform, a program design well worth considering is the one adopted in the early **days** of the HMO. Under the Federal HMO program, grant **funds** were **made** available for feasibility, planning, and initial development of **HMOs**, and loans and loan guarantees were made available for initial operating deficits. This amounted to the equivalent of venture capital for local innovation.

The Federal Government can play other invaluable roles in local health care reform. For example, it can stimulate interest in the **idea**, network among people and organizations with something to offer, voice concerns **about** the effects on vulnerable populations” share information about lessons learned, and affirm the essential parochial character of viable health care reform efforts.

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**CHAPTER II**

**ALAMEDA COUNTY PROFILE**

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## CHAPTER II

### ALAMEDA COUNTY PROFILE

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This chapter presents a profile of Alameda County health care needs, resources, and initiatives, set against the background of Federal and State activities. The chapter serves several purposes:

- The data collected here influenced the selection of the county and guided the development of the implementation activities.
- The process of gathering the information afforded valuable insights into dynamics within the county, and these were useful to the project.
- The profile provides a context within which to place the county health care reform implementation plans.
- The profile affords the reader the opportunity to compare key characteristics of Alameda County with those of other counties, thus providing guidance on the **replicability** of this local health care reform initiative in other locations.

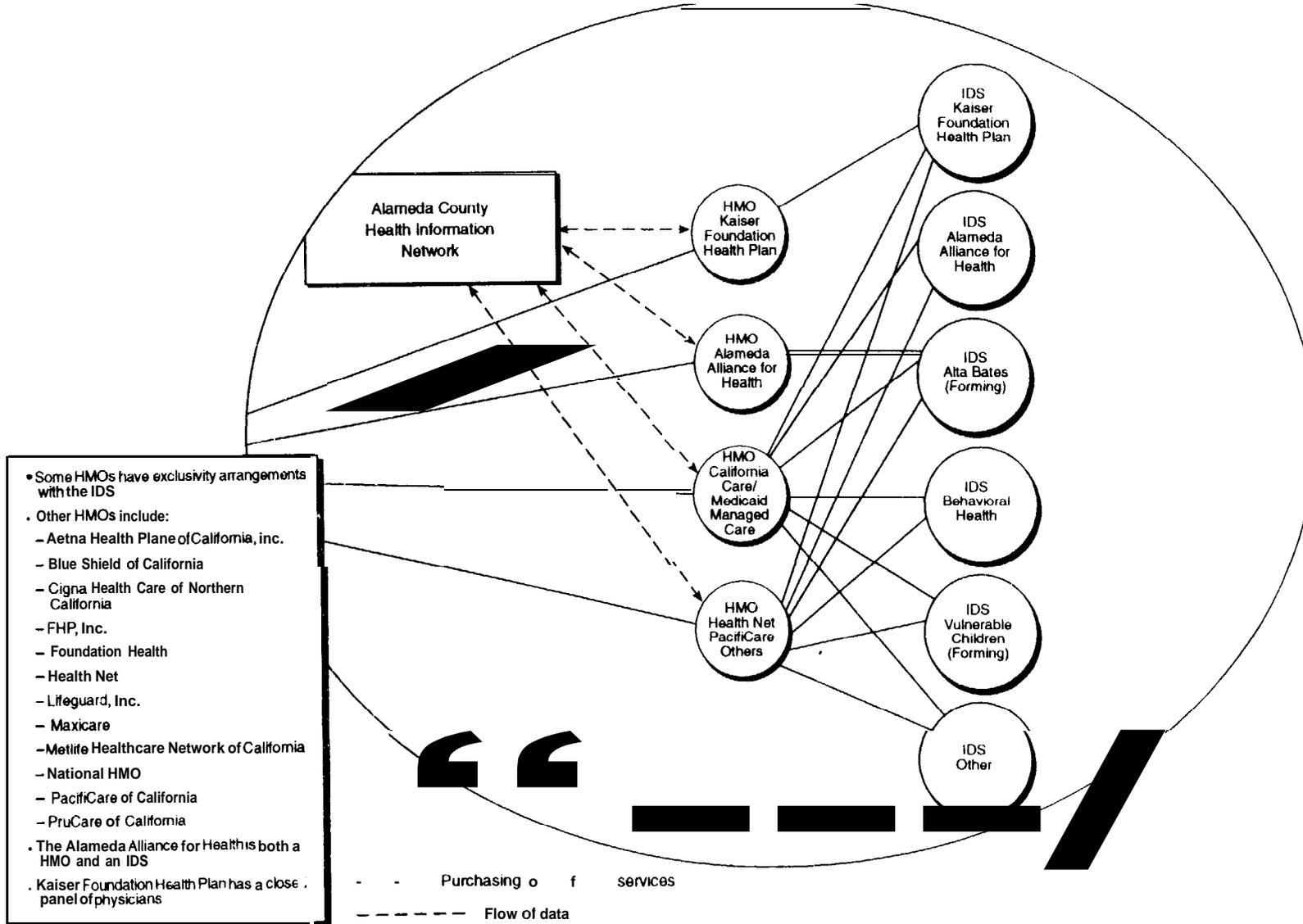
The **first** two sections of this chapter provide a brief overview of health-care-related activities at the Federal and California State levels. The remainder, the major focus of this chapter, presents a comprehensive description of Alameda County. Specifically, it describes the ways in which health care, particularly primary health care, is purchased and provided in the county and how that care is delivered to and accessed by the most vulnerable sectors of the population. It also includes descriptions of the providers and purchasers, targeted medical-oriented health initiatives, the county public hospitals, and Medicaid managed care programs, such as the Section 1915(b) waiver program. At the end of the chapter is a description of the Alameda Alliance for Health, the integrated delivery system developed by the county in response to the local initiative opportunity. Exhibit II- 1 presents a model health care reform infrastructure for providers,

#### **1. FEDERAL HEALTH CARE ACTIVITIES**

The 104th Congress has made reducing the Federal deficit its highest priority. To assist in achieving this objective, priority attention has been given to developing approaches to restructure the health care delivery system, especially the Medicaid and Medicare programs. Americans spend approximately \$900 billion a year on health care-14 percent of the gross national product. Health care consumes approximately 18 percent of the Federal budget, and health care costs climbed at twice the rate of inflation during the late 1980s and early 1990s. However, after much debate and

EXHIBIT II-1

ALAMEDA COUNTY REFORM PROTOTYPE  
THE PROVIDER NETWORK



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negotiation-during the past year on ways to modify Medicare and Medicaid, these issues are still pending, along with welfare and health care reform.

There is substantial support and agreement between the President and Congress for increasing enrollment of the Medicaid and Medicare populations into managed care plans as a way to control medical costs. Moving away from the non-incentivized, costly fee-for-service reimbursement mechanisms and towards incentivized, utilization-controlled, **capitated** mechanisms is expected to make purchasing medical care on behalf of these populations more economically and financially advantageous.

Over ~~the~~ past few years, the importance of Health Care Financing Administration (HCFA) Medicaid waivers, Section 1115 research and demonstration waivers and Section 1915(b) program waivers, has increased. Both types of Medicaid waivers permit States to seek exemption from certain sections of the Social Security Act so they can experiment with health care services delivery to improve access, cost, and quality. Waiver programs emphasize managed care and mandating Medicaid beneficiary enrollment in managed care plans. They also promote the use of prepaid **capitation** reimbursement. The Section 1115 research and demonstration waiver offers States more flexibility in the operational and **financial** flexibility of Medicaid managed care programs than does the Section 1915(b) program waiver. As of March 1996, 13 States have received approval for Section 1115 research and demonstration waivers, eight of which are operational, and 11 States have waiver applications pending HCFA approval. However, with the uncertainty surrounding the future of the Medicaid program and the use of block grants, no new waiver programs have been approved, and no States have submitted waiver applications since December 1995. Maryland intends to submit one very soon.

Enrollment of Medicare beneficiaries in managed care has not been as aggressive as enrollment of Medicaid beneficiaries, and fewer than 10 percent of all Medicare beneficiaries are currently enrolled in some kind of managed care arrangement. Hence, rapid movement of the Medicare population into managed care is a priority.

Since 1978, HCFA has promoted the use of waivers and variances to initially **fund** five demonstration projects involving eight **HMOs** to further test the effects of HMO participation on the Medicare beneficiary. Subsequently, HCFA solicited additional participation in demonstration projects designed to test whether competition in the health care sector would bring about a decrease in costs while maintaining administrative efficiency, providing increased benefits, and rendering high-quality care to Medicare beneficiaries. Under these demonstrations, there were no restrictions on the recoverable amount or use of any savings realized by the **HMOs**. These demonstration projects established the foundation for current efforts to foster managed care systems for the Medicare program.

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## 2. STATE HEALTH CARE ACTIVITIES

Californians realize that health care expenditures cannot continue to increase as they have over the past several years. The State's health care expenditures have been growing faster than its economy. Public programs such as Medicare, Medicaid, and local government account for over half of total health care expenditures, and providing medical care to the uninsured has contributed to the serious drain on the State's health care budget. Innovative managed care programs have been implemented in the hope that they will better control and monitor health care dollars.

### 2.1 Health Care Spending in California Is Expected To Spiral to \$186 Billion by the Year 2000

As are most States in this country, California is faced with a health care crisis that stems from spiraling health care costs. For years the State's health care expenditures grew at a faster rate than the State's economy. Between 1980 and 1990, health expenditures grew by 10.3 percent annually, while the gross State product grew only by 8.8 percent annually.' While this percentage is high California's per capita health care spending grew less than the national average. Total health expenditures in California are expected to reach \$137 billion in FY 96 and to increase to \$186 billion by FY 2000.<sup>2</sup> The share of State revenues channeled into health programs also increased. In 1985 State health care spending (excluding Federal funds) was approximately 16 percent of tax revenue, in contrast to 20 percent in 1992.<sup>3</sup>

#### Sources of Health-Related Expenditures

In 1994, total health-related expenditures in California were approximately \$116 billion.<sup>4</sup> Private insurance and private out-of-pocket dollars accounted for over 55 percent of these 1994 expenditures. Public programs such as Medicaid and Medicare each accounted for approximately 16 percent of the total expenditures, while State and local governments contributed approximately \$2.1 billion, of which \$8 billion was for Medi-Cal, \$7 billion was for State and local government employees' health insurance, and \$6 billion was for other State and local **spending**.<sup>5</sup> Exhibit II-2 shows estimated California health expenditures by payment source. Forecasts suggest that by the

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<sup>2</sup>Health insurance Coverage and Health Expenditure Trends in California, New York, and Texas 1994-2000, A Comparison of Key Findings From Three State Studies, Barents Group, LLC, for the Henry Kaiser Family Foundation, May 31, 1995, page 9.

<sup>3</sup>Ibid, page 8

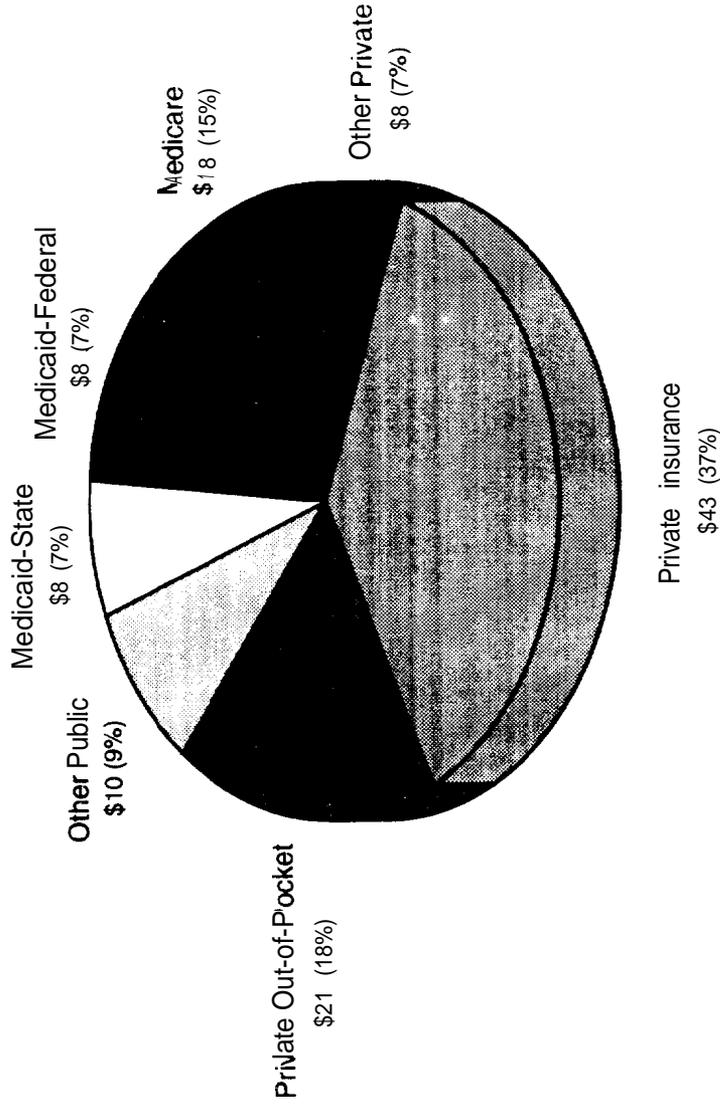
<sup>4</sup>Ibid, page 9

<sup>5</sup>Ibid, page i 0.

<sup>6</sup>Ibid, page 10

EXHIBIT II-2

CALIFORNIA HEALTH CARE EXPENDITURES BY SOURCE OF FUNDS, 1994  
(IN BILLIONS OF DOLLARS)



Source: *Health insurance Coverage and Health Expenditure Trends in California, New York, and Texas 1994-2000, A Comparison of Key Findings From Three State Studies*, Barents Group, LLC, for the Henry Kaiser Family Foundation, May 31, 1995, page 10.

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year 2000, public sources such as Medi-Cal and Medicare will contribute approximately 40 percent of the State's total health care expenditures.

State and local government health care outlays are projected to increase to \$25 billion in FY 96 and \$34 billion in the year 2000.<sup>6</sup> Exhibit II-3 shows the projected growth in State and local government health care spending broken down by Medicaid, employee health, and other categories.

### **The Uninsured Population**

The cost of providing medical services to the uninsured population contributes significantly to the State's increasing health care costs. In 1994, California had the highest percentage of uninsured persons among all States. **Approximately 20 percent (over 6 million persons) of the State of California's population were uninsured.**<sup>7</sup> In California the uninsured population has the following characteristics:

- Over 40 percent of the uninsured are persons between the ages of 19 and 34
- Over 68 percent of the uninsured population work or have a family member in the workforce, and only 31.7 percent of the uninsured population have no working affiliation.

Approximately 43 percent of the uninsured population are from families with incomes of less than \$5,000. Approximately 20 and 9 percent of the uninsured population are from families with incomes between \$35,000 and \$50,000 and above \$50,000, respectively.

- Approximately 49 percent (706,090) of the undocumented (illegal alien) population are uninsured.

### **2.2 The State Has Promoted the Use of Managed Care Strategies To Control Health Care Costs**

In order to combat escalating health care costs and to control the budget, the State has been following the private sector's lead and has implemented and promoted managed care strategies. Various managed care models exist, yet they all focus on reshaping the relationships among health care purchasers, providers, and patients; on promoting new ways in approaching the delivery and financing

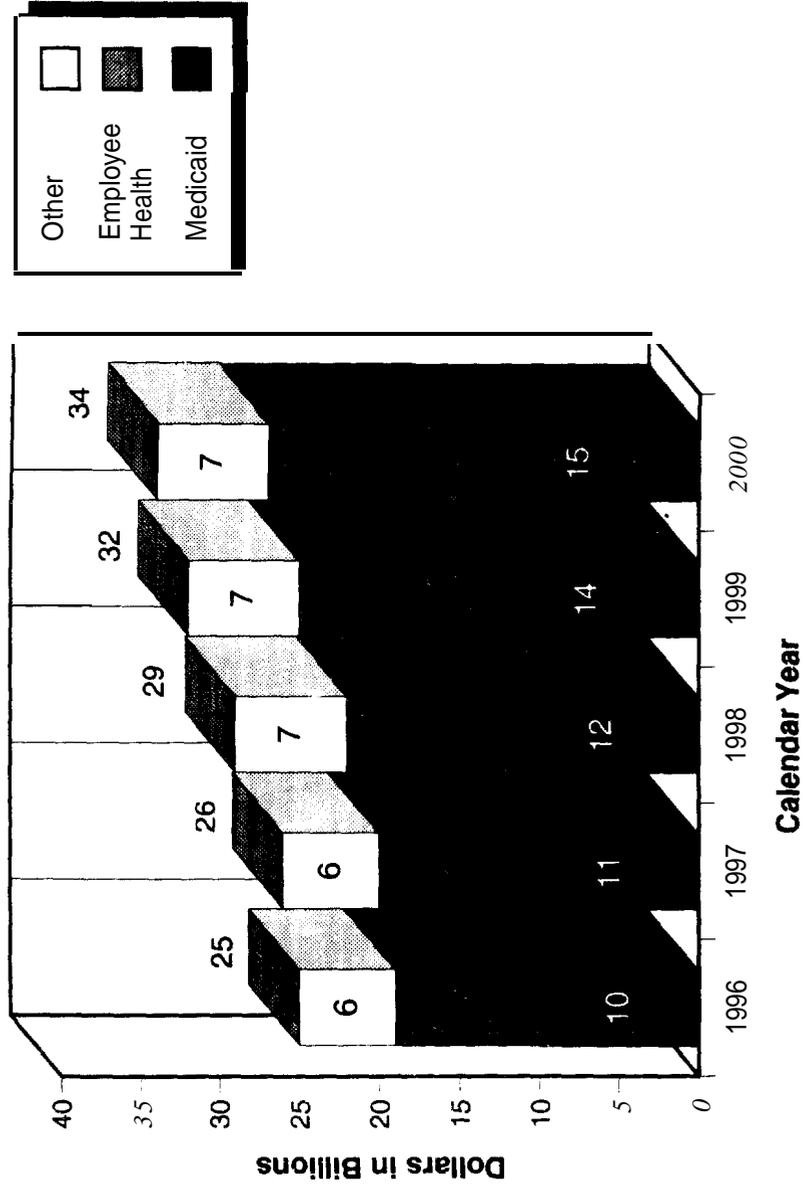
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<sup>6</sup>Tbid, page 14.

<sup>7</sup> *A Report on the state of Health Care in California*, Lewin-VHI, Inc., for the California Business Roundtable and the Kaiser Family Foundation, August 1995, page 18.

EXHIBIT II-3

PROJECTED CALIFORNIA STATE AND LOCAL GOVERNMENT HEALTH FUNDING, 1996-2000



Source: Health Insurance Coverage and Health Expenditure Trends in California, New York, and Texas 1994-2000, A Comparison of Key Findings From Three State Studies, Barents Group, LLC, for the Henry Kaiser Family Foundation, May 31, 1995. page 14.

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of health care services; and on emphasizing continuity of care that starts with prevention and primary care.

The State of California has the highest health maintenance organization penetration rate in the nation. Over 38 percent of the population receive medical care from HMOs. In the San Francisco area alone, over 80 percent of the persons with commercial health insurance are in HMOs or preferred provider organizations (PPOs).<sup>8</sup>

Decisionmakers in California have realized that implementing managed care strategies in the private sector can achieve financial benefits without sacrificing quality health care and that these strategies can be used as effectively for public programs such as Medicare and Medicaid. HMO participation among Medicare beneficiaries almost doubled during the seven years from 1987 to 1994. Medi-Cal beneficiary participation in HMOs is even greater. Exhibit II-4 shows HMO penetration rates for the Medicare and Medi-Cal populations.

### **2.3 California's Section 1915(b) Program Waiver Will Expand the Medi-Cal Population's Participation in Managed Care**

California is committed to the rapid expansion of managed care within the Medi-Cal program as a means of improving access to primary care services and controlling Medi-Cal expenditures. In 1993, the number of Medicaid beneficiaries in California amounted to almost 17 percent of the number of people eligible nationwide. Currently about 1 million of the State's 5.5 million Medi-Cal recipients are enrolled in an HMO or some other Medi-Cal managed care plan.

In January 1996, the Health Care Financing Administration (HCFA) approved the California Department of Health Services' (DHS) Section 1915(b) program waiver application. The waiver describes a two-plan model that requires Medi-Cal beneficiaries in each of 12 counties to choose between a comprehensive, locally developed (initially by the county government) managed care plan (termed the "local initiative plan") and a nongovernmentally operated HMO (termed the "mainstream plan"). This Medi-Cal Managed Care Expansion Plan is expected to shift 2 million more Medi-Cal recipients to managed care by the end of 1996.

The alternative plans have the following characteristics:

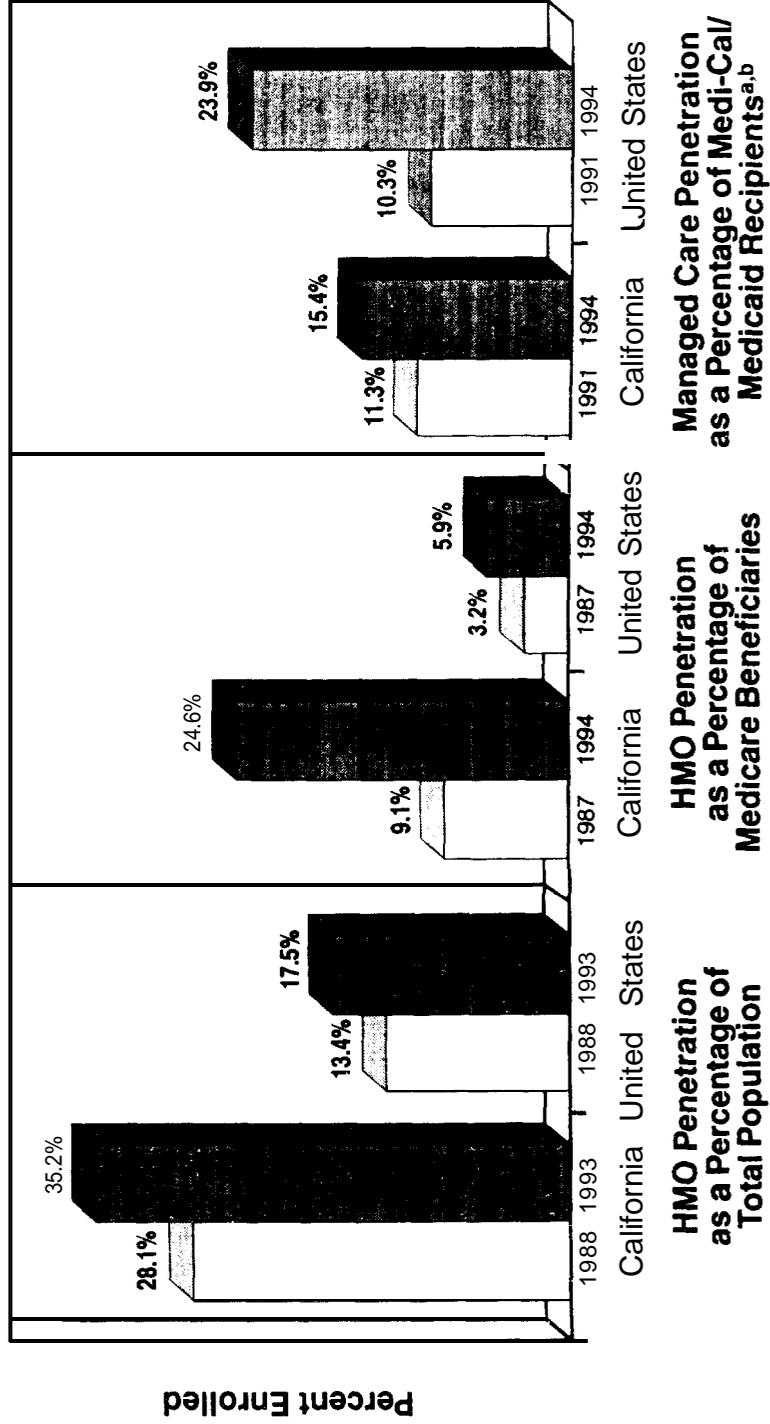
- **Local Initiative-The** board of supervisors in each of the 12 counties has been given the first opportunity to develop a local initiative plan. If the county is not interested,

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<sup>8</sup>Group Health Association of America, *1995 National Directory of HMOs*.

EXHIBIT II-4

PERCENT OF POPULATION ENROLLED IN MANAGED CARE  
CALIFORNIA AND UNITED STATES COMPARISONS, SELECTED YEARS



<sup>a</sup> Office of Medicaid Cost Estimates, HCFA Office of Managed Care.

<sup>b</sup> The States as Payers: *Managed Care for Medicaid Populations*, Lewin-VHI, Inc. 1995.

Source: Group Health Association of America data and data provided by the Health Care Financing Administration

Source: *A Report on the State of Health Care in California*, Lewin-VHI, Inc., for the California Business Roundtable and the Henry Kaiser Family Foundation, August 1995, page 10. Data from Group Health Association of America and the Health Care Financing Administration.

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the Department of Health Services (DHS) will entertain proposals from certain other parties in the region. The local initiative may take any of these form:

- *A health care consortium* in which local stakeholders share governance of an organization that is responsible for administering Medi-Cal managed care
  - *A county-organized health system “look-alike”* in which the county board of supervisors establishes an entity for purposes of administering the local initiative as one of the two full-risk plans in a region
  - *Any alternative system* local stakeholders develop that meets the requirements of State and Federal law and State criteria
- **Mainstream Plan-DHS** has selected a commercial HMO for each region through a competitive “invitation to bid” process. In Fresno county, DHS selected two mainstream plans.

A key concept of the California waiver program is that the local initiative and mainstream plans “compete,” meeting the statutory and HCFA requirement that patients must choose. DHS has set a minimum enrollment of 30,000 for each plan. Enrollment in the mainstream plan will be limited to 30 to 40 percent of those eligible. This approach will preserve a choice for Medi-Cal beneficiaries, will ensure that the local initiative plan has a stable volume of business to support participating traditional **providers**<sup>9</sup> and safety net providers” during its start-up phase, and will allow the mainstream plans a sufficient volume of business to maintain their economic vitality. When DHS begins implementing this strategy, new enrollment in existing prepaid health plans and primary care case management programs will cease.

The 12 counties designated to participate in the two-plan model waiver program are:

- **Alameda**
- Contra Costa
- Fresno
- **Kern**
- Los Angeles
- Riverside
- San Bernardino
- San Francisco
- San Joaquin
- Santa Clara
- **Stanislaus**
- Tulare

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<sup>9</sup>Traditional providers are providers who have demonstrated a consistent commitment to serving the Medi-Cal population.

<sup>9</sup>Safety net providers are providers who receive State and Federal subsidies to care for both Medi-Cal and unsponsored medically indigent recipients.

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Except for Fresno county, which will have two mainstream plans, each of the designated counties will have a local initiative and a mainstream plan

## **2.4 Other Types of Medi-Cal Health Reform Programs Are in Place**

The Section 1915(b) program waiver has been the State's most ambitious attempt to modify the health care delivery system for Medi-Cal beneficiaries. However, prior to this two-plan program, the State implemented some other managed care-related programs for this population. These programs will continue to operate even after the start of the waiver program. The following are brief descriptions of three Medi-Cal managed care programs.

### **Selective Provider Contracting Program**

Under the statewide Selective Provider Contracting Program, the State of California contracts with selected hospitals to provide inpatient services to Medi-Cal beneficiaries. This program is operational and will continue to operate in 11 of the 12 counties designated for the two-plan model.

### **County-Organized Health Systems**

County-organized health systems (COHSs) are arrangements in which a local agency has the responsibility for managing the Medi-Cal program in a county by contracting with local providers for most Medi-Cal services. All arrangements (including reimbursement methods and reimbursement rates) are negotiated locally, and most providers are at risk for some portion of their services. The COHS itself is paid by the State on an actuarially determined **capitation** basis, calculated to equal slightly less than the State would have paid for fee-for-service Medi-Cal in the area. Santa Barbara, San Mateo, and Solano counties have COHSs already in place. These are not two-plan waiver program counties. Orange and Santa Cruz counties are developing COHSs.

### **Primary Care Case Management Program**

Under the Primary Care Case Management (PCCM) program, primary care providers contract formally with DHS to assume risk for primary care, specialty physician's services, and selected outpatient preventive and treatment services provided to the Medi-Cal population. PCCMs share savings on inpatient hospital costs with the State.

The PCCM program will be scaled down after the implementation of the two-plan model. PCCM plan contracts in the 12 counties designated for the two-plan model will end approximately three months **after** full implementation of the two-plan model. The State anticipates that PCCM providers will join either the local initiative or the mainstream plan. PCCM plan contracts in counties not designated for the two-plan model will not be affected.

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## 2.5 Purchasing Alliances Represent Another Managed Care Strategy

California is well ahead of other States in experimenting with marketplace reforms that reinforce key characteristics of managed care programs. In fact, California has been at the forefront of designing and demonstrating the merits of purchasing alliances targeted at specific populations using the forces of managed competition. California's introduction of managed competition supported with managed care plans has proven financially advantageous. The Pacific Business Group on Health, the California Public Employees Retirement System (CalPERS), and the Health Insurance Plan of California are three successful employer purchasing alliances.

### **Pacific Business Group on Health**

The Pacific Business Group on Health (PBGH), which evolved from a coalition of large Bay Area employers, is the preeminent large business coalition in California. It consists of more than 30 member companies throughout the State, each of which has at least 2,000 employees and is not in the health care industry. Together, these PBGH members spend approximately \$3 billion on health care for over 2.5 million employees, dependents, and retirees.

When PBGH was formed, it focused on standardizing health data collection and benefits among its member companies. However, as the health care market changed, so did the focus of PBGH. It began developing ways to promote competition in the marketplace. It formed, along with several of its members, a negotiating alliance to negotiate health care premiums and benefits collectively on behalf of its members. In 1995, the first year in which the bargained rates became effective, PBGH reduced the variance in premiums by 22 percent and the enrollment-weighted average premium by 9.2 percent." It also formalized fixed rates for 1996 and 1997.

Another way the PBGH members promote competition is by tying their health benefit contributions to the premiums charged by the lowest-cost health plans available, so that their employees must pay additional charges to enroll in a higher-cost plan.

PBGH believes that quality monitoring and competitive prices can foster competition. PBGH negotiated with the HMOs the provision that a percentage of the premium be linked to meeting quality performance goals. The group has also developed an HMO report card, so that employees can make informed decisions about which participating provider they want to select as their primary care provider (PCP).

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<sup>11</sup>"California Employer Coalition Saved \$36 Million on HMO Premiums, Study Says," *BNA's Managed Care Reporter*, Bureau of National Affairs, Volume 2, Number 2, January 10, 1996.

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## **California Public Employees Retirement System**

The California Public Employees Retirement System is a statewide purchasing cooperative for State and county employees. It covers approximately 910 public-sector employers and serves approximately one million public employees, retirees, and dependents. It spends approximately \$1.6 billion annually.

Joint purchasing through the cooperative has been extremely effective in reducing premium rates for its members. In FY 1993- 1994, CalPERS negotiated a rate decrease of 0.4 percent, which represented the first health care premium reduction that had been achieved in many years. Then, in February 1995, CalPERS negotiated an average premium reduction in excess of 3.8 percent for all its plans for FY 1995-1996.

As with PBGH, CalPERS wants to ensure that its participating HMOs provide high-quality care and that plan performance is evaluated. In 1995 it published the first health plan performance and quality report for its members.

Many public agencies in Alameda County participate in CalPERS. As of February 1995 they represented approximately 38,761 employees and included such agencies as:

- Alameda City Housing Authority
- City of Alameda
- Alameda County Congestion Management Agency
- Alameda County Municipal Court
- Alameda County Fire Department
- Alameda County Law Library
- Alameda County Mosquito Abatement District
- Alameda County Transportation Authority
- Alameda County Waste Management Authority
- City of Albany
- Albany City Retirement Plan, Fire/Police
- City of Oakland

## **Health Insurance Plan of California**

In 1992, the State of California implemented a small business insurance reform law, which created a State-sponsored purchasing pool for small businesses, the Health Insurance Plan of California (HIPC). The Managed Risk Medical Insurance Board, an independent State agency, administers this voluntary health care alliance/insurance purchasing pool. The objective of implementing joint purchasing was to give small employers the administrative, financial, and economic advantages that had historically been afforded only to large companies.

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HIPC represents companies that employ between 3 and 50 persons. As of January 1996, HIPC had approximately 103,000 enrollees from over 4,000 employer groups.

Through a purchasing arrangement, small employers gain leverage in negotiating reduced premium rates. HIPC negotiates aggressively with many managed care plans on behalf of the small employers. For FY 1994-1995, HIPC obtained reduced premium rates for its members of about 6.3 percent, and for 1995-1996, it achieved further reductions of 5.1 percent. Currently, 25 health plans are HIPC providers.

Of the 103,000 persons participating in HIPC, approximately 10.7 percent are from Alameda County. These 11,000 persons are primarily small business employees and their dependents, but a small number are retirees. The participation of Alameda County workers in HIPC is disproportionately high relative to percentages in other counties with larger total populations.

## **2.6 Community Clinics Have an Important Role To Play as the State Undertakes Health Care Reform Initiatives**

In 1993, there were 409<sup>12</sup> primary care community clinics providing predominantly general medical or family planning services to vulnerable populations in 51 of 58 counties in California. The clinics also offered dental, HIV testing, mental health, and substance abuse services. These clinics served over 1,957,000 patients. Approximately 42 percent of clinic patients did not speak English as their primary language, and over 80 percent had incomes of less than 200 percent of the Federal poverty level. Total aggregate revenue of these clinics was \$502,954,560, with 60 percent deriving from direct patient revenue, 38 percent from contracts and grants, and 2 percent from donations. Of the patient revenue, 30 percent was from Medi-Cal (the largest contributor) and 3 percent from Medicare. Of the revenue from contracts and grants, 18 percent was Federal, 9 percent State, and 8 percent county or local.

As the presence of Medi-Cal managed care increases, primary care community clinics will have an increasingly larger role to play and become vital network providers. They know the medical and social needs of the Medi-Cal population, have developed a trusting and loyal relationship with that population, and remain committed to fulfilling the mission of providing quality, accessible health care to the neediest people.

## **3. ALAMEDA COUNTY HEALTH CARE ACTIVITIES**

Alameda is a county rich with diversity, characterized by innovative, targeted, health-oriented programs, and known for its interested and vocal stakeholders. But most of all, it is a county that wants to improve the health of the neediest people within its boundaries. Of the 58 counties in California, Alameda County stands out as the one that has taken the most visionary approaches to

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<sup>12</sup>1993 *Community Clinic Fact Book*, April 1995

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improving the health conditions of its people. The following section describes Alameda County, its constituent and provider makeup, the numerous health care programs in place, and obstacles that the county faces in fulfilling its goals as it moves forward.

### **3.1 Alameda County Comprises Several Regions with Distinct Characteristics**

Alameda County is located on the east side of San Francisco Bay in Northern California. It extends from Berkeley in the north to Fremont in the south and Livermore in the east. It is bounded by Contra Costa County to the north, Santa Clara County to the south, San Joaquin County to the east, Stanislaus County to the southeast, and San Francisco Bay to the west. It occupies approximately 737.5 square miles and is made up of 14 cities and several unincorporated areas.

The county can be divided into three regions, each with different demographic and geographic characteristics:

- **North Region-This** area comprises the northwest part of the county, encompassing the cities of Berkeley, Oakland, Alameda, and San Leandro. This area is the most populous and has the greatest concentration of industry. Most of the direct health services and **welfare** programs are targeted to the populations in this region. Because of the area's high population and commercial enterprise densities, most social, political, ethnic, and community issues are focused here.
- **South Region—This** area comprises the southwest part of the county, encompassing the cities of Hayward, Newark, and Fremont. This area is suburban, with the population evenly distributed throughout.
- **East Region-This** area comprises the eastern part of the county, encompassing the cities of Dublin, Livermore, and Pleasanton. This area is sparsely populated and has a large agricultural component.

Exhibit II-5 presents a map of Alameda County.

### **3.2 The Composition of the County's 1.3 Million Persons Reflects a Rich Diversity**

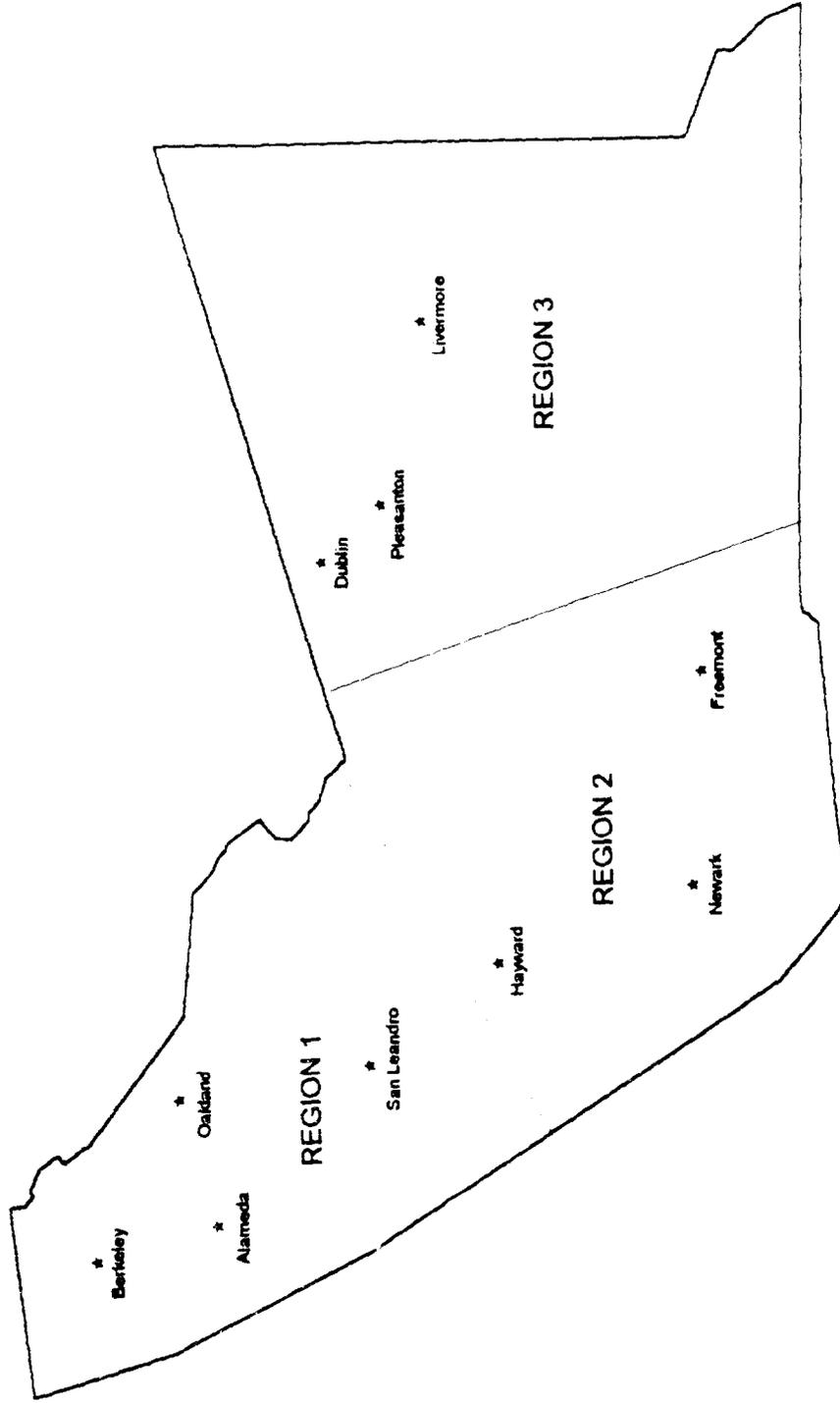
As of 1992, the county had a total population of 1,307,572 persons. This is a 2-percent increase over the 1990 total population (1,279,182). The projected total population for the year 2000 is 1,457,419.<sup>13</sup> The population in Alameda County has steadily increased at an average annual growth rate of 1.6 percent since 1980, making it the sixth most populous of the 58 counties in California.

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<sup>13</sup>Projected Total Population of California Counties, Report 93P-3, Department of Finance, May 1993.

EXHIBIT II-5

MAP OF ALAMEDA COUNTY



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Approximately half of the population increase can be attributed to natural increases (births minus deaths) and the other half to net migration.

Most of the county's population are concentrated in the small area between the East Bay Hills and the Bay. The population migrates toward the cities, where the greatest gain in population has occurred, with the fastest-growing cities in the southern and eastern parts of the county.

### **Ethnic Origins**

The 1990 census showed the following ethnic makeup for Alameda county's inhabitants:

<b>Ethnicity</b>	<b>Percent of Total Population</b>	<b>Ethnicity</b>	<b>Percent of Total Population</b>
White, non-Hispanic	53.16	Asian and Pacific Islander	14.45
Black, non-Hispanic	17.42	Hispanic	14.21
American Indian, Eskimo, and Aleut	0.53	Other, non-Hispanic	0.23

The number of Asians and Pacific Islanders increased dramatically (more than doubled) from 1980 to 1990, as did the county's Hispanic population (it grew 39 percent. Other ethnic groups grew at a much lower rate.

Projections for the year 2000 indicate that 45 percent of the total county population will be white, 18 percent black, and 17 percent **Hispanic**.<sup>14</sup> A large percentage of the Hispanic population is concentrated in the Hayward area, and Union City is home to much of the Asian population, predominantly Filipinos.

### **Population Age**

There appear to be equal numbers of *males* and females in Alameda County, with similar breakdowns for age categories between males and females, except (as might be expected), for slightly more women than men age 64 and over. These breakdowns are expected to remain the same for the year **2000**.

### **The Uninsured**

Alameda County has a higher number of indigents than any other county in California. Recent statistics show that between 300,000 and 375,000 persons are indigent. County officials indicated

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<sup>14</sup> Ibid.

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that this number is constantly changing and warn that reference to it should be made cautiously. These are people who do not have health insurance and whose incomes are under 200 percent of the Federal poverty level. A large portion of the indigent population are the working poor.

The number of undocumented persons was not available

### **The Medi-Cal Population**

As of December 1995, there were approximately 203,467 fee-for-service Medi-Cal eligibles in Alameda County. Expenditures for these persons totaled \$28,529,352.<sup>15</sup> Also as of December 1995, in addition to the fee-for-service population, approximately 9,650 Medi-Cal recipients were enrolled in a managed care plan such as a prepaid health plan, a primary care case management program, or a health maintenance organization.

### **3.3 Alameda County Allocates over \$445 Million Dollars Annually To Provide Health Care to its Residents**

Alameda County budgeted \$455,347,000 for its health care budget in FY 1995-1996. Exhibit II-6 presents the county line-item health care budget. The largest component of the budget is for the hospitals **affiliated** with the county medical center. The next largest allocation, of **\$84,000,000**, is for mental health. Alcohol and drug abuse is allocated over \$17 million, and HIV/AIDS is allocated 8.3 million.

Despite the large financial outlays for health care, Alameda County officials realize that health status indicators for the poor and uninsured, who are predominantly cared for by the county's public health system, are extremely alarming. Health indicators for these populations clearly reflect **higher-than-average** levels of preventable disease and premature death, a high prevalence of communicable disease, and high morbidity and mortality rates. These rates suggest that **funding** is insufficient or that the county's public health system, both the public hospital and public health department, are not performing optimally. The county acknowledges that given the fiscal crisis and tightening of budgets, increased **funding** for health care is improbable; therefore it is hoping that a restructuring of the county hospital and public health department will help in providing more and higher-quality care to the vulnerable populations.

### **Areas of Major Health Concern**

Several health conditions are at noticeably high levels among Alameda County residents. Low-income, **minority**, and culturally diverse residents are at greatest risk. The county has conducted several studies identifying these health concerns and realizes the need for targeted educational, medical, and community-oriented approaches to combat communicable diseases. In addition, many

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<sup>15</sup>Month of Payment Report, December 1995, Department of Health Services, Medical Statistics Section.

## EXHIBIT II-6

ALAMEDA COUNTY HEALTH CARE BUDGET  
1995-1 996

Area	Allocation
City Health Care Central Administration	\$ 710,000
Public Health Administration	10,237,000
Public Health District Services (including the five ambulatory care clinics)	21,000,000
Public Health—Maternal and Child Health (direct delivery, contracts)	10,500,000
Prevention, Education, and Advocacy	1,500,000
Public Health—Communicable Disease	3,000,000
HIV/AIDS	8,300,000
Emergency Medicine	2,500,000
Public Health—Field Nursing	3,700,000
Mental Health	84,000,000
Environmental Health	10,800,000
Alcohol and Drug Abuse	17,200,000
Criminal Justice—Medical	1,600,000
Adult Detention—Medical	11,000,000
County Medical Services Program	7,000,000
Highland Hospital Campus (part of Alameda County Medical Center)	148,000,000
Fairmont Campus (part of Alameda County Medical Center)	47,000,000
John George Psychiatric Pavilion	17,300,000
Medical Care Financing	40,000,000
<b>Total</b>	<b>\$445,347,000</b>

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of the county's residents have multiple health and social problems that require a complex array of services. Residents of Berkeley, West Oakland, San Antonio/Fruitvale, East Oakland, and Elmhurst have high to very high rates of all key indicators. The most disturbing data include the following.

**Tuberculosis and Hepatitis-One** of the most pressing and disconcerting health-related issues in the county is the prevalence of tuberculosis and hepatitis. Despite a decline from the reported 5,116 cases in 1994, there were nonetheless 3,984 reported cases of tuberculosis in 1995. Also, there were 8,165 reported cases of type A and type B hepatitis in 1995, down from 8,640 reported in 1994 but still high compared with previous years.

**Prenatal Care**—Many women who are at high risk for problem pregnancies do not receive sufficient prenatal care, and in many instances, they do not receive any care until they give birth. They typically do not access the health care system for preventive or prenatal care—for several reasons, including lack of knowledge of the system or the benefits of using it, language and cultural barriers, and illiteracy.

**Infant Mortality-In** October 1995, the Oversight Committee on Infant Mortality presented a report to the Alameda County Supervisors discussed the current rates of infant mortality in the county and suggested ways to address the alarming statistics. The report focused on action plans to reduce infant mortality by focusing on preventive efforts. In 1994, the total county infant mortality was 6.69 per 1,000 live births and the rate for the county's African American population was 12.2. The report presented several action plans, such as determining appropriate objectives for reduction, developing methods to prevent preterm delivery, and developing community profiles through assessing multiple major public health problems and community assets.

The infant mortality rate in East Oakland, West Oakland, and San Antonio/Fruitvale declined from 18.0 per 1,000 live births in 1988 to 8.7 in 1993. This is where Oakland Healthy Start has been in operation.

**AIDS**—A growing concern among county health officials is the increasing number of persons with AIDS, primarily stemming from drug use and prostitution. There were 9,777 reported cases of AIDS in 1995. Despite its being a 17-percent decrease from the number of reported cases in 1994, this is still a large number and a major challenge for the county's health system. Approximately 50 percent of the total number of reported AIDS cases in Alameda County in 1993 and 1994 were in African Americans. Most of the persons with AIDS reside in Oakland or Berkeley.

**Other Sexually Transmitted Diseases**—Diseases such as syphilis and chlamydia are at high levels as well, with 54,167 and 4,558 reported cases respectively in 1995. There is reportedly not enough education about the transmission of disease, especially of high-risk populations.

**Cultural Challenges**--There is concern that women in Asian cultures do not use the county health care system as frequently as they should. Deep-rooted cultural beliefs about the role and status of

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women may encourage the neglect of their medical and social needs. Even with the visibility of Asian practitioners and Asian-oriented clinics, many women in the county are still reluctant to obtain care.

### **Alameda County Medical Center**

To ensure that Alameda County Medical Center (Highland Hospital, Fairrnont Hospital, and John George Psychiatric Pavilion) would respond to the changing health care environment, a Medical Center Governance Committee was formed and charged with developing recommendations for new governance structures. The Committee first reviewed and evaluated six governance options. Then the members reviewed and selected 10 criteria for evaluation in four categories: (1) preservation of the Medical Center mission and Section 17000 fulfillment, (2) removal of constraints and increases in flexibility, (3) potential for increased revenues or savings, and (4) feasibility of implementation. The next step the committee took was to review a preliminary report on governance options in six other California counties and other governance models throughout the country.

Upon completion of these tasks, the Medical Center Governance Committee arrived at two decisions. The majority recommended developing a nonprofit public benefit corporation (PBC), and the minority recommended developing a hospital authority (HA). Both recommendations represent a transfer of governance to an independent governing body, a means for the Medical Center to maintain operational and financial viability in the volatile health care environment while maintaining its mission, and a way to receive direct county appropriations.

There are several differences between the two types of governance structure, including:

- The PBC would be a private entity and the HA would be a public entity.
- The PBC could not be disbanded by the Board of Supervisors, unlike the HA
- The PBC could be formed within the current statutes, but the HA would require new legislation.

After these recommendations were made public, several groups, including labor unions, strongly indicated that a county-chartered hospital **commission** should be another option. The Alameda County Board of Supervisors has the charter power to create commissions and identify their power and authority. The board could create a hospital commission made up of stakeholder members with medical and hospital expertise to manage **day-to-day** operations and perhaps control the budget of the Medical Center. The Medical Center would not have independent powers nor independent authority to enter into financial or management agreements without the approval of the County Board of Supervisors. This alternative would allow the earliest possible implementation date.

In February 1996, the Alameda County Health Care Services Agency voted to adopt the HA as the new governing model of choice. The HA will retain public accountability while incorporating and

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adopting private-sector practices and incentives, A hospital commission will be formed immediately and evolve into the HA. The Health Care Services Agency will also pursue the PBC on a parallel track in the event that enabling legislation for the HA is not passed. The target implementation date for the PBC is July 1, 1997

### **The Alameda County Public Health Department**

To remain viable in the future and to continue to serve the needs of the community, the county is reorganizing its public health department. The reorganization will ensure that similar services are combined, categorical thinking and practices are reduced, administration is streamlined, collaboration with community residents is promoted, and department strengths are maximized.

The new organization for the public health department emerged from input provided by department staff, community leaders, and county residents. Through focus groups, Town Hall meetings, and planning workgroups, the conceptual framework and mission were developed. Active participation of **all** community stakeholders was imperative. A significant component of the restructuring was the formation of Community Health Teams (**CHTs**), groups of department staff who work closely and collaboratively with residents and community providers to promote health and prevent disease. With **CHTs**, the county hopes to strengthen its ability to address the most urgent public health problems in the community as efficiently and effectively as possible as well as positioning the department to face obstacles from outside the county.

Through the following seven divisions, the department will be able to better perform its duties of policy development; health promotion, protection, and prevention; health assessment; and service accessibility and quality:

- Community Assessment, Planning, and Education
- Community Health Services
- Office of Disease Control and Prevention
- Children's Medical Services
- Environmental Health
- Emergency Medical Services
- Administrative Services

### **3.4 There Are Numerous Collaborative Efforts Among Those Who Know the Vulnerable Populations Best**

Numerous joint efforts among its health centers, medical societies, religious affiliates, schools, and social service providers (food banks, homeless shelters, AIDS clinics, special projects, etc.) demonstrate Alameda County's commitment to collaboration and innovation to develop programs to improve the health and well being of vulnerable populations. Knowing the targeted populations intimately, these community resources work together to develop tailored programs of effective reach

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and scope. Exhibit II-7 lists collaborative efforts in Alameda county. The following highlights of some of the County's efforts in promoting collaboration

### **Alameda County Youth Pilot Program (AB 1741)**

In 1993, the State Legislature passed Assembly Bill (AB) 1741, which established a five-year Youth Pilot Program to determine whether local communities can better serve children and families if categorical funds are "blended." Five counties, one of which is Alameda County, were chosen to blend various child and family service funds in support of the integration of services. By blending the funds, many restrictions and limitations on their use are eliminated. The bill does not appropriate any new **funding** for the pilot program, but instead promotes more efficient and effective use of existing staff and fiscal resources.

The **AB 1741** plan also includes two reform strategies: integration of services for children at the "high end" of the system and development of a neighborhood approach to reduce the risk of out-of-home placement of children. The program promotes locally controlled service and fiscal strategies that are comprehensive, family-focused, prevention-oriented, and outcome-based. However, for some strategies, the county may have to submit a regulatory or statutory waiver. Alameda County wants to reduce duplication and **fragmentation** of services by bringing together providers to better coordinate prevention and early intervention services for the whole family. Collaborative approaches to issues related to child welfare, foster care, health care, mental health, drug and alcohol abuse, employment, and juvenile delinquency should be addressed.

The pilot program started in July 1995 and will continue for the next five years. The target population is 1,300 children, approximately 7 percent of an estimated 17,000 Alameda county children already in or at risk of being placed in emergency foster care, a foster home with relatives or nonrelatives, a residential or therapeutic group home, a psychiatric hospital, juvenile hall, juvenile camp, or California Youth Authority facility.

### **The Oakland Child Health and Safety Initiative**

The Oakland Child Health and Safety Initiative (OCHSI) is a two- year planning grant program of the Robert Wood Johnson Foundation. It is an approach to promote the welfare of the city's children and serve as a national model of community empowerment to nurture and sustain healthy children and **families**. The Youth Services Policy Council, which will guide and provide oversight to the initiative will be co-chaired by **Elihu** Harris, Mayor of Oakland, and Alameda County Supervisor Wilma Chan. Task forces addressing pertinent issues related to improving the overall well-being of children and families will support the Policy Council. The East Bay Community Foundation will be the lead organization for the planning and organization of the initiative. This foundation is a model of how a community foundation can promote change in the community.

**EXHIBIT II-7**  
**COLLABORATIVE INITIATIVES IN ALAMEDA COUNTY**

<b>COMMUNITY NETWORK</b>	<b>DESCRIPTION</b>	<b>NUMBER OF PARTICIPATING AGENCIES*</b>
CoordiNet	Develops cooperative projects through coalition building in south county	15
Emergency Services Network	Prevents homelessness and hunger	5
FUND (Freemont-Union City-Newark-Destiny)	Increases service delivery in south county, an advocacy organization	25
INTERACT (Inter-Agency Coordinating Task Force)	Fosters awareness about the need for services in east county, an advocacy organization	25
Oakland Collaborative	The collaborative of collaboratives	15
South County Youth Services Network	Coordinates youth services	11
Alameda County Gang Prevention Coordinating Council	Prevents and reduces youth and gang violence	6
Alameda High School Tri Health Student Center	Provides school-based clinical services for adolescents	5
Center for Integrated Services for Families and Neighborhoods/Prescott Neighborhood Initiative	Provides service integration in Prescott neighborhoods (West Oakland)	3

\* Agencies include social service organizations (i.e., transportation, homeless programs, foodbanks, shelters) religious organizations, schools, universities, clinics, health centers, and public health departments.

EXHIBIT II-7

COMMUNITY NETWORK	DESCRIPTION	NUMBER OF PARTICIPATING AGENCIES
Community Health Improvement Project	Provides health education, promotion, and community empowerment	4
Comprehensive Teenage Pregnancy and Parenting Program	Provides school-based educational, vocational, and support service programs for pregnant and parenting teens and their families	8
East Oakland Fighting Back	Provides drug and alcohol prevention targeting high-risk youth in East Oakland	20
Eden Youth Center	Provides children and youth services and publishes a county-wide needs assessment and resources guide	10
Fruitvale Community Collaborative	Promotes capacity building of residents, community agencies, and stakeholders to address community problems and create healthier communities	12
Healthy Start	Reduces infant mortality in high risk areas of Oakland by strengthening community resources and clinical services	6
International Child Resources Institute	Provides multi-service family support center in Fruitvale/San Antonio District	3
Kellogg Community Based Public Health Initiative	Promotes community health building on existing resources by focusing on service integration and public health practices	9
Oakland Community Partnership	Improves life by community involvement and drug and alcohol prevention	10
Representatives of Infant Services Infant/Toddlers Alameda County	Improves services for at-risk infants and toddlers for developmental delays or disabilities by focusing on promoting interagency coordination and communication	12

\* Agencies include social service organizations (i.e., transportation, homeless programs, food banks, shelters), religious organizations, schools, universities, clinics, health centers, and public health departments.

EXHIBIT II-7

Page 3 of 3

COMMUNITY NETWORK	DESCRIPTION	NUMBER OF PARTICIPATING AGENCIES*
Healthy Start: Grimmer School	Provides school-linked services	10
Healthy Start: Hawthorne and Whittier	Provides school-linked services	12
School-aged Mother Programs and Parenting Program Castlemont, <b>McClymonds</b> , San Leandro High School	Provides school based educational, vocational, and support services for pregnant and parenting teens	8
Thurgood Marshall Family Resources Center	Provides school-readiness, community, and family empowerment in the Acorn Housing Project	3
Tiger Medics Health Clinic Fremont High School	Provides school-based services for adolescents	4

\*Agencies include social service organizations (i.e., transportation, homeless programs, food banks, shelters) religious organizations, schools, universities, clinics, health centers, and public health departments.

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## **Interagency Children's Policy Council**

The Interagency Children's Policy Council is an innovative and collaborative strategic planning body designed to increase communities' capacity to integrate policies and services targeting children and families. A 22-member Foundation Consortium for School-Linked Services, with support from State agencies, sponsors the Council. The Council affords county and school officials, along with other service providers, the means to pursue options for refinancing and reorganizing services for children and families in order to make the services more effective. The collaboration among services helps ensure that children live in a safe, healthy, and nurturing family environment, that foster parents and other substitute caregivers have enough support (emotionally, physically, and developmentally), and that the service system is well integrated, family focused, and outcomes driven.

The Council also has developed system reforms, such as new fiscal strategies (pooling and decategorizing), outcomes accountability, service redesign, training programs, and modified governance and administration that will enhance coordination among agencies and optimize financial resources.

## **Alameda County Adolescent School-Based Health Center Coalition**

Alameda County received a one-year grant from the East Bay Community Foundation to develop models for linking school-based clinics (both health and mental health clinics) and managed care networks. The goal is to integrate the clinics with the managed care networks for financial (capitation) and administrative (enhanced continuity of care) purposes.

## **Oakland Healthy Start**

In 1991, Oakland Healthy Start was implemented as one of 22 five-year federally funded demonstration programs. The program started with a \$3 million budget, and now, four years later, has a budget of \$7 million. The program's goal is to reduce infant mortality in East Oakland, West Oakland, and the **Fruitvale/San Antonio** District. Baseline data indicated that infant mortality was 18. per 1,000 live births. Thus far, the program has had tremendous success in reducing infant mortality in the targeted areas. Between 1984 and 1993, the overall infant mortality rate was reduced by 49.9 percent. From 1991 to 1993, the African American infant mortality rate fell 13.2 percent.

Oakland **Healthy Start** was able to achieve these dramatic results through three one-stop Family Life Resource Centers, which offer a mix of health, social, and educational services geared toward empowering families and individuals and revitalizing the community.

## **Empowerment Zone/Enterprise Community Initiative**

The City of Oakland has won the first Federal waiver under the Clinton administration's Empowerment Zone/Enterprise Community initiative. Oakland was granted \$3 million in social

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services block grants to operate the Oakland Community Building Team (CBT) Demonstration Project and to provide stipends for welfare recipients. This effort will allow the city to develop innovative programs to bring economic self-sufficiency and revitalization to the most distressed parts of the city. The project aims at rebuilding both the physical and human infrastructure of the neighborhood. Areas can develop community-specific initiatives to address the unique needs of the targeted populations. As CBT staff train residents and place them in community service projects, these program eligibles will gain work experience and acquire marketable skills that will permit them to rejuvenate their communities. Participants will receive formal education in addition to practical job experience. Sponsors for the projects and job training will be community organizations. This program stresses public/private partnerships and collaborative efforts. This program will have a single funding source for many services, with flexibility and minimal restriction on how to use the dollars.

### **Oakland Homeless Families Program**

In 1990, the Oakland Homeless Families Program was chosen as one of nine organizations nationally to implement a demonstration program funded by Robert Wood Johnson Foundation and the Department of Housing and Urban Development. The purpose of the demonstration was to prove that providing housing with intensive case management and support services could break the cycle of chronic homelessness for multiproblem families. The program housed 200 families, increased family access to support services, increased family stability, and moved families toward self-sufficiency. In 1993 the program was recognized by the U.S. Department of Health and Human Services as one of the 23 most promising programs nationally for children and families.

### **3.5 The AmeriCorps Program Has an Active Role in the County**

The East Bay Conservation Group received a 2-year, \$2.3-million grant to help high-school-aged children gain job skills and earn a general educational development certificate and to oversee the AmeriCorps program. The AmeriCorps program is tailored to young adults ages 17 to 24. This 11-month program places college-aged students in minimum-wage jobs in health and human needs-related positions, covers their health care, and provides child care if needed. After completion of the 11-month program, participants get \$4,725 to use toward their education or special skills advancement programs. However, they can apply to participate in the AmeriCorps Program for a second year. The program has placed over 110 young adults in over 32 public health-related organizations in Alameda County. One graduate of the program entered the Leadership Program, in which she took a permanent salaried job in an AmeriCorps agency. The AmeriCorps program is approaching the end of its second year, and the future of the program is uncertain.

Agencies in Alameda County that employ AmeriCorps students range from public health agencies to youth homes, ethnic and multicultural foundations and alliances, schools, and wellness projects.

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## **National Health Services Corps**

There is no National Health Services Corps presence in the county.

### **3.6 Through Implementation of Waiver Programs, Alameda County Has Been Able To Move Forward in its Health Care Reform Efforts**

Alameda County has been in the forefront of understanding the ideas behind managed care, implementing managed care programs, and including the Medicaid population in such arrangements. Alameda County knows that to gain more flexibility in implementing these managed care programs and to provide more accessible care in the most cost-effective way, it must obtain Federal waiver approval from the Health Care Financing Administration. The county is participating in several managed care waiver programs.

#### **Section 1115 Research and Demonstration Waiver**

Alameda County expressed interest in participating in the Los Angeles Section 1115 waiver program; however, it is now evident that Alameda County will not be able to be included under the Los Angeles waiver and will have to submit its own waiver. Alameda County is eager to write a Section 1115 research and demonstration waiver that proposes a demonstration project allowing it to stabilize and restructure its health care system, build upon the delivery system already in place, reorganize its governance structure, and move toward an outpatient-based system of care. The waiver program would permit the county to use disproportionate-share hospital (DSH) funds for purposes other than paying hospitals for inpatient care. Under this type of waiver, a local government can develop creative ways to obtain and use DSH funds for the provision of ambulatory services and to expand eligibility to the uninsured.

#### **Section 1915(b) Program Waiver**

Alameda County is one of the 12 counties designated for the State's Section 1915(b) program waiver two-plan model implementation program. In order to participate with a local initiative, the Alameda Alliance for Health, the public agency that was established to operate the local initiative, had to obtain a Knox-Keene license. The county's Knox-Keene license application was approved in September 1995. The license permits participation of the AFDC population in the program, and if the Alameda Alliance for Health wants to expand participation to other populations, it will need to submit an amendment to the Knox-Keene application. The program began enrolling in January 1996 and had over 13,000 members by April 1. The Alliance was the first local initiative plan in operation.

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**Program Goals**—The Alameda Alliance for Health anticipates operating an integrated health services delivery system that provides high-quality, accessible, coordinated care through both public and private providers. Goals of the program include:

- Build a provider network focusing on traditional and safety net providers, those who have traditionally provided care to this population.
- Maintain an exceptional organizational staff and provider network with congruent values and beliefs, providing valuable health care and customer service to all Alliance members and providers.
- Emphasize member and provider education in preventive care and adequate primary care and specialist providers.
- Maintain high standards for quality health care and customer service.
- Promote collaborative planning and resource sharing.<sup>16</sup>

**The Local Initiative's Governing Board**—A 12-member board unanimously appointed by the Alameda County Board of Supervisors governs the Alameda Alliance for Health. This board can be expanded to 15 members if required. The board members consist of providers, Medi-Cal beneficiaries, labor union representatives, and government officials. The board member composition reflects a strong public-private partnership and the diversity of the county constituents. This board is responsible for policymaking, contracting, and oversight of all Alliance activities.

**The Aid to Families with Dependent Children Medi-Cal Population—Medi-Cal** recipients will be the **only** population participating in the first phase of the program's operations. Sixteen percent (203,933) of the county's population are Medi-Cal beneficiaries," ranking Alameda County seventh among all California counties in the number of Medi-Cal recipients. Approximately two-thirds (132,410) of these Medi-Cal eligibles receive Aid to Families with Dependent Children (AFDC) (the mandatory aid beneficiaries) and the other third receive Supplemental Security Income (the non-mandatory beneficiaries).<sup>18</sup> Of these two groups, the AFDC eligibles will enroll in the program first. The AFDC group includes public assistance AFDC-Family, AFDC-linked Medically Needy Family, medically indigent children, and refugees and entrants.

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<sup>16</sup>*Alameda Alliance for Health Overview*, October 2, 1995

"Expansion of the Medi-Cal Managed Care Program, "The Two-Plan Model," Section 1915(b) Capitated Waiver Request, Department of Health Services, State of California, June 1995.

<sup>18</sup>*Alameda Alliance for Health, Changing The Way Medi-Cal Is Delivered in Alameda County*, April 1996.

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**The AFDC Population Are of Diverse Ethnic Descent**—The AFDC population consists of persons of diverse ethnic and language origins. Over 47 percent are African American, 19 percent are non-Hispanic white, and 14 percent are Hispanic. The rest are of Vietnamese, Cambodian, and Laotian descent. This diversity is geographically reflected throughout the county; however, Oakland has the highest concentration of each group, except for Hayward, which has the highest concentration of non-Hispanic whites.

Nearly 25 percent of Medi-Cal beneficiaries do not speak English as their primary language. Their most common languages are Spanish, Cantonese, Vietnamese, and Farsi. As with its geographic dispersion of ethnicity, Oakland has the highest concentration of non-English-speaking AFDC-related persons. To optimize participation of the diverse group of AFDC Medi-Cal recipients in the local initiative and to ensure the effectiveness and goals of the program, the Alameda Alliance for Health has included in its provider network numerous providers of varying ethnicities and some who are **multilingual**. It also has recruited interpreters to provide translation services. The Alliance intends to work with county and State officials to develop mechanisms to collect, analyze, and evaluate ethnicity and language data.

**Over 71 Percent of the AFDC Population Are Under the Age of 21**—A majority of the AFDC population (71 percent) are under the age of 21. Fifty-nine percent of the females (66,722) and 86 percent of the males (42,592) are under the age of 21.

**Most of the AFDC Population Live in the North Region of the County**—Approximately 67 percent of the AFDC population reside in the north, approximately 30 percent in the south, and approximately 3 percent in the east.<sup>19</sup> The most populous part of the northern region is the city of Oakland.

**Program Enrollment**—In December 1, 1995, the AFDC Medi-Cal population began voluntarily enrolling in the **Alliance**. As of April 1, 1996, voluntary enrollment had exceeded 13,000 persons. They can continue to voluntarily enroll until late summer of 1996, when the mainstream plan (**CaliforniaCare**) is anticipated to begin enrollment. At that time all AFDC Medi-Cal families will have to enroll in either the **LI** or the mainstream plan. If they do not select a plan they will be randomly assigned to one or the other.

**Three Health Areas Require the Greatest Effort**—The areas of highest public health concern for the AFDC population are its high infant mortality rate, high homicide rate, and high incidence of tuberculosis. The Alameda Alliance for Health will focus its efforts on these health issues and work to develop risk factor, prevention, and other reduction-related strategies to combat these problems within the Medi-Cal population.

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<sup>19</sup>Ibid.

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**The Comprehensive Provider Network**-The Alameda Alliance for Health has ensured that its provider network is comprehensive and capable of responding to and satisfying the health care needs of its diverse clientele. The local initiative includes both safety net and traditional providers in its network. The network has a comprehensive provider base approximately 150 primary care providers, 400 specialty providers, 12 community-based organizations, 9 hospitals, and 138 pharmacies. With the comprehensive provider network established, the Alliance can adequately serve more than the projected number of enrollees:

- **Primary Care Providers-Primary** care providers include pediatricians, general practitioners, family practitioners, internists, and obstetricians/gynecologists, most of whom are board certified or board eligible. As the majority of the AFDC population are under the age of 21, the Alliance has made a special effort to recruit pediatricians. The Alliance also has ensured that the number of physicians is proportional to the number of recipients in all geographic areas throughout the county.
- **Specialty Care Providers**-Through contracting with over 400 specialty care providers, the Medi-Cal beneficiaries are ensured access to all types of specialty care. The Alliance plans to constantly evaluate the medical needs of the AFDC population and the types and numbers of specialists, and adjust them as necessary.
- **Community-Based Organizations-Several** community-based organizations are participating as Alliance providers. One is the Alameda County Ambulatory Care Clinics (ACACC), which currently includes five freestanding and one hospital-based clinic associated with Highland General Hospital. The 12 Federally Qualified Health Center members, with 22 sites, of the Community Health Network of Clinics have a contract with the Alliance as well. Planned Parenthood and the West Oakland Health Center also have contractual arrangements with the Alliance. All of these clinic groups have strong primary care capabilities and referral relationships with specialists, and their physicians have admitting privileges at several Alliance-participating hospitals. No contracts between the Alliance and any alcohol detoxification clinics exist, as the services they provide are not part of the LI benefit package and are carved out.
- **Family Planning Providers-A** substantial number of pediatricians, family practitioners, obstetrician/gynecologists, general-practice physicians, and some outpatient clinics provide some form of family planning services. The AFDC population can choose among family planning providers.
- **Hospitals-Nine** hospitals in Alameda County are participating in the Alliance. Most of the hospitals serve the northeast part of the county, where most of the AFDC beneficiaries live.

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- **Pharmacy—The Alliance** has decided to include any pharmacy that wants to participate, provided it satisfies certain requirements. Over 130 pharmacies are participating providers. Wellpoint, Inc., is the pharmaceutical benefits management (PBM) company that performs all pharmacy-related activities, including pharmacy claims processing.
  - **Other Providers—The Alliance** also has other participating providers that enhance the network. These include individuals and organizations that provide services such as rehabilitation, dialysis, medical transportation, orthotics/prosthetics, podiatry, physical therapy, and optometry. The Alliance plans to work very closely with the Alameda County Health Care Services Agency to ensure that all necessary services can be provided and to ensure their accessibility.

**Provider Accessibility—**As stated previously, the AFDC Medi-Cal population are dispersed throughout the county; however, most of this population reside in the North Region, specifically the Oakland area. Thus, the areas with the greatest density of AFDC recipients also have the most providers. The lowest number of AFDC recipients reside in the East Region, in Pleasanton, Livermore, and Dublin; therefore, there are fewer providers serving those areas. The Alliance has developed standard geographic and time accessibility standards.

Public transportation within the county is extensive, providing access to many providers. Medical transportation services will be provided through the County of Alameda Emergency Medical Service District's contract with American Medical Response West. Both emergency and nonemergency services are included in the contract.

**Health Care Benefits—The Alliance** provides all required services, as stipulated by DHS. It provides additional services beyond the mandated ones. These include adult check-ups, health education, and a nurse-staffed telephone advice system. For covered services that are **carved out**, the Alliance has formed relations with State and county agencies to ensure that medical services are offered to Medi-Cal beneficiaries in a seamless manner.

**Quality Management Review Activities—The Alliance's** Clinical Services Quality Management (CSQM) program is a comprehensive quality improvement program that incorporates both quality assurance (QA) and utilization management (UM) activities. The QA staff will assess the adequacy, appropriateness, and timeliness of care: access to care; and coordination and continuity of care. The UM staff will provide planned and methodical monitoring to ensure that members are receiving medically necessary and **adequate** levels of preventive, diagnostic, and curative services.

**Marketing and Enrollment Functions—As** stipulated in the waiver application, neither the Alliance nor the mainstream plan will be permitted to directly market to Medi-Cal recipients. Instead, they will give marketing and other informational materials to the Health Care Options Program (HCOP), which will act as a health benefits manager. HCOP will inform Medi-Cal beneficiaries **about** the two

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managed care plans offered and assist them in selecting a plan. If the recipient does not choose a plan, he or she will be automatically assigned at random to one or the other.

Since the Alliance may not market directly to the AFDC population, the Alliance will rely heavily on primary care providers who traditionally serve this population to promote the Alliance. Since favorable patient-provider relations exist, it is anticipated that this will be the best form of marketing.

**Health Care Management Information System Functions-**The management information system (MIS) that is in place for the Alliance will not only provide the automated infrastructure to support and link all facets of program operation from an administrative perspective, but also provide the capability to collect, store, and analyze data that will be used to assess quality, health care outcomes, cost, provider performance, member and provider satisfaction, and a host of other variables. This system is envisioned to give not only the Alliance but providers and members much of the necessary information for them to provide high-quality, accessible health care in the most cost-effective manner.

- **Alliance Providers and Staff-**Participating providers will be directly linked to the Alliance MIS, and eventually each other, through computers in their offices. They will be able to access the following:
  - Patients' historical data
  - On-line protocols
  - Referral processing, including monitoring and tracking status
  - **Preauthorizations**
  - Eligibility
  - Practice profile reports
  - Claims

AU QA and UM data **will** be accessible on the MIS. The Alliance Medical Director and QA and UM **staff will** have direct, real-time, on-line access to treatment, referral, and **preauthorization** information.

- **Alliance Members-The Alliance** envisions using community-based kiosk terminals as a dissemination channel for information on providers, services, and health programs.
- **Financial Enhancements-The** MIS will be used to improve the efficiency, timeliness, and accuracy of all financial information for the Alliance and providers. Specifically the MIS will have the capability to improve the following functions
  - **Claims Processing**—All claims will be processed electronically, and claims editing will be done at the provider level prior to the Alliance's receiving them. The MIS will provide the capability to make direct deposits for providers.

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- **Capitation and Contract Management-** The MIS will have the capability to manage and determine capitation rate development and assist in risk pools analysis. The MIS will have a complete contract management component that will track all contracts between the Alliance and providers.

**Risk Management-**Data that are collected and filtered into the MIS will assist in identifying high-risk patients, These patients will be identified through on-line protocols, automatic referrals to specialists, public health programs, and clinical decision support programs. Providers will be given access to patient profiles, utilization rates for their patients and other patients, and diagnosis and outcome information.

- **Financial Analysis-The** MIS will support all accounting, general ledger, stop-loss, risk pool and capitation payment analyses.

### **Behavioral Health Freedom of Choice Waiver**

Under the State of California's freedom of choice waiver, Alameda County began moving its SSI-linked seriously and persistently **mentally** ill population out of the fee-for-service environment and into the managed care arena. In the first phase of this mandatory enrollment program, Alameda County has focused on the inpatient setting and will begin mandating that outpatient services be rendered through managed care in 1997.

### **3.7 A Multitude of Health Care Providers Serve County Residents**

Through contracting with many community-based providers, the county tries to maintain a sufficient number of providers who can serve the most vulnerable and special populations in the county. These providers are **from** many ethnic backgrounds, and many are especially sensitive to the cultural needs of the diverse population.

#### **Primary Health Care Providers**

In most States, many primary care **facilities** are members of a State primary care association or similar centralized governing body. However, California has not had until very recently a State association or coalition representing its State's primary care providers. Therefore, obtaining comprehensive information on primary care clinics in Alameda County is difficult and somewhat piecemeal. With certainty, it can be stated that there are many primary care clinics that provide quality targeted medical services to the neediest and multicultural populations in the county. The following section identifies some of the primary care providers in the county.

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**County-Operated Clinics--The** county operates the following five outpatient clinics:

- Alameda Health Center
- Central Health Center
- Eastern Health Center
- Hayward Health Center
- Newark Health Center

**Alameda Health Consortium--The** Alameda Health Consortium is a group of 10 nonprofit community health centers that provide primary health care to the indigent residents in the county. It was formed over 20 years ago and is the principal provider of publicly funded primary health care to Alameda County's low-income populations, primarily the minority and working poor. Exhibit II-8 lists the member clinics. All of the clinics provide general medicine and family planning services, and some provide sexually transmitted disease and HIV testing and treatment and dental services. In 1993, members of the Alameda Health Consortium (excluding Planned Parenthood of Alameda/San Francisco and the Berkeley Community Health Project, due to the unavailability of data) served approximately 63,000 patients<sup>20</sup> and provided over 158,000 clinic visits. Most of these visits were routine primary care visits.

The Consortium has played a major role in planning and implementing a public-private partnership with the county Health Care Services Agency (HCSA). The HCSA contracts with the Consortium to provide primary care to uninsured indigent patients. The arrangement is community-based and focuses on early intervention and treatment.

**Planned Parenthood of Alameda/San Francisco—**Planned Parenthood of Alameda/San Francisco offers family planning services, education, and counseling. It is a member of the Alameda Health Consortium. Its services are accessible to patients **from** four sites strategically located where the need is most evident and can have the most impact (two in Oakland, one in Hayward, and one in Fremont). In 1993<sup>21</sup> the four sites collectively served 18,148 patients, of whom 95 percent were female. They provided services in the following areas:

- Approximately 2 percent for general medicine
- Approximately 78 percent for family planning
- Approximately 15 percent for sexually transmitted diseases
- Approximately 5 percent for **HIV/AIDS** testing

In 1993, Planned Parenthood had total revenues of \$3,010,043 and total expenses of \$2,954,74

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<sup>20</sup>The patient number does not include unduplicated patients or encounters. A patient is counted once each time his or her payer source changes. For example, a patient with two Medi-Cal visits, two CMSP visits, and two patient pay visits would be counted as three patients, once for each payer, regardless of separate visits.

<sup>21</sup> 1993 *Community Clinic Fact Book*, April 1995.

EXHIBIT II-8

ALAMEDA HEALTH CONSORTIUM MEMBER PROFILE 1993

Clinic	Encounters	Operating Revenue*		Patient Ethnicity
		Patient (Medicare, Medicaid, Private, Siding Fee, CHDP, Other)	Federal, State, and Local Grants/Contracts	
Asian Health Services, Oakland	30,647	1,748,732	1,355,298	99% Asian
Berkeley Community Health Project	N/A	N/A	N/A	N/A
Berkeley Primary Care Access Clinic, Berkeley	15,177	518,190	463,837	38% African American 28% Euro-American 7% Hispanic
East Bay Native American Health Center, Oakland	20,832	774,373	1,411,668	46% American Indian 75% Hispanic 74% African American
La Clinica De La Raza, Oakland (site 1)	34,940	1,397,140	3968,131	96% Hispanic
La Clinica De La Raza, Oakland (site 2)	10,300	457,719	433,809	89% Hispanic
Over 60 Health Center, Berkeley	18,723	741,990	846,871	55% African American 27% Euro-American
Planned Parenthood of Alameda/San Francisco, Fremont (site 1)	7,280	433,373	0	42% Other Ethnicity 38% Euro-American
Planned Parenthood of Alameda/San Francisco, Hayward (site 2)	14,792	906,966	93,872 (all Federal)	70% Euro-American 79% Hispanic 75% African American

EXHIBIT II-8

Page 2 of 2

Clinic	Encounters	Operating Revenue*			Patient Ethnicity
		Patient(Medicare, Medicaid, Private, Sliding Fee, CHOP, Other)	Federal, State, and Local Grants/Contracts		
Planned Parenthood of Alameda/San Francisco, Oakland (site 3)	13,727	987,596	35,258 (all Federal)	45% Hispanic 32% Euro-American	
Planned Parenthood of Alameda/San Francisco, Oakland (site 4)	10,621	469,677	26,762 (all Federal)	70% African American 18% Hispanic	
Tiburcio Vasquez Health Center, Hayward (site 1)	11,634	596,464	394,059	75% Hispanic	
Tiburcio Vasquez Health Center, Union City, (site 2)	14,752	683,500	822,093	81% Hispanic	
Tri-City Health Center	19,776	1,101,930	1,381,486	37% Euro-American 28% Hispanic 15% Other Ethnicity	
Valley Community Health Center, Livermore (site 1)	4,707	246,003	80,071	43% Euro-American 35% Hispanic	
Valley Community Health Center, Pleasanton, (site 2)	22,628	1,184,235	385,463*	49% Euro-American 33% Hispanic	

\*Total revenue includes patient revenue, contracts/grants, private funding, and donations. Private funding and donations are not listed in this exhibit

Source: 1993 Community Clinic Fact Book. April 1995.

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**California Primary Care Association** - This newly formed organization represents approximately 100 nonprofit member clinics that operate from 200 sites throughout the State. At the time of this report, the Association did not have overall funding or utilization data or county-specific statistics available. The five county-operated clinics, the Alameda Health Consortium, and Planned Parenthood of Alameda/San Francisco are members of the Association.

**West Oakland Health Council, Inc.**-West Oakland Health Council, Inc., has two sites in Berkeley and 12 sites in Oakland. Only three of these locations provide general medical and primary health care. The other sites are drug and alcohol, crisis, residential, and treatment facilities. It also operates an adult day care facility. The medical clinics primarily serve the Medi-Cal African American population. They are:

- William Byron Rumford Medical Clinic, Berkeley, providing primary care
- Albert J. Thomas Medical Clinic, Oakland, providing primary care
- East Oakland Health Center, Oakland, providing prenatal care

**Berkeley Women's Health Center**—The Berkeley Women's Health Center has been providing general medical, gynecologic, and family planning services to women in Alameda County for over 24 years. In 1993 over 60 percent of the 2,403 women served were between the ages of 20 and 34. The Center had annual revenues of \$429,398, of which \$10,004 was State grants or contracts and \$156,000 was local grants/contracts.

**Native American Health Services Agency**-The Native American Health Services Agency, operating in Oakland, targets its services to the Native American population.

**Migrant/Rural Health Centers**-There are no farm worker/rural health programs in Alameda County.

### **Managed Care Providers**

There are 36 HMOs in the State of California. Of these, 14 include Alameda County in their service area. Exhibit II-9 presents information about these HMOs.

### **Hospitals**

There are 15 hospitals in Alameda County. Most have emergency services as well as inpatient care, and several also provide specialized/secondary and tertiary care such as a regional burn unit, a community cancer service, 24-hour adult and children's trauma centers, and cardiac care units. Exhibit II-10 lists these facilities. The hospitals offer 3,203 hospital beds and have an average daily census ranging from 52 to 86 percent of capacity.

EXHIBIT II-9

HEALTH MAINTENANCE ORGANIZATIONS THAT SERVE ALAMEDA COUNTY

Name	Federally Qualified HMO	Medicaid Contractor	Medicare Contractor	Federal Employee Health Benefit
Aetna Health Plans of California, Inc.	X		Risk	X
Blue Shield of California HMO			Prepaid	X
Cigna HealthCare of Northern California			Prepaid	
California Care (Blue Cross)*		X	Risk	X
FHP, Inc.	X	X	Risk	X
Foundation Health, A California Health Plan	X	X	Risk/prepaid product	X
Health Net	X	X	Risk	X
Kaiser Foundation Health Plan, Inc. Northern California Region	X	X	Risk/HCPP	X
Lifeguard, Inc.		X	Prepaid product	X
Maxicare, California	X	X	Risk	X
MetLife Healthcare Network of California, Inc.				X
National HMO	X		Risk/prepaid product	X
PacifiCare of California	X		Risk cost	X
PruCare of California	X		Risk	

\* California Care (Blue Cross) is the proposed mainstream plan for the Two-Plan, Section 1915(b) waiver program.  
 Source: 1995 National Directory of HMOs, Group Health Association of America.

**EXHIBIT II-10**

**HOSPITALS IN ALAMEDA COUNTY**

<b>City</b>	<b>Facility</b>	<b>Beds</b>	<b>Census</b>
Alameda	Alameda Hospital	98	58
Berkeley	Alta Bates Medical Center-Ashby Campus	499	367
Castro Valley	Eden Hospital Medical Center	259	Not reported
Fremont	Washington Hospital	202	135
	CPC Fremont Hospital	Psychiatric facility	
Hayward	Kaiser Foundation Hospital	224	147
	St. Rose Hospital	175	Not reported
Livermore	Valley Memorial Hospital	110	Not reported
	Veterans Affairs Medical Center	165	Not reported
Oakland	Children's Hospital	193	153
	Highland General Hospital (Alameda County Medical Center)	247	213
	Kaiser Foundation Hospital	220	165
	Summit Medical Center	420	220
San Leandro	Fairmont Hospital (Alameda County Medical Center)	193	192
	San Leandro Hospital	136	Not reported
	Vencor Hospital-San Leandro	62	36

Source: 1995 American Hospital Association Guide.

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## **Physicians --**

Neither Alameda County nor the State of California keeps comprehensive or reliable statistics on the numbers, types, and locations of physicians and physician assistants. Neither the California Medical Association nor the California Medical Licensing Board had such data available. The Alameda-Contra Costa Medical Association compiled the most comprehensive database on these statistics. Participation in this medical association is voluntary; therefore, its statistics represent only those who participate. The Alameda-Contra Costa Medical Association indicated that its membership represented approximately 75 percent of the providers in the counties. As of June 1995, the association compiled the following statistics for Alameda County:

- 7 general preventive medical
- 30 general practitioners
- 69 family practitioners
- 93 pediatricians
- 99 obstetrician/gynecologists
- 256 internists

Many of these physicians practice in group settings, health and medical centers, and hospitals. No data were found to profile physician employment and practice setting.

## **Department of Veterans Affairs**

The Northern California System of Clinics, a group of Department of Veterans Affairs (VA) clinics, has two sites in Alameda County, one in Oakland and the other in Berkeley. The Oakland facility provides primary, secondary, and tertiary care, whereas the Berkeley site provides mental health services. The Livermore VA facility in Alameda County has merged with the Palo Alto facility in the northern part of Santa Clara County. The merged VA will still provide services in both communities. The Livermore site provides primary and long-term care.

As of 1990, the total veteran population in Alameda County was 127,881. Of this total 95 percent were male.<sup>22</sup>

In 1994, veterans residing in Alameda County used VA health services in the following ways:

- They made 134,971 outpatient visits to VA facilities.
- There were 150 unique long-term care patients.
- There were 1,395 unique inpatient care patients.
- There were 10,138 unique outpatient care patients.

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<sup>22</sup>Transitional Regional Office (TR04), Department of Veterans Affairs, San Francisco, California, January 31, 1996.

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## **Department of Defense**

In the mid-1960's the Department of Defense (DoD) **started** a health care program, CHAMPUS, for its military personnel. This fee-for-service program was successful for many years; however, as the Department's health care costs increased and became a financial concern, it began evaluating managed care options. As a result, in the late 1980s DoD implemented a five-year managed care demonstration program, which achieved significant cost reductions and increased health care access, leading DoD to continue this program, known as Tri-Care. There are three components of the Tri-Care program: Tri-Care Standard, which is a fee-for-service component, Tri-Care Extra, a preferred provider component, and Tri-Care Prime, the HMO component. Active-duty dependents, retirees, and their dependents can participate in Tri-Care.

During Tri-Care managed care program development and implementation, DoD realigned its operations into 12 regions. Alameda County is in Region 10, which includes northern California as far south as Monterey. Active-duty personnel of the Army, Navy, and Air Force in Alameda County are required to go to David Grant Hospital at Travis Air Force Base for their basic health care. Travis is the regional **Tri-Care** site. If their medical needs exceed what is offered through David Grant, then they can receive treatment from Tri-Care providers. David Grant Hospital is located in Solano County, approximately **halfway** between San Francisco and Sacramento. Projections for 1996 indicate that approximately 346,356 persons will be eligible for medical care in Region 10. In the catchment area of 40 miles around David Grant Hospital, there are approximately 139,241 eligible persons.

### **3.8 Many Hospitals in Alameda County Have Medical School Affiliations**

There are no medical schools in Alameda County. The Davis and San Francisco campuses of the University of California have **affiliations** with hospitals in Alameda County. A number of hospitals have teaching arrangements with these universities, including Children's Hospital, Highland Hospital, and Raiser Foundation Hospital. Medical specialties include pediatrics, internal medicine, obstetrics, gynecology, and emergency medicine.

The universities support and perform extensive research and policy analysis.

### **3.9 The Public Sector Employs a Significant Number of People**

In Alameda County, approximately 100,000 persons work in the public sector. The school districts and the Federal Government employ the largest number of persons. The following chart shows where these employees work.

Employer	Percent of Public Employees <sup>23</sup>
Federal Government	15.1
County government	11.1
City government	11.6
State Government	14.5
University of California	13.6
State University	1.7
Community colleges (three)	3.9
School districts	28.5

The Oakland Army supply depot, the Naval Hospital, and the Naval Air Station in Alameda, which historically have been large public employers, are scheduled to close in FY 1996. Approximately 5,400 of these Federal employees will be absorbed into the military's civilian workforce.

The City of Oakland offers health benefits to employees, their dependents, and retirees. Through CalPERS participation, it purchases medical benefits for approximately 3,314 employees and 5,691 dependents at a cost of \$995,161,94.<sup>24</sup> The city uses Kaiser Permanente premiums as the benchmark for the portion of the premium that it will pay (e.g., if Kaiser's premium is \$189 for a single person, that is what the city pays for a single person; if another CalPERS provider charges \$200 for a single person, the city pays only \$189 (Kaiser's rate) and the city employee has to pay the remainder). The city also offers dental, vision, and disability coverages, for which the employee's contribution is minimal or nothing at all.

Alameda County offers HMO and PPO managed care options to its employees. Like the city of Oakland, the county is generous in the portion of the premium it pays and uses Kaiser Permanente rates to determine its contribution. As of February 1996, approximately 9,300 active employees are in an HMO or a PPO. For those who selected Kaiser Permanente, the county spent \$24 million on premiums.

Two years ago, six counties in Northern California tried forming a purchasing alliance to collectively purchase health coverage for county employees and other county eligibles. However, due to geographic limitations and weakening county commitment, this attempt was unsuccessful. Alameda

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<sup>23</sup>1995 Estimates: Numbers of Public Employees in Alameda County, Report, Economic Development Department. February 1996.

<sup>24</sup>City of Oakland, OPRM Custom Report Request of Active Employees and Dependents Enrolled in Medical Plans With the City's Contribution, March 8, 1996.

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County was very enthusiastic at that time and is still interested in such a collective purchasing endeavor (see Chapter III). Also, Kaiser Permanente and several other HMOs were interested in the proposition.

### **3.10 The County's Leaders and Residents Are Active Participants and Interested Stakeholders in County Matters**

One of the distinguishing characteristics of Alameda County is the involvement, aggressiveness, and uninhibited nature of the county leaders and constituents. Their involvement in decisionmaking, development of innovative approaches, and support of collaborative initiatives have been primary forces enabling the county to advance in its health care reform efforts.

#### **Cooperation and Openness among Government Officials**

Another distinguishing characteristic of Alameda County is the cooperation and openness among government officials. For example, the County Board of Supervisors and Department heads meet regularly and attend joint retreats. The County Board and Administration review budgets, develop programs, and troubleshoot problems together. All county officials promote collaborative efforts and a cohesive approach to improving Alameda County to make it more efficient, cost-effective, and responsive to the community.

#### **Strong Involvement of the Business Community**

Alameda County is home to a host of large businesses, such as Kaiser Foundation, **Safeway, Inc.**, and Pacific Bell. The senior members of large organizations (chief operating officer, chief executive officer, president, etc.) tend to be civic-minded, concerned about community issues, and active in community endeavors. They also provide financial and technical assistance to the county.

#### **Organized Groups**

Alameda County is one of the most politically organized in the State. Strong union representation and aggressive advocacy groups throughout Alameda County are very effective in influencing county politics, social issues, and funding.

Advocacy groups also perform extensive health care outreach and education. Civic groups, religious affiliates, political clubs, and other organized groups develop and promote specific health-related programs for targeted populations. These efforts are considered a very effective grassroots form of communication and information channeling.

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### **3.11 Several County-Specific Issues must Be Acknowledged To Fully Understand the Community**

The following are issues in Alameda County that distinguish it from other counties.

#### **Apparent Resistance to Change**

According to some county officials, the Alameda County Medical Center's board appears to be resistant to change and innovation and wants to maintain the status quo. They say this has hindered the facility in responding and adapting to the changing health care environment.

#### **Geographic Tension**

The Oakland area has the county's highest density of people and industry, making it a focus of county issues. This causes resentment among county residents in other geographic regions. All persons pay equal taxes, yet most of the efforts are seen as devoted to the Oakland area.

#### **The Changing Nature of Industry**

Service-oriented jobs are replacing the manufacturing jobs that have historically dominated the workforce of Alameda County. With fewer manufacturing jobs, union participation has been declining and there has been negative impact on health care access. In addition, with the changing marketplace, not all Alameda residents have the skill mixes required to perform the new service-oriented jobs. There is a lack of qualified persons to fill the jobs. This could further reduce health insurance coverage.

#### **Growing Perception of Violence**

There is an increasing concern with gang-related violence, gun availability, drug-related crime and death, and homicide in the cities of Oakland, Hayward, and Union City.

#### **The Role of the Media**

A county supervisor indicated that the residents of the county feel that the print media does not represent the cities very well and that coverage of local issues is inadequate.

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## Alameda County Profile Contact List

Page 1 of 3

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Bob Benjamin, MD. MPH  
Medical Director  
Communicable Disease Division  
Alameda County Health Care  
Services Agency  
5 1 0-268-2640

Rita Boyle  
Coordinator  
Interagency Children's Policy Council of  
Alameda County  
5 10-268-2025

Mary Brown  
Health Benefit Advisor  
Travis Air Force Base  
707-423-3935

Bill Burnett  
Office of Statewide Health Planning and  
Development  
Division of Primary Care Resources and  
Development  
916-654-2093

Lieutenant Carino  
Tri-Care  
Travis Air Force Base  
707-423-7920

Wilma Chan  
Supervisor Third District  
Alameda County Board of Supervisors  
5 10-272-6693

Emory "Soap" Dowell  
Member  
Medical Risk Insurance Board  
916-324-4695

Tom Elkin  
President  
Elkin Consulting  
916-482-4168

Ken Fiating  
California Primary Care Association  
916-440-8170

Patti Frist  
California Medical Association  
808-586-4410

Laurel Golden  
Supervising Team Leader, Health and Human  
Needs  
AmeriCorps  
510-208-6138

Dick Haggaman  
Research Analyst II  
Labor Market Information Division  
Employment Development Department  
State of California  
9 16-262-2228

Paula Henning  
Department of Health Services  
Primary and Rural Health Care Systems  
Branch  
State of California  
9 16-654-0348

---

Katsuko Hiro ta  
Medi-Cal Managed Care Division  
California Department of Health Services  
9 16-322-6065

Robin Jones  
Center for Health Statistics, Office of Health  
Information and Research  
California Department of Health Services  
9 16-657-3057

Mike Kassis  
Project Director  
California Health Information Policy  
Project  
Office of Statewide Health Planning  
and Development  
9 16-324-005 1

David Kears  
Director  
Alameda County Health Care Services  
Agency  
Chief Executive Officer  
Alameda Alliance for Health  
510-618-3452

Jack Lewin, MD  
Chief Executive Officer  
California Medical Association  
808-586-4410

Leanne Marshall  
City of Oakland Health Benefits  
Supervisor  
5 10-238-6775

Chris Martinez  
Alameda Health Consortium  
510-567- 1550

David Maxwell-Jolly  
Consultant  
California Appropriations Division  
916-445-3284

Nina Muriyamo  
Alameda County Health Care Services Agency  
510-618-3452

Felicia Richmond  
Alameda-Contra Costa Medical Association  
5 1 O-654-5383

Sandy Rivera  
Alameda County Planning Department  
5 10-670-5400

Susan Rosenthal  
Supervisor's Assistant  
Third District, Alameda County  
5 10-272-6693

Joni Rubin  
Transitional Regional Office  
Department of Veterans Affairs  
415-744-7506

Marjorie Sue- Wolf  
Veterans Integrated Service Network  
Department of Veterans Affairs  
4 15-744-7506

Keith Sutton  
Alameda County & Economic and Business  
Development  
5 10-272-3885

---

Mildred Thompson  
Executive Director  
Oakland Healthy Start  
510-639-1251

Bonnie Williams  
Department of Health Services  
Medical Care Statistics Section  
916-657-0895

Helen Wright  
Benefits Analyst  
Alameda County Personnel and Labor  
Relations Department  
510-272-3868

Medical Board of California  
Physician Licensing Board  
916-263-2388

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**CHAPTER III**

**IMPLEMENTATION PLAN FOR THE ALAMEDA COUNTY  
VALUE PURCHASING COOPERATIVE**

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CHAPTER III

IMPLEMENTATION PLAN FOR THE  
ALAMEDA COUNTY VALUE PURCHASING COOPERATIVE

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**1. INTRODUCTION**

This chapter presents an implementation plan for the Alameda County Value Purchasing Cooperative (ACVPC). The Cooperative is one of two local health care reform initiatives recommended **by** the Institute for Health Futures project team, the other being the related initiative of a health information network.

The concept behind the ACVPC recognizes the power of the marketplace, bringing public and private sector purchasers of health care together to make informed choices about the price and quality of the care they purchase on behalf of families. While individually these purchasers may have little influence over **HMOs** and other providers, collectively they can wield significant influence.

The chapter contains an overview of relevant elements of managed care and purchasing alliances, a discussion of the proposed ACVPC, and a phased implementation strategy. Project team members have discussed this strategy with key stakeholders in Alameda County. Implementation could begin immediately, with cost savings realized within a very short time.

**1.1 Quality, Access, and Service Are Increasingly Important Issues**

Despite the advantages managed care offers in terms of cost containment and administrative simplicity, health care purchasers, consumers, and clinicians are becoming concerned about issues of quality, access, and service. As **HMOs** continue to grow, the size and power of these managed care companies give them significant leverage over both providers and employers. Once the **fee-for-service** relationship between the purchaser and provider no longer exists, the ability of employers to collect and analyze cost and encounter data is removed. The new method of reimbursing health plans on a monthly, **capitated** basis removes the need for individual claims from providers. Access to performance, cost, and quality data is controlled **by** the health plans, and employers are dependent on their **HMO** for information of this type-but employers have been less than successful in obtaining meaningful information, for various reasons. In some cases the health plan **does** not collect the information, while in other cases the plan refuses to share the information with the employer.

The increased power of **HMOs** makes it extremely **difficult** for small and medium-sized employers to negotiate competitive premiums. Many of these employers have **stated** that they are unable to obtain data or to negotiate rates as low as those negotiated by very large employers and large purchasing coalitions. There is growing concern that the large **HMOs** can negotiate very low rates

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with providers due to their market leverage yet not pass on the savings in the premiums they charge to employers. Low medical loss ratios, healthy excess earnings and profits and record-setting corporate executive compensation packages intensify this concern. Many clinicians, purchasers, and consumers have expressed concern that the economic and utilization incentives of capitated managed care plans may result in the underutilization of care and the erosion of customer service.

Despite the fact that in California large portions of the health care market have been consolidated into a few very large HMOs, with the exception of a few purchasing cooperatives, most employers have not consolidated their purchasing power. They have little or no leverage to influence the large plans and are without power to insist on adequate data to help them manage their programs. Even large public purchasers like Medicare and the Federal Employee Health Benefits Program (FEHBP) do not take advantage of their significant market leverage.

## **1.2 Information about Managed Care Is Urgently Needed for Policy and Program Management**

In order to demonstrate the value of managed care and assure purchasers and consumers that neither service nor quality will suffer as more of our citizens migrate into managed care plans, it is essential that purchasers and consumers have access to accurate, meaningful information about the care provided. This information will enable employers to assess the value of the care they purchase, measure the outcomes of medical procedures, determine the long-term impact on the health status of those receiving the care, and assess the comprehensive value that managed care has for the total community.

The importance of information related to access, service, and quality has been recognized recently by various public and private health care policy and financing organizations. Several are examining methods to measure these elements of care. The Health Care Financing Administration (HCFA) **and** the Institute of Medicine (IOM) are both conducting studies of the accountability of managed care plans. HCFA has funded two pilot studies to examine competitive pricing strategies for Medicare risk plans and how an annual open enrollment process, combined with adequate information, could assist Medicare eligibles in selecting **quality** plans. The Institute of Medicine (IOM) has been funded by the Robert Wood Johnson Foundation (RWJF) to examine issues related to health plan accountability, including data collection for consumer choice as well as monitoring the performance of Medicare risk plans. Much of the **work** in these three efforts is focused on the collection, availability, and dissemination of valid, meaningful data.

If managed care is going to succeed as a financing and delivery system, it must be able to demonstrate that it adds value to health services delivery. This **will** not be possible without adequate information about services, costs, medical outcomes, health status, **and** provider performance. The February 1996 cover stories of both *Modern Health care* and *Hospitals **and** Health Networks* discuss the critical issues related to the role of information technology in the world of managed care. There is an increased awareness that access to useful information is an essential element of an effective health

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care services delivery system. As the cottage industry of individual physician practices and community hospitals is transformed into integrated managed care systems, accurate measurement of the health of a community is essential if we are to assure ourselves that our significant investment in health care results in positive outcomes.

The current fragmented approach to the purchase of health care and the management of information about the health of Americans is expensive and illogical, and should no longer be tolerated in the managed care environment that exists in California today. At a time when tax-supported health programs are coming under increased fiscal pressure, it is unacceptable to ignore proven methods and strategies to slow the rising cost of care and begin to measure the value of the health care dollar. At a time when an increasing number of families find themselves uninsured or underinsured due to a change in employment or health status, and the number of vulnerable populations such as Medicaid recipients, disabled, chronically ill, and elderly increase, **all** stakeholders in the health care market must explore new and better ways to organize, finance, and deliver health care.

Numerous organizations are involved in this debate and are attempting to define quality and provide techniques to measure value and quality. The National Committee for Quality Assurance (NCQA), a nonprofit accrediting organization, performs comprehensive reviews of **HMOs** and awards various levels of accreditation. Part of its review is an **assessment** using NCQA's Health Plan Employer Data Information Set (HEDIS) quality indicators, including rates of prenatal care in the first trimester, mammography screenings, immunization of two-year-olds, and other preventive health measures. These assessments are used to determine whether a plan receives **full**, partial or no accreditation. Most **HMOs** recognize the value of a NCQA review and have requested a **full** accreditation review. Many purchasers require NCQA accreditation as one method of demonstrating quality.

A new organization, the Foundation for Accountable Health Plans initiated by Paul Ellwood and the Jackson Hole Group, is developing specific outcome measures that could be incorporated into health plan assessments. The first measures **will** be available in the summer of 1996.

The Joint Commission on Accreditation of Health care Organizations is developing outcome measures for **HMOs** and has become more active in this area. It recently allied with the California Medical Association (CMA) and has been selected by the California Department of Corporations to perform medical audits of California **HMOs** as part of the State licensing function. In addition, numerous data companies are developing systems and techniques to collect and measure the performance and quality of care provided by their **HMOs**. There is clear recognition that better methods of measuring and quantifying health care must be developed and implemented.

In addition to these efforts, some large employers and purchasing coalitions have developed their own systems and measures to assess the performance of managed care plans. The Pacific Business Group on Health (PBGH), Southern California Edison (SCE), GTE, Xerox Corporation, and the California Public Employees Retirement System (**CalPERS**) have been active in developing and using plan performance and quality measures.

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Despite this activity, most employers have little or no information about the care they purchase from managed care companies. Except for report cards developed by the individual plans and summary information available from NCQA reviews, there is virtually no information about cost, quality, access, service, outcomes, morbidity, mortality, or health status or any other meaningful information necessary to adequately manage a health benefits program. There is little consensus on the definition of quality, there are few well-established systems that employers can use to give them the information they need, and there is a strong reluctance on the part of many managed care plans to provide employers with the most rudimentary information to assist them in determining value.

This fragmented and ineffective approach to the collection, analysis, and publication of information is exceeded only by the uncoordinated and isolated approach to purchasing health care. Despite the significant amount of money employers invest in providing health care for their employees and despite the power that health plans have gained through consolidating their purchasing leverage, most employers continue to individually negotiate premiums and individually collect limited information about the care they buy. The result is that most employers are paying more than they should for health care and have little or no useful information on whether they are receiving the care specified in their contracts.

### **1.3 Many Public Sector Purchasers Are Based in Alameda County**

Alameda County contains dozens of cities, school districts, fire departments, police departments, irrigation districts, water districts, special districts, community colleges, and other public nonprofit agencies. All of these individual public employers purchase care from the same plans; Kaiser Foundation Health Plan, Inc., Health Net, PacifiCare, Foundation, California Care and Aetna Health Plans of California, Inc. Most of these employers are unable to negotiate the price concessions they deserve and are unable to secure the information and data they need to more effectively manage their health benefits programs. This is because they lack the purchasing leverage necessary to change the behavior of HMOs. The managed care industry has consolidated itself and is enjoying the power that consolidation brings; employers have not, and do not.

Some of these organizations and agencies have joined CalPERS and are enjoying the clout of their \$1.5 billion annual premium budget. CalPERS has used its size and market presence to negotiate competitive rates as well as obtain valuable data that enable them to measure performance and quality and provide their members with valid, independently collected information about the performance of each plan. CalPERS publishes this information each year and mails plan report cards to its one million members. The strength and value of collective purchasing not only enables purchasers to stabilize the price of health care but also enables employers to obtain crucial information about cost, service, care, health status, and other essential data.

In addition to the large numbers of local public employers individually purchasing care in Alameda County to cover over 100,000 residents employed in the public sector, several large Federal purchasers are doing the same thing. FEHBP, CHAMPUS, Medicaid, and Medicare are significant

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purchasers in Alameda County and they purchase care from the same six large managed care companies listed above. Every one of these purchasers is struggling with the same issues: price, data, performance, outcomes, value and accountability. Each purchaser's population requires different medical attention, especially the Medicaid population where the needs of the vulnerable population are quite targeted and specific. None of them has information adequate to perform the most rudimentary assessment of the impact of the hundreds of millions of dollars spent on health care in Alameda County.

All public health care purchasers also need to assure their boards, city councils, CEOs, oversight committees and employees that managed care is the right way to proceed and that service and quality will not be sacrificed in order to contain costs. At the present time, due to the limitations of existing data and/or poor access to data, these assurances cannot be made.

In response to many of these concerns, the Alameda County Board of Supervisors has formed the Alameda **Alliance** for Health to address the needs of Medi-Cal recipients and indigent citizens of the county. Under the leadership of the Board of Supervisors, the Alliance Governing Board, and its Director, the Alliance is a public HMO that is demonstrating the strengths of integrating the delivery of care to these patients through public private-partnerships. The **Alliance** is a unique example of the power of bringing managed care to a publicly funded program by taking advantage of the innovation and support of the private care delivery system. Central to this new model are the collection, analysis, and publication of critical information regarding service, costs, quality, access, and other relevant measures.

The following implementation strategy describes an approach that harnesses the power of collective purchasing with the strength of a health information network to create an alliance of purchasers and information that will provide the citizens of Alameda County with access to affordable quality health care.

## **2. IMPLEMENTATION STRATEGY FOR ALAMEDA COUNTY**

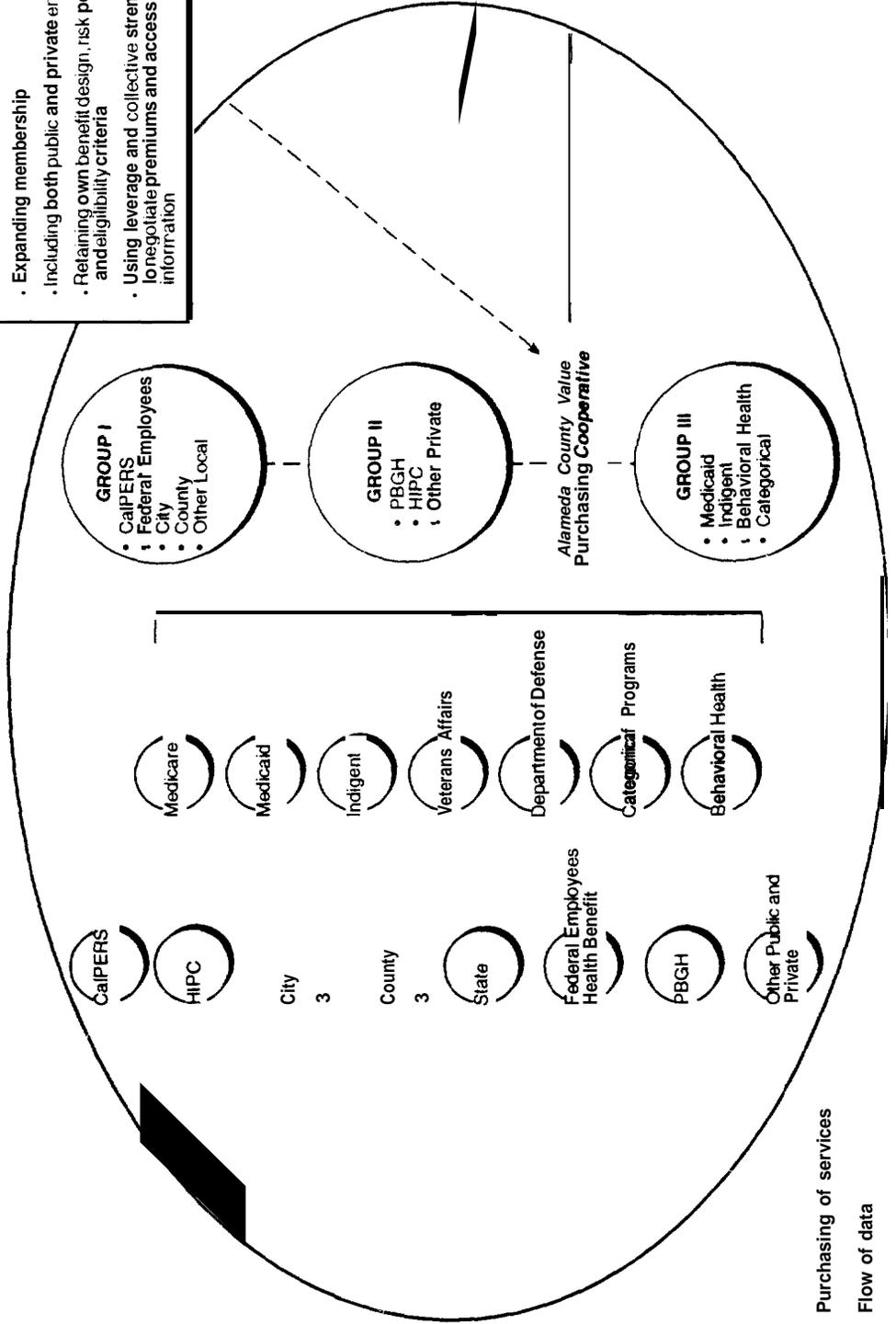
The recommended objective is to develop an ACVPC of public and private employers in Alameda County to support and be integrated with a Health Information Network (HIN). By combining the purchasing power and influence of dozens of public and private purchasers, the Cooperative will be able to negotiate affordable premiums and obtain useful information about the care provided to their employees, retirees, and dependents. Each purchaser will be in a better position to offer specialized services to respond to their population's unique medical needs, especially those of the most vulnerable people in the county. The strength of a large purchasing cooperative will encourage large HMOs marketing in Alameda to alter their behavior and assist the County in reaching its objectives. Exhibit III- 1 presents the a health care infrastructure model for the ACVPC.

The ACVPC will be a central information collection entity providing data for premium negotiations, plan monitoring, service standards, quality measurement, outcome studies, and documentation of

EXHIBIT III-1

ALAMEDA COUNTY REFORM PROTOTYPE  
THE ALAMEDA COUNTY VALUE PURCHASING COOPERATIVE

- Acting as driving force behind the Alameda County Health Information Network
- Consolidating purchasing power and effectively uses information and data to intelligently buy goods and services from HMOs
- Expanding membership
- Including both public and private entities
- Retaining own benefit design, risk pools, and eligibility criteria
- Using leverage and collective strength to negotiate premiums and access information



— Purchasing of services  
- - - - - Flow of data

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consumer experience and health status. It will design and implement surveys, studies and reports for its members and ultimately serve not only consumers and purchasers. but providers and health plans.

The Cooperative will negotiate, assist in negotiating or support negotiations for its members. It will perform analyses of cost information, risk-adjust benefit designs, perform comparative analyses of rates and benefits, conduct consumer experience surveys, and perform other studies and analyses as necessary.

While the benefit of combining employers into one risk pool with one benefit design has been proven at the State level by the CalPERS model, this consolidation is not necessary to gain the advantage of collective purchasing. The model that will work well in Alameda County will require participating employers to agree to join in collective purchasing and not erode the strength of the group by purchasing their care outside ACVPC. However, each employer will retain its own benefit design, separate risk pool, and eligibility criteria. The Cooperative will risk-adjust the benefits and demographics of each employer so that no one will be disadvantaged by participating in collective purchasing.

Strategies and tactics will be developed and agreed to by all participants prior to negotiations, and the members of the Cooperative will support sanctions, enrollments, freezes, and other actions necessary to cause health plans to cooperate. A negotiating team will represent all participants in the Cooperative. The power of this model is the collective strength of twenty or thirty employers representing several hundred thousand members negotiating as one for competitive premiums and access to information.

In order to form the ACVPC, the implementation team will contact **all** potential participants in Alameda County. Ground rules will be outlined to provide an initial framework of the Cooperative. Some public entities in Alameda County currently belong to CalPERS. While it is not our intention to recruit these agencies away from CalPERS, some may **find** the local, more flexible aspects of the ACVPC more attractive than their current relationship. We **will** seek strategic partnerships with CalPERS, PBGH, the Health Insurance Plan of California, and the **University** of California at Berkeley as well as NCQA, HCFA, and the State Department of Health Services (**DHS**). These purchasing cooperatives and government agencies are pursuing similar goals and **will** welcome an opportunity to ally with the Alameda County initiative.

It **will** take no more than 20 employers to give the Cooperative market presence, leverage and value. Once Alameda County employers learn about the initiative, a critical mass will form quickly. A purchasing cooperative needs to represent four percent of the commercially insured in California before it has a dramatic impact on the managed care market in terms of price and data provided by its plans. It will not take many participants for the cooperative to be successful.

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## 2.1 The-Benefits of a Purchasing Cooperative

As outlined above, benefits of collective purchasing of health care in Alameda County are many. The following is a list of the most obvious:

- It offers opportunities to stabilize or reduce the price paid for health care.
- It provides the leverage to obtain **data** to be used for negotiations, quality measurement, outcome studies, health status. prevention. provider profiling, consumer reports, and other community health needs.
- It provides an opportunity to integrate the provision of care for Medi-Cal recipients and indigent patients into the commercial market.
- It provides the opportunity to integrate and measure County public health programs with the managed care efforts in prevention and education.
- It offers managed care companies the opportunity to participate in an innovative. integrated county health model that which will enable them to play a more active role in serving the health needs of all residents of the county.
- It establishes a platform from which to implement a purchaser-oriented HIN, one which will serve all participants; physicians, health plans, consumers, and employers.
- It provides a central uniform data collection methodology which will reduce costs to HMOs who now must generate separate information for dozens of separate purchasers. This uniform approach will also reduce costs to employers who currently manage their own data systems.
- It will eliminate the fragmented, inefficient approach to purchasing health care and provide the information needed to better manage the health needs of the county.

## 2.2 Phase 1 of Implementation Will Enroll Public Employers

In this first phase, 20 or 30 public employers will be brought into the Cooperative.’ Included in this first phase will be Alameda County, several cities, school districts, community colleges, and special districts. In addition, this first phase should include the participation of strategic partners such as the City of Oakland, the University of California at Berkeley, and the Bay Area Rapid Transit Authority.

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<sup>4</sup>Given the limitations of this project's initial planning timeframe, the exact sequence in which groups will be recruited into the ACVPC has not been determined. Project team members have had initial discussions with candidate groups but no commitments have been made.

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These entities already purchase health care through large cooperatives but should be willing to assist the county in developing a successful model.

These initial participants will develop the fundamental strategy for premium negotiations and begin to define the data elements of the HIN. The goal of phase one will be to successfully negotiate in a cooperative manner and collect uniform cost, quality and performance data.

### **2.3 Phase 2 of Implementation Will Enroll Private Employers**

Once public employers are successfully enrolled, the ACVPC will be opened to the private sectors. This will require working with entities such as the Health Insurance Plan of California and the Pacific Business Group on Health, as well as the Chambers of Commerce, Business Alliances, and business leaders in Alameda County to define how the purchasing cooperative can best meet their needs. This phase is critical, for it will demonstrate that the integration of public and private purchasing of health care and the integration of cost, quality, service and health outcome **data** is possible and highly effective at the county level.

Many private employers will want access to the integrated data system that the Cooperative has developed. Both access to accurate, **useful** information and collective purchasing will be very attractive to employers of all sizes.

The goal of phase two will be to increase the number of public employers participating in the ACVPC, as well as to have integrated private employers into the Cooperative. A key element of success will be the maturity and growth of the information network. Its value to all participants cannot be overemphasized.

### **2.4 Phase 3 of Implementation Will Enroll Federal Purchasers**

In this phase, the ACVPC will establish strategic partnerships with Medicare, the FEHBP, CHAMPUS, and the Department of Veterans Affairs in order to perform premium negotiations and/or data collection and analysis for them. The maturity and success of the Cooperative will have demonstrated the value of collective purchasing, and access to information in the information network will be highly useful to these programs. The **value** of these large Federal purchasers participating in the Cooperative will be mutually beneficial.

The goal of this phase is to integrate the care purchasing, data collection, and quality measurement for most major **government** and private purchasers into one cooperative. The **value** of accomplishing this will be evident in reduction of premiums funded from tax dollars, reduction of health care costs to private businesses, greater access to care for the indigent, and the availability of information **about** the effectiveness of health care to the residents of Alameda County.

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### **3. IMPLEMENTATION PLAN**

The following is a list of major activities necessary to implement the ACVPC. The chapter that follows describes the related tasks to implement the MH.

#### **3.1 Create a Value Purchasing Executive Committee or Steering Committee**

This Committee should include one member of the County Board of Supervisors, one local legislator, the Mayor of Oakland, a mayor of another city participating in the ACVPC, a Board member from a school district participating in the ACVPC, a local member of Congress, and two employees of the county. It should be no larger than 13 members. Members of the County Working Group that has supported the Institute for Health Futures project would make a useful core group within this committee.

#### **3.2 Form a Value Purchasing Work Group**

To ensure success, it is essential that a work group of benefit managers from a representative sample of potential member organizations design and develop the ACVPC. The value of including these individuals in the design and development of the project is twofold: **first**, these are the individuals who understand the complex issues related to managing a health benefits program; and second, their participation will give these employers a sense of ownership in the final product. This group should not exceed ten members and should represent large, medium, and small purchasers.

#### **3.3 Develop a Purchasing Strategy**

The initial negotiating tactics, leverage, sanctions, and process will be determined by this group. Discussion and analysis of the differences in benefit designs, demographics, risk adjustment and other variations must be explored and clearly understood before collective negotiations can take place.

#### **3.4 Develop a -Marketing and Public Relations Plan**

It will be essential for the ACVPC to be clearly perceived by all stakeholders in the county. Meetings with medical groups, health plans, the press, community and consumer groups, and local elected officials throughout the county early in the project will be **important**. This effort will be continuous throughout the early years of the ACVPC.

### 3.5 Proposed Timeline and Staffing Requirements

Phase	Staff Estimate	Time Estimate
<b>Phase I: Public Employees</b>	<b>Five FTE to complete all tasks</b>	<b>Ten months to complete all tasks</b>
Task 1 Create a Value Purchasing Executive Committee or Steering Committee		Two months
Task 2 Form a Value Purchasing Work Group		Two months
Task 3. Develop Purchasing Strategy		Six months Tasks 3 and 4 to be performed simultaneously.
Task 4. Develop Marketing and Public Relations Plan		Six months
<b>Phase II: Private Employees</b>	<b>Four FTE to complete all tasks</b>	<b>Eight months to complete all tasks</b>
Task 1. Create a Value Purchasing Executive Committee or Steering Committee		Two months
Task 2. Form a Value Purchasing Work Group		Two months
Task 3. Develop Purchasing Strategy		Two months Tasks 3 and 4 to be performed simultaneously.
Task 4. Develop Marketing and Public Relations Plan		Two months

Phase	Staff Estimate	Time Estimate
<b>Phase III: Federal Purchasers</b>	Four FTE to complete all tasks	Eight months to complete all tasks
Task 1 Create a Value Purchasing Executive Committee or Steering Committee		Two months
Task 2. Form a Value Purchasing Work Group		Two months
Task 3. Develop Purchasing Strategy		Two months Tasks 3 and 4 to be performed simultaneously
Task 4. Develop Marketing and Public Relations Plan		Two months
<b>Phase IV: Implementation and Operation</b>	15 FTE senior health personnel; clerical and data entry personnel to be determined	Ongoing

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**CHAPTER IV**

**IMPLEMENTATION PLAN FOR THE ALAMEDA COUNTY  
HEALTH INFORMATION NETWORK**

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## CHAPTER IV

### IMPLEMENTATION PLAN FOR THE ALAMEDA COUNTY HEALTH INFORMATION NETWORK

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#### 1. **A COMMUNITY HEALTH MANAGEMENT INFORMATION SYSTEM FOR ALAMEDA COUNTY**

Residents of Alameda County will receive more effective health care at a better price because of two mutually supportive **initiatives**: the ACVPC that will bring the power of the marketplace to bear and the Community Health Management Information System (CHMIS) that will provide immediate and current information to support health system management, judge effectiveness, and decrease administrative costs. The ACVPC was discussed in Chapter III; this chapter presents the CHMIS.<sup>1</sup>

Agencies, programs, providers, and payers in Alameda County participate in a large number of information gathering, analysis, and reporting tasks. The Director of the County's Systems Integration **Program** identifies at least 26 information systems currently in place in the county. This fragmentation is not only wasteful of valuable resources but also, and perhaps even more importantly, it results in a critical missed opportunity—that of supporting local health care reform. The reform goals of access, efficacy at reasonable cost, and quality of care require informed decisionmaking at a number of levels and the careful monitoring of health outcomes in the community. A CHMIS is an essential component of this reform.

The essence of a CHMIS is the data repository of claims, encounter, payer, provider, and patient information. Prior to the development of the CHMIS concept, such information has historically been fragmented in multiple locations and no vehicle for its pooling existed. Even though there may be electronic submission of claims for some providers and payers in the county, these do not collect or analyze the data in their transactions or pool information from other networks. This pooling of information into one location will provide the very first opportunity to effectively analyze all aspects of the health care delivery systems currently in place, including financial comparisons, quality and provider performance measures, and outcomes analysis. The CHMIS data repository serves the widest potential set of users and purposes of any health data management system to date.

As a result of the ACVPC HIN, the purchaser, provider, payer, and patient participants in the ACVPC will gain integral support and services, which will facilitate the expansion of the value purchasing concept and lead to more cost savings. The HIN will facilitate this expansion because of

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<sup>1</sup>In this section, descriptions of the CHMIS concept will be referred to as CHMIS; we will refer to the CHMIS as it is envisioned for the ACVPC as a health information network (HIN).

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the electronic communications network for claims, encounter, and financial data it offers payers and providers, and because of the value to purchasers, patients, and the medical community the extensive databases will offer.

The HIN is not limited to a single benefit plan design, nor **does** it dictate one for any purchaser, whether public or private. It is a support vehicle for ACVPC for multiple benefit designs and the management of these designs or plans. Government program officials and private employers, regardless of their particular benefit design specifics, need **data to** monitor and evaluate policy and benefit changes, and to **track** changed patterns in utilization, health outcomes, and satisfaction.

Purchasers of health care typically do not have influence that extends beyond plan benefit design in a cost context; cost and encounter data are difficult to obtain from payers. Even if **data are** obtained, the age of the data does not accurately portray what is **needed** to make a decision based on current information for present needs. As an example, to produce a report card on quality of care for a provider, three-year old data would not reflect current mortality rates for particular procedures. HIN **data** provides immediate and current information to judge effectiveness for both purchasers **and** payers.

### 1.1 Cost Savings and Value to Users

The HIN is to be constructed to function as a *single-source* data repository for a wide range of information and users. Cost savings to all **HIN** participants will be realized in various ways: reducing duplicative administrative functions; making the provision of care more comprehensive and efficient; and supporting management decisionmaking.

Different agencies in the health and welfare services arena in Alameda County create and maintain independent eligibility files, which has led to a lack of care coordination partly as a result of multiple identification numbers for patients. A HIN provides the vehicle that will allow the combination of both welfare and health care services eligibility and related information, resulting in an elimination of duplication of data collection and maintenance and consequently freeing up system and staff resources. The electronic network services offered **by** the HIN will make administrative tasks in providers' offices more cost-effective while providing **data to the** providers that will lead to improved quality of care for their patients.

Health care costs will also be diminished **because** of a participating provider's access to the total patient care history through the HIN: medications, recent lab tests **and** results, and treatment protocols available to the provider can eliminate the cost of unnecessary and duplicative testing and promote more effective **treatments**.

Further, the HIN will provide the ACVPC purchasers, county officials, State officials, providers, and the public with the most reliable information on which to base decisions. The **data** will show which

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providers offer the greatest quality of care, in the most cost-efficient manner, and these **data can be** used to make informed and responsible choices.

By providing the infrastructure for collecting, analyzing, and communicating the abundance of health care information that is needed to support this decisionmaking, the HIN will give *purchasers something concrete on which to base choices, with evidence of quality for their money*. **Once the** information that the HIN collects gets into the public domain, pressure will be exerted externally on health plans to improve their performance as measured by indicators of quality that will **be** monitored with HIN data.

## **1.2 Health Care Delivery Systems Management and Control**

Specific information that will contribute to the management and control of health care cost **and** delivery systems in Alameda County include the following examples:

- Information about health status within Alameda County serves at least three purposes:
  - Any commercial insurer will carefully review the population mix and prepare rates that take into account the typical experience among such a population. Utilization of health care services varies widely in different population groups. Biostatistical and epidemiological indicators can explain the different patterns of utilization within specific communities.
  - Public entities need to have immediate knowledge of health trends in the population as a whole in order to meet public health goals and objectives.
  - The Alameda HIN will produce a population-based analysis to assist providers in determining clinical pathways and **track** variations in practice patterns to improve the quality and outcomes of medical care.
- Analysis of quality of care for outcome assessment and report **cards**:
  - As managed care entities have **garnered** a large share of the marketplace, the responsibility falls to purchasers of care to evaluate the effectiveness of the managed care plans **and** their providers. Although NCQA and other agencies are addressing **this issue, the** Alameda HIN can produce and analyze decision support **data** that incorporates national, payer-specific, and ACVPC-specific standards using current information germane to the demographics and geography of the county and including both public and private health care delivery systems.

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- This aggregate picture, produced from a data repository where a complete longitudinal record of patient care is maintained, can identify differences in treatment modalities between payer/provider groups, as well as overall outcomes for different payer groups. An independent report card on quality of care can result from such analysis.
  - Assessment of comparative cost:
    - Related to the evaluation of quality of care, the data from the HIN will produce data that are relevant to performance evaluations of differing types of **delivery models**, such as PPOs, HMOs, staff model managed care, etc.. *as well as* the relative costs of each provider network and **delivery model**. An assessment of comparative costs can be performed, adding to the ability of purchasers to make informed decisions.
  - Support for disease and patient behavior management initiatives:
    - With the **longitudinal** encounter **data** records available in the HIN, purchasers and payers will be able to make comparisons of treatment modalities that can be related to the cost of care.
    - Health promotion, disease prevention, and disease management techniques are likely to be shown by the HIN to be cost-effective over the long run.

### 1.3 All Health Care System Participants Benefit from the HIN

The key to a building successful HIN in Alameda County is to provide services to the participants that are needed and that will form a basic part of their business and practice operations:

- Purchasers or employers will be able to update enrollment, eligibility, **and** benefit plan information **and** generate public health surveillance reports for their members' inquiry. A self-insured purchaser can function as a payer **through** the network. Purchasers can design and order customized reports that contain benefit usage, costs, and **trend** information, as well as reports that illustrate provider cost and quality indicators.
- Providers will be able to verify enrollment **and** eligibility on-line, identify coordination of benefit situations, generate public health surveillance reports, and review benefit plan descriptions and utilization review requirements. Providers **will submit** claims and encounter **data** electronically. and receive reimbursement and electronic funds transfer along with electronic statements of remittance. Providers can access the longitudinal patient record to assess patient condition and **plan** treatment, as well as order and receive results of **lab** and other tests. Providers can also order reports that profile their

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practice, access medical libraries and information services, and use the HIN network as an e-mail tool.

- Patients will be able to check benefit levels, provider participation, provider locations and office hours, plan coverage limitations, and deductible information, in addition to report card information on participating plans. The HIN will provide the patient with the opportunity to submit information regarding satisfaction with care received. Patients can also receive an explanation of benefits for services rendered, and in some cases. make payments with credit or debit cards.
- Payers will be able to receive claims electronically, send statements of remittance and reimbursement electronically, and subsequently realize savings. Enrollment and eligibility can be accessed by payers and the e-mail capabilities of the network can reduce administrative considerations. Further, payers who successfully deliver quality care benefit from report cards, as enrollees and recipients who have a choice of plans will select the plan with greater access and quality.

## **2. GENERAL CHARACTERISTICS OF A COMMUNITY HEALTH MANAGEMENT INFORMATION SYSTEM**

The paradigm for an Alameda County HIN is referred to as a community health management information system (CHMIS). It is essentially a repository or warehouse of data: ( 1) that is built with existing participant **datafiles** and refreshed from electronic transactions generated from providers, payers, and other parties involved in the health care delivery system. and (2) makes its data available through the same electronic network while providing software that will analyze and present the data in a useful manner.

The greater the number of participants in the network that provide complete data, the more effective the analysis of the data can be. Additionally, the electronic network used for data collection will ideally foster and support expanded standardization of electronic records and processing of claims and remittance or financial transactions.

The participants in a model CHMIS include purchasers, both public entities, such as government programs of Medicaid and Medicare, and private employers, including those that are self-insured, TPAs, PPOs, HMOs and other managed care organizations, facility and professional providers, patients, and payers.

The John A. Hartford Foundation initiated the development of functional specifications for the definitive CI-IMIS in a document produced by Benton International in November 1992. The CHMIS described in this detailed document sets the standard for the most complete of these types of systems. Information from this landmark document has been incorporated, in the following section describing the general characteristics of a CHMIS.

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A CHMIS functions not only as a repository of data but the network through which providers, payers, patients, purchasers, and financial institutions are connected to effect the unified completion of a health encounter. A CHMIS operates in four general areas:

- Database storage and access
- Transaction processing and switching
- Reporting
- Network Services

Exhibit IV-1 illustrates the CHMIS general areas of operation.

The functions that are performed within each area are complex and varied. To support the functionality, the components required to create a CHMIS are discussed below.

## **2.1 System Architecture**

A CHMIS is an integrated electronic health management information system that functions as a point of collection for electronic health data and as a communication network. A CHMIS can be configured on a mainframe, in a client **server** environment, or as a hybrid. The architecture of a CHMIS must include flexibility and the ability to expand functionality and capacities with a phased approach.

The hardware selected must offer advantages to the selection of software, capacity for growth, granularity of capacity upgrades, operational stability **and** disaster recovery features, security capabilities, and network interface ability. Constraints for the processor, communications capability, and direct access storage requirements must be considered when selecting the CHMIS platform, as well as cost considerations.

The CHMIS must be sized appropriately, to allow for the initial population of the databases and to accommodate the increase in data as users of the network route transaction data to the CHMIS. The hardware and software selected will support the attractiveness of the hardware, or even the portability of the software to a new platform.

An example of a typical CHMIS architecture appears in Exhibit IV-2.

## **2.2 Relational Databases**

The databases in the CHMIS repository are the central component of the CHMIS. The databases must be designed and structured to provide data independence and follow logical **database** design to support normalization of data structures. This will allow the elimination of repeating groups of data elements, dependencies on keys, and fosters flexibility. Physical database design must balance the needs of system performance, data redundancy, and flexibility by indexing the data.

**EXHIBIT IV-1**

**CHMIS GENERAL AREAS OF OPERATION**

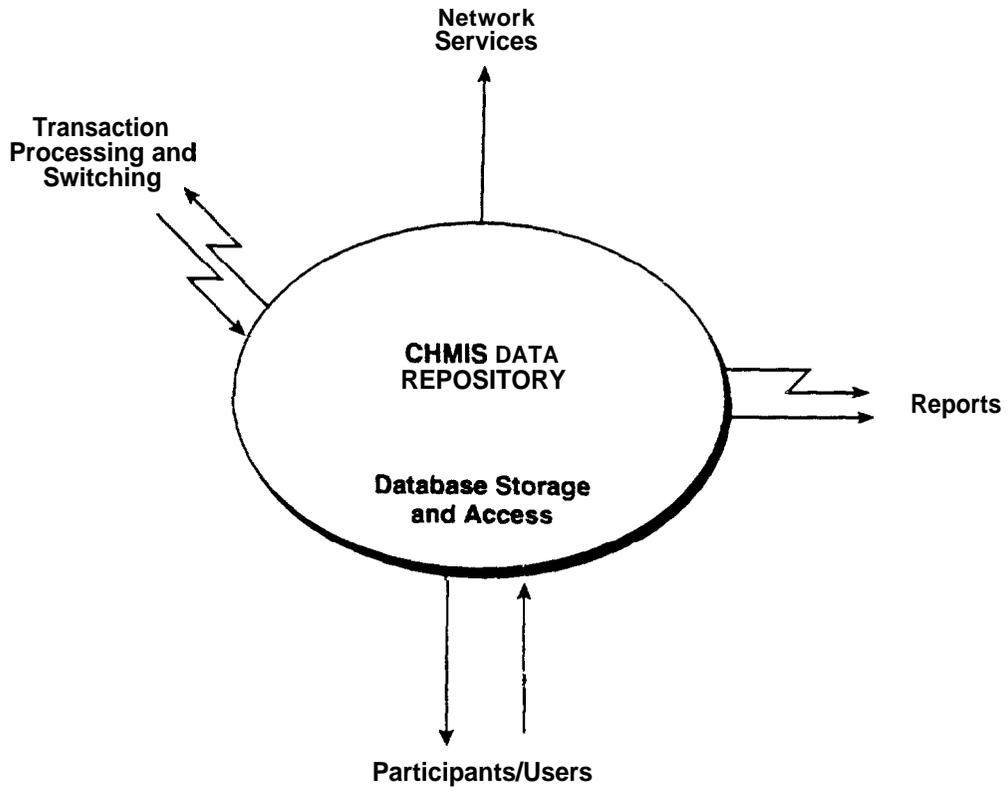
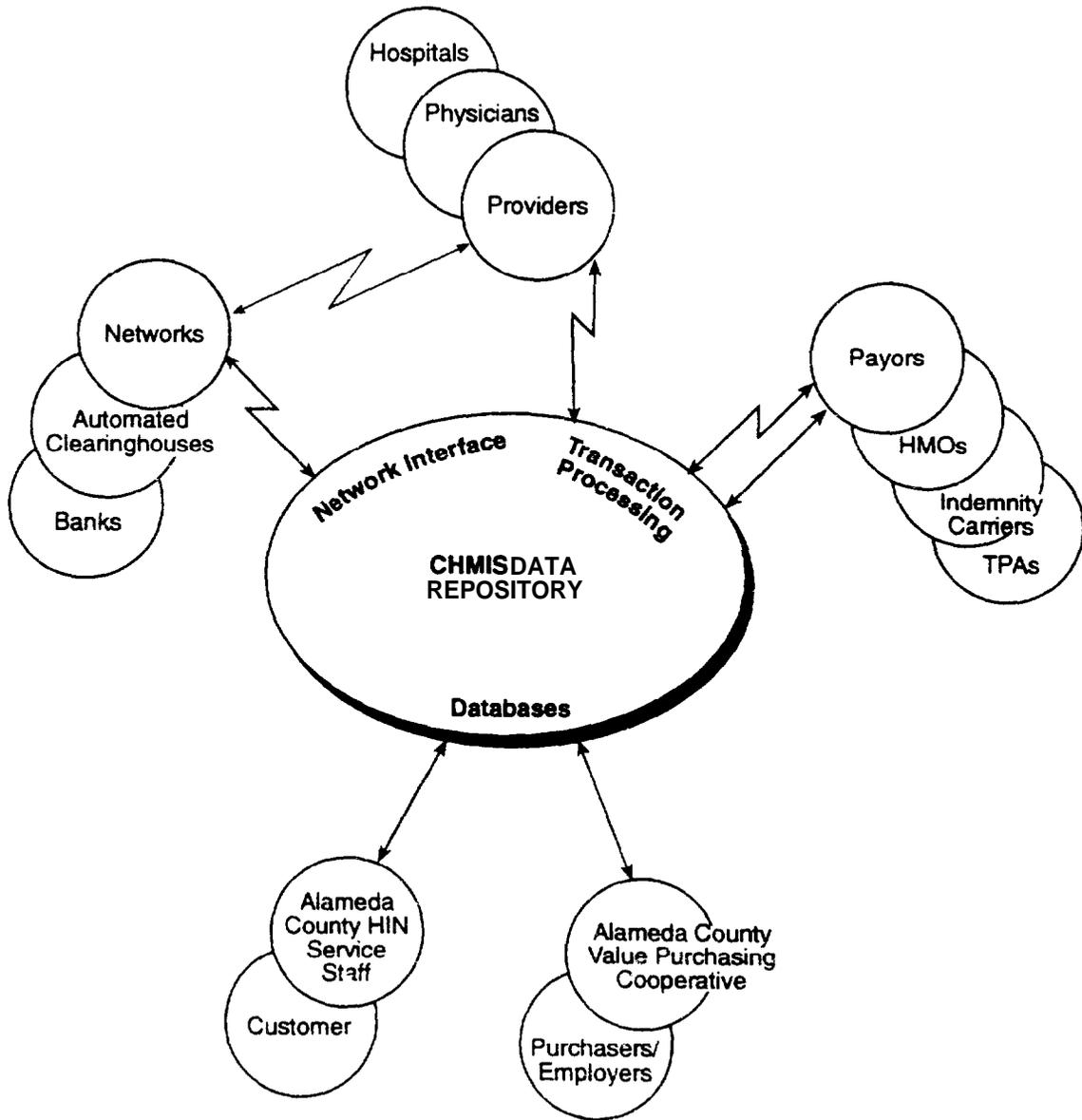


EXHIBIT IV-2  
CHMIS ARCHITECTURE



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The software selected to operate the CHMIS must be able to effectively manage the **data** so retrieval and analysis is quick, portability is ensured, and referential integrity of data is maintained in all databases. An example of the databases that can comprise a CHMIS repository is represented in Exhibit IV-3.

### 2.3 Network Interface Engine

As illustrated in Exhibit IV-4, a network interface engine is required to validate, edit, and format incoming data elements. An effective engine must validate, translate, and map incoming data, provide quality control of transactions received from the networks **and** switched to other networks, and test for reasonableness of the data received.

### 2.4 Analytical Software

The CHMIS **will** require effective software that allows the retrieval, analysis, and reporting of information contained in the databases. This is crucial to the satisfaction of CHMIS users and the **useability** of the data. The software should be in fourth-generation language and include the ability to perform normalization of data, data comparisons, and both detail and summary data manipulation for reporting purposes. A graphical user interface that allows Windows format will allow users to perform Structured Query Language (SQL) queries in a menu-driven, point-and-click environment.

### 2.5 Security, Confidentiality, and Access Issues and Tools

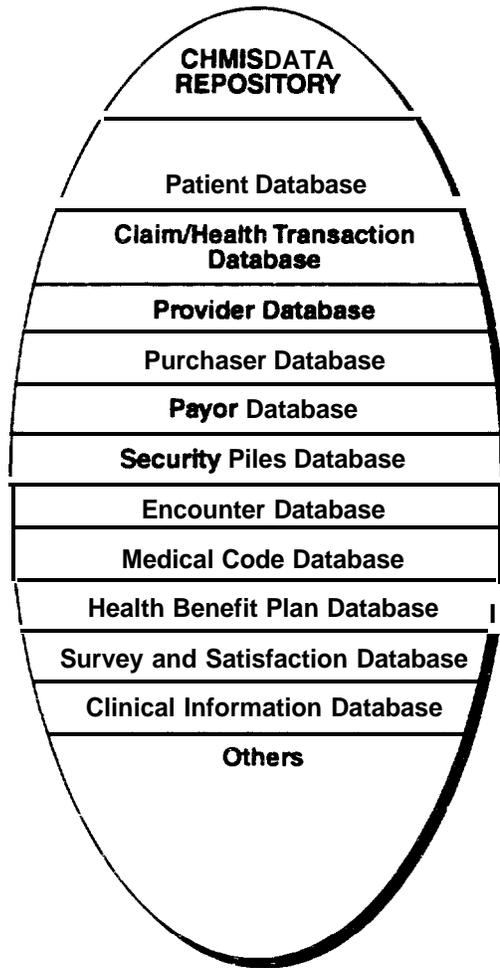
Appropriate system security measures must be applied to ensure that unauthorized access is prohibited, that levels of confidentiality and access to sensitive medical data are assured **and controlled, and** the data are protected from both intentional and unintentional access by unauthorized persons. Limiting access, especially as technology advances with smartcard capabilities, becomes extremely imperative. The addition and maintenance of user information must be easily maintainable. Software that meets current standards is commercially available for the application of the ACVPC's finalized security measures.

### 2.6 EDI/Network Control and Protocols

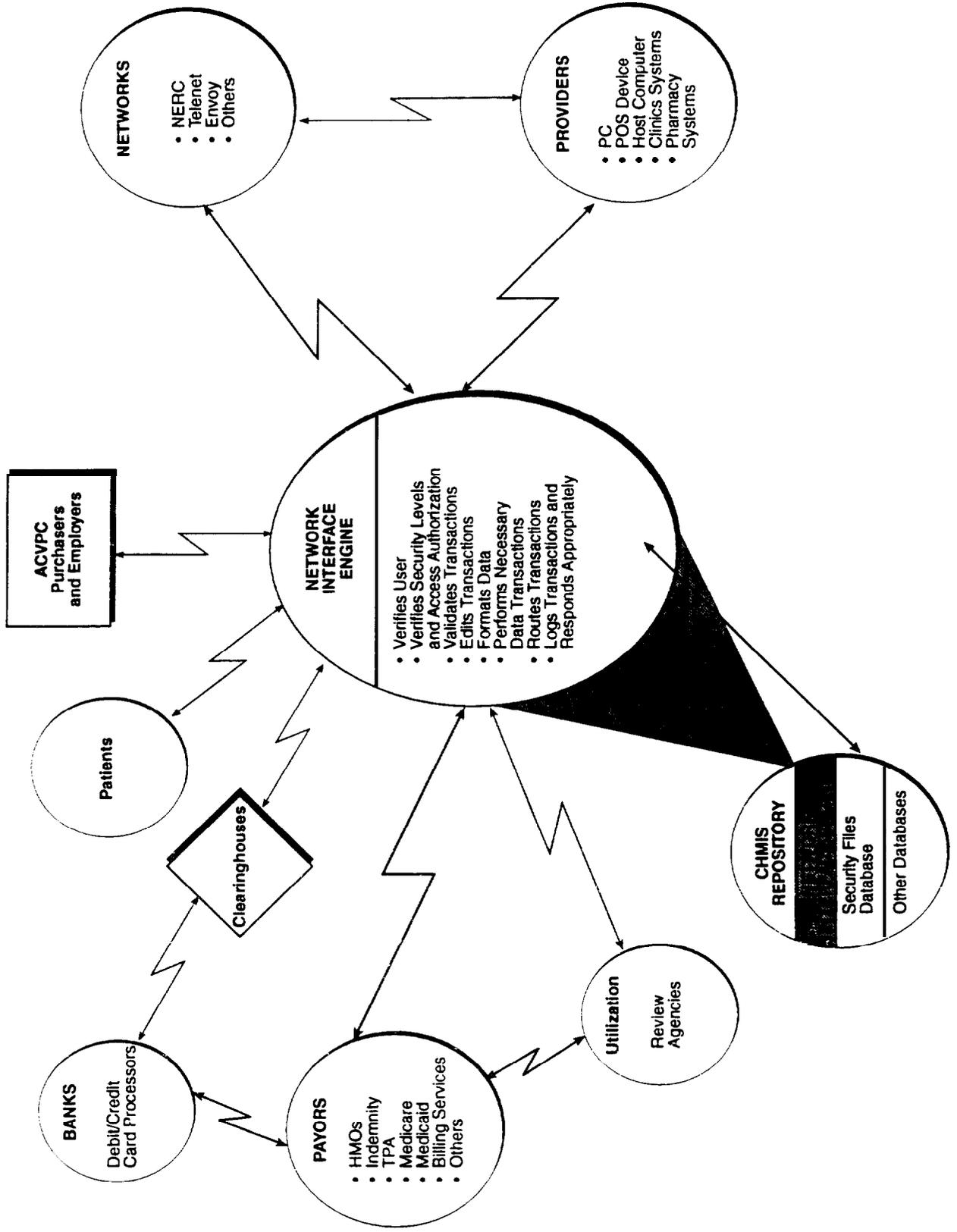
The CHMIS is an **electronic** network. Interfaces must be built to accommodate the connection to provider, payer, employer, or commercial transaction network vendor and other CHMIS participants' networks to allow and control the collection and dissemination of data. The control of access from other networks and the specific technical protocols required must be established and programmed, **and software** must be developed to control the reliability **and** integrity of the electronic transactions.

Both frame relay and transfer control protocol internet protocol (TCP/IP) network interfaces must **be** available to accommodate the inclusion of all participants in the CHMIS. The network must consider

EXHIBIT IV-3  
**CHMIS DATABASES**



**EXHIBIT IV-4**  
**NETWORK INTERFACE ENGINE FUNCTIONS**



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data security and access requirements. The network control functions **will** monitor network connections and communications links and provide re-routing of transaction traffic as necessary.

## 2.7 System Platform and Databases

A CHMIS is created using a relational or distributive database, a series of integrated databases, or a multidimensional database. The data are indexed to **allow** the development of access and analysis routines that are quick and efficient. A CHMIS **will** typically include several primary databases, such as patient, provider, purchaser and payer, and additional databases, such as customer satisfaction, facility, medications history, and health plan information. The databases can be expanded to include databases for survey information or importation of national health claim information. An illustration of the variety of data exchange facilitated by a CHMIS is found in Exhibit IV-5.

Incoming transaction/encounter records are used to populate multiple databases **simultaneously**. The great advantage to be gained with multiple **databases** is that information is sorted with detailed and summary-level data resident in different databases, allowing much faster access and to data already organized and summarized to meet the needs of different users.

### 2.7.1 Patient Database

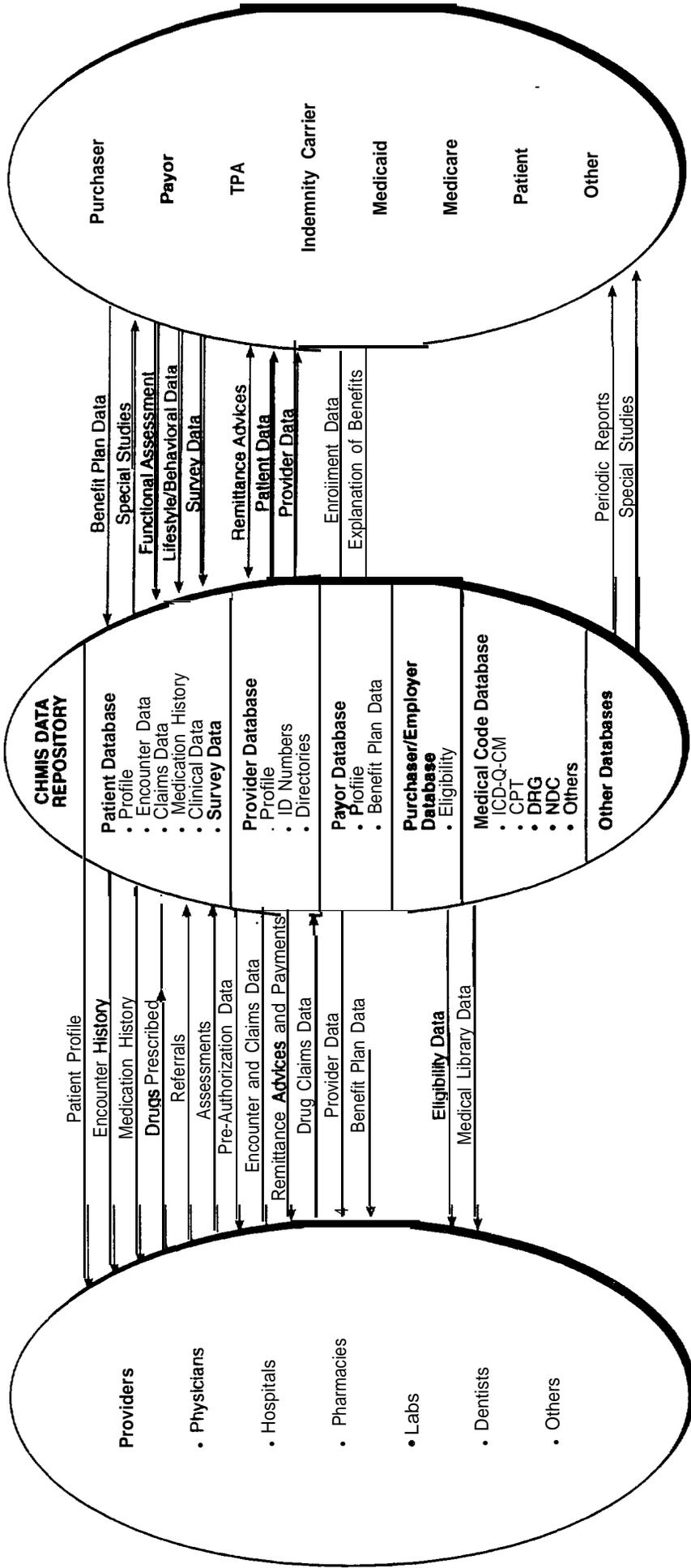
The information for this database is obtained from various purchaser, employer, and patient sources. The provision of these data is not an additional administrative function, but rather an extension of administrative tasks that presently exist.

The patient database is the heart of the CHMIS and comprises patient files that include:

- Identification numbers
- Employment information
- Addresses and telephone numbers
- Health plan details (deductibles, copays, maximums, coverage limitations)
- Encounter history detail and summary information
- Hospital encounter information
- Prescription drug data
- Laboratory test data, results, and imaging data
- Health assessment information
- Lifestyle behavior data
- Satisfaction **survey** information
- Claims history data

Patient eligibility data, coverage, effective dates, and relationship to others in the household for coordination of benefits are included **in** this **database**. Patient satisfaction survey **data** regarding rendered health care services can be contained in this or a separate database.

EXHIBIT IV-5  
CHMIS DATA EXCHANGE



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Multiple, linked patient identification numbers can be carried in this record, allowing access to information should the patient be enrolled in multiple public or private sector programs. As an example, a school-based program or welfare services program number can be cross-referenced to a Title XIX Medicaid program number or a Social Security Number.

### **2.7.2 Claim Database/Health Transaction Repository**

The claims repository contains the elements from the American National Standards Institute (ANSI) X12-837 claim standard as sent to the payer and includes other elements required for the submission of the HCFA 1500 and the Uniform Billing Claim Form of 1992 (UB-92). There are multiple access keys into the repository, and the claims are linked to the other databases.

Patient-specific encounter detail and summary data contain the patients' histories of medical encounters, including procedure codes, diagnoses, and dates of service usually associated with claims that have been submitted. In this or a separate database, encounter history is maintained in a fully secured, access-restricted and confidentiality-sensitive manner. The identification of the provider rendering the service, and the setting (office, clinic, etc.), charges, and directives for referral or follow-up care are carried on the file.

Separate encounter data sets are maintained for care received in an institution, such as a hospital or an emergency room. Admitting physician identification, length of stay, DRG, procedure codes, utilization review status, **preauthorization** status, discharge status, take-home drugs, diagnoses, and admitting history and physical information are examples of data that can be contained in the record.

### **2.7.3 Provider Database**

Data regarding providers participating in the CHMIS network, through a vendor or a particular delivery system are maintained in a database that includes their provider numbers (including multiple provider identification numbers (IDs) for individual programs, such as Blue Cross and Blue Shield organizations, Medicaid, Medicare, etc.), taxpayer ID numbers, UPIN, address, phone number, and licensing information. Providers can be identified as an individual practitioner, as a member of a group or facility, and by affiliation with an IPA, PPO, HMO, or clinic. The profile information also contains the provider's specialty, bank account information for financial transactions, and licensing and certification dates and information.

The provider database is linked to the other databases in the CHMIS, such as the claims history, encounter, patient, vendor, and administrative files used for billing and security. The provider database will also carry the e-mail address information of the provider, which is used for billing, electronic funds transfer, and capture of other electronic transactions.

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**Profile information** for each facility that is a provider within the CHMIS network or is affiliated with any plans or organizations that are members of CHMIS can be maintained and contain name, **address**, phone, rate, size, payer affiliation, and bank account information.

All providers are linked through a CHMIS, allowing exchange of and access to total patient information as well as data on other the providers of care maintained in the provider database. as illustrated in Exhibit IV-6

#### **2.7.4 Purchaser Database**

The purchaser information will profile private employers and government agencies that purchase health care, such as the ACVPC, the individuals responsible for administering health care benefits, **and** the payers, **TPAs**, or ASO entities acting on their behalf. All patients in the patient database will be linked to a payer.

The entities contained in this database will be users of the CHMIS network and database files. These users will be able to request reports and analytical information through the CHMIS network.

#### **2.7.5 Payer Database**

Payers that are participating in the network through the purchaser agreements or that provide data to the CHMIS **will** be profiled in this database. The payer ID, name, address, and pertinent contacts will be carried in the files. Payers include **TPAs**, ASO providers, self-insured purchasers, government programs such as Medicaid and Medicare, managed care organizations, **and** commercial insurers. Payer profiles can include third-party billing agencies that submit claims on behalf of providers.

Typical information that is maintained for a payer includes address and telephone numbers, **pre**-authorization requirements, UR agency **affiliations**, bank account information, and associated vendor networks used by the payer.

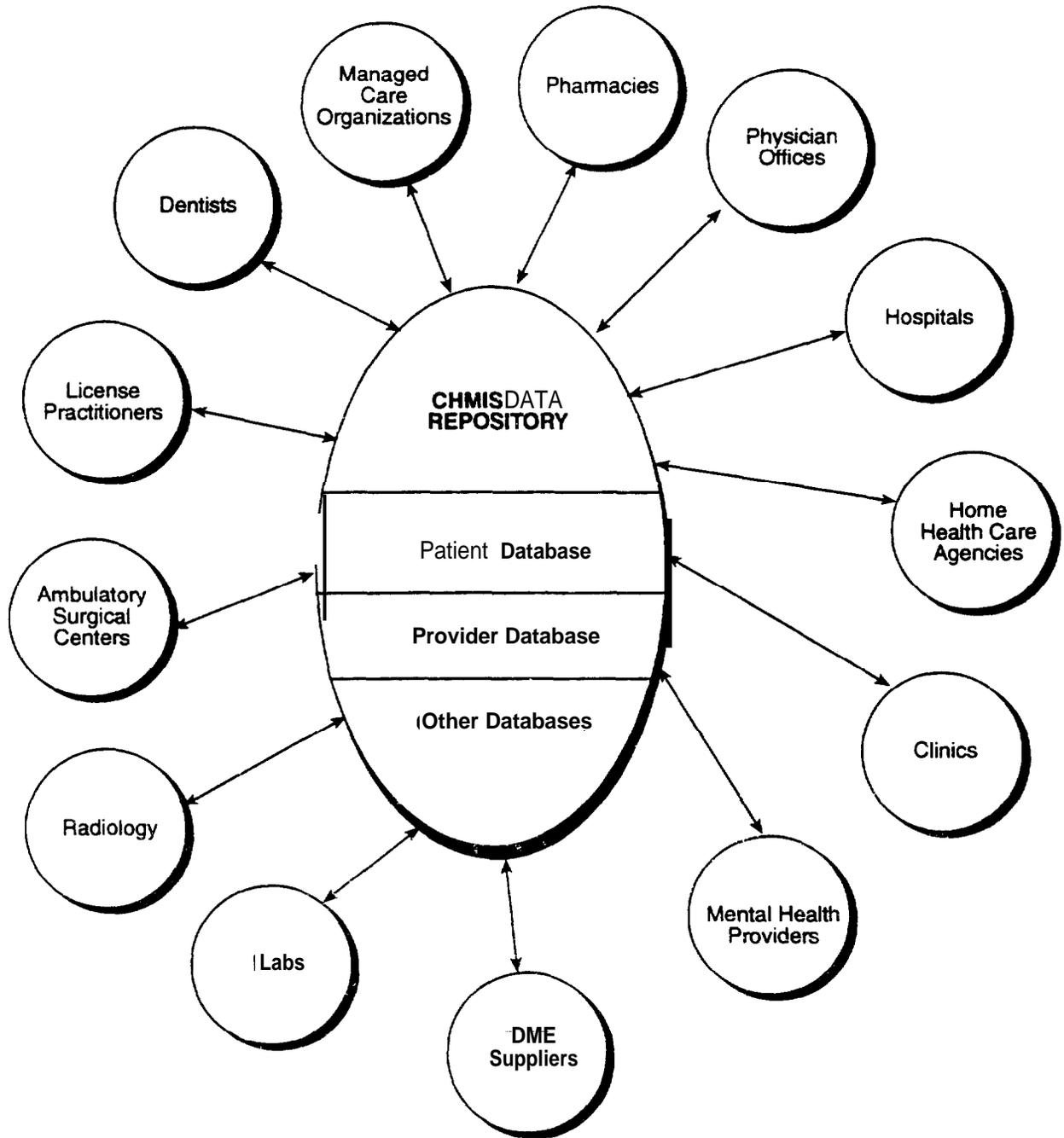
An optional database that can be accessed by a user through the payer profile is the utilization review database. This contains information about the utilization review agency used by the payer. Typical guidelines include which agency to contact, the person to contact, the phone number, **and** what information is required. Detailed records can also be sorted for each procedure that describe the **pre**-certification procedures that each payer requires for specific procedures.

#### **2.7.6 Security Database**

This database contains the user identification numbers, terminal identification numbers, **and** passwords. along with related information, for all users of the CHMIS. This file works in association with systems **security** software to prevent any unauthorized person from accessing CHMIS records, and defines the level of access any user has to data. Mechanisms to control access to confidential

EXHIBIT IV-6

INTERCONNECTION OF HEALTH CARE PROVIDERS



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data must be a top priority in developing the CHMIS. Also, considerations of availability of **data due** to confidentiality (i.e., vital record access lag time and Medicaid data access) must **be** addressed.

### 2.7.7 Encounter Database (Optional)

A distinct, separate encounter database is an optional database for a CHMIS. By keeping encounter data separate from the claims history or patient data, a reduction of processing problems in the summarization of data for reports or on-line inquiries from users can be realized. Summary detail **can be** organized geographically, **by** procedure **code**, or simply by patient or plan.

Whereas a claim record will define what services were rendered to a patient and where, along with financial data, an encounter record provides a different view. It contains an overview of the encounter, including all the tests conducted, what (if any) drugs were administered or prescribed, and if referrals were made. Over time, a picture develops that can indicate if the patient followed through with **filling** prescriptions, seeing the health care professional to whom the referral was made, etc. **Such** information is useful to providers in their treatment approach to patients and can indicate if patient education is required in the management of their health care, which can lead to overall cost savings.

A further advantage is the emphasis on **integrating** primary care community clinics into the encounter data maintained **by** the CHMIS. **Pooling** information from ambulatory care networks enhances the ability to analyze patient care histories.

### 2.7.8 Miscellaneous Databases

A CHMIS can include medical dictionary **and** code databases for medical, surgical, pharmaceutical, dental, **and** laboratory terminology and codes as a convenience to users of the system. Users can access the system to determine, as an example, the correct Physician's Current Procedural Terminology (CPT) **code** for a procedure being performed, or through a point-of-service mechanism learn if a drug to be dispensed is contained in the **formulary** established for the patient's benefit plan.

Additionally, if a facility profile database is developed, DRG "grouper" software can also be included in the CHMIS that will determine the appropriate DRG codes from claim data submitted and the rate information on file.

A database separate from the encounter **and** claims history for patients' medications history can be established and maintained, with two advantages: first, to foster greater access speed into encounter **data**, and to have immediate access to pharmaceutical-only information.

A separate **database** for laboratory and clinical test information can be built that is capable of accepting **and** maintaining test result **data**. **These specific and** detailed data can be valuable to certain users of the system and form a part of data that can be used as a revenue stream in support of the CHMIS.

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Functional assessments, patient satisfaction surveys, **and** clinical profiles are data gathered from forms that are mailed to the appropriate party, completed, and returned for entry into the CHMIS databases. The **data** provided by these sorts of survey **tools** contribute to outcomes analysis, risk evaluation, and disease and behavior management.

A health plan database is a service-related feature of a full-range CHMIS. This database contains information on the features of each plan offered **by** a group or payer. It describes co-payments, deductibles, frequency and dollar maximums, and any noncovered services.

A vendor profile database contains information about the vendors of the computer or communication systems that interface with the CHMIS. Interface requirements and specifications for each are maintained here, along with contact name, address, **and** telephone information.

## 2.8 Software

Required tools include the relational database management system (RDBMS), a front-end query tool, and tools to monitor and maintain the data in the databases to provide and maintain performance as the databases grow and change.

The RDBMS software structures the data into a relational **model** and manages the data in the underlying files. The file organization and methods of access to the data in the files are transparent to the user, as the RDBMS allows the user **to** view the data as two-dimensional tables made up of columns and rows. The RDBMS also manages the retrieval of data and provides security and control of the data.

The front-end query tool provides the interface **used** to request data from the database. The query tools use a standard SQL to retrieve or manipulate the data managed by the RDBMS. Many query tools provide a graphical user interface to **build** queries, so the user does not have to be proficient with SQL to retrieve information from the database.

Some SQL tools offer the advantage of the ability to control and schedule database **tasks** instead of relying on the capabilities of the general-purpose operating system. This enhances performance and efficiency. A software tool that provides portability, allowing future migrations to another hardware platform, is important when considering the future and growth of a CHMIS.

Query and reporting tools should provide users with a Windows-based application that allows them to select data from the databases with easily created queries.

A translator engine will validate incoming data elements and editing functions. An effective translator engine will validate **data**, translate and map incoming data, provide quality control of transactions received from the networks, test for reasonableness of **the data** received, **detect** hardware and

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software failures that create illogical transactions, request retransmission of erroneous transactions, and conduct internal audits of the database.

### 3. FUNCTIONALITY OF A CHMIS

Much of the rich functionality that supports all users of and participants in the CHMIS has been discussed above in the description of the databases. The extent of the functionality of a CHMIS depends on the level of effort in software development. With sufficient sophistication in software, decision support and executive activities can be performed to expand the benefits of the CHMIS to other users. Examples of functionality are:

- Normalized and risk-adjustment data
- Analytically enhanced data
- Analytical and reporting methodologies that raise high-level issues and allow “drill-down” analysis
- Internal and external normative databases and other benchmarks to enable measurement and evaluations
- Evaluations involving linkage between types and episodes of care, making the information analytically ready by enhancing raw data
- Construction of inpatient admissions (linkage of all claims-related dates to an admission)
- Assignment (i.e., procedure groups, treatment groups) outpatient classifications
- Standardization of data to permit meaningful comparison with public and private normative data
- Tracking of files for families, households, and individuals
- Case-mix, age-sex, and severity (level-of-care) adjustments for comparison purposes
- Associative subsetting that pulls all data on a specific age group or price group, and then generates ad hoc reports on that subset.
- Cost-effectiveness evaluations that blend case mix and severity into the equations, necessitating severity adjustments

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- Creation of internally generated norms
  - Readmission analysis
  - Automated processing of integrated eligibility and claims data for purposes of calculating rates, tracing costs per capita, etc.
  - Modeling and trend analysis for rate checking, performance profiling, and projecting effects of various proposed policy changes on budget. quality of care. etc.
  - Best-practice “benchmarking” for measuring performance
  - Ability to compare fee-for-service with managed care encounter data
  - Ability to export data to other applications such as Excel, Lotus, and SAS
  - Ability to store custom reports and customized norms in user-specific on-line libraries
  - Identification and importation of foreign databases
  - Data analysis and selected clinical datasets

These data and the analysis possible with a CHMIS not only allow vast improvement in the approach to and delivery of health care, they form a body of information that is of value to paying participants in the HIN. Such descriptions of the health care continuum, involving all county residents and spanning a wide socio-economic cross-section of citizens, are invaluable to policy research and decisionmaking efforts that have previously not had access to such data. Access to the data by the Medical Schools will greatly enhance their ability to guide medical education priorities and focus areas.

In addition, a CHMIS must include provision of customer service functions. The participants will require that staff be available for billing questions, technical assistance, enrollment/disenrollment purposes, and coordination of incoming data. These are discussed below in Section 4.

### 3.1 Contingencies

A CHMIS must be designed with fail-safe mechanisms to anticipate routine problems. Such contingencies include:

- **Hardware and Software Failures-Planning** for alternative processing options in the case of hardware failures or software problems can ensure that the CHMIS is

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capable of continuing to accept incoming information from participants and can function while the problems are corrected.

- **Erroneous Transaction-The** network and database software and technical service interfaces must be capable of handling failed or erroneous transmissions and the subsequent correction of the database files.
- **Disaster** Recovery-Standard contingency plans for operations in the case of a disaster or failure of major proportions must be in place to ensure data collection and distribution, as well as network services to all participants, can continue uninterrupted.
- **Security and Confidentiality-Sufficient** planning for the security and confidentiality of all data must be undertaken to guard the integrity of the CHMIS data.

This brief summary has described a full-service CHMIS. As a CHMIS will be most effective when planned to be implemented with a phased approach, the following sections suggest a plan for the inception of a CHMIS for the ACVPC that can grow with the needs of Alameda County.

#### **4. AN ALAMEDA COUNTY VALUE PURCHASING COOPERATIVE HEALTH INFORMATION NETWORK**

This section discusses a CHMIS specifically designed and built for the ACVPC. The term Alameda County Health Information Network (HIN) is used to distinguish this custom-designed CHMIS. Many of the components and much of the functionality of the total CHMIS described earlier will be required or suggested for the first phase and subsequent phases of the Alameda County HIN. Exhibit IV-? presents the a model health care reform-infrastructure for the health information network.

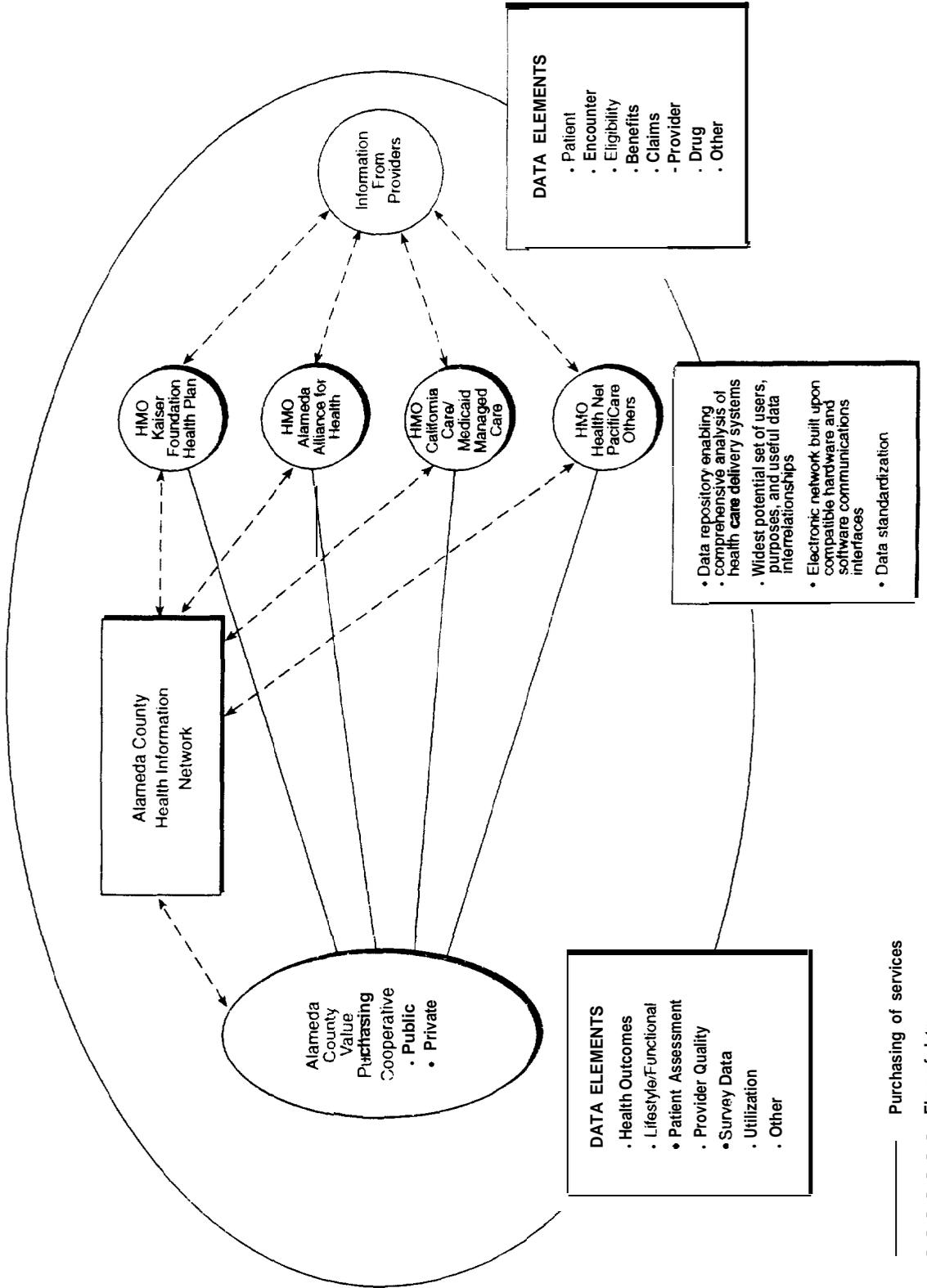
##### **4.1 Considerations in Forming the Alameda County HIN**

The HIN is viewed as a fundamental support function for the ACVPC. In that context, the development of the HIN and the features to be included must be considered from a cost-benefit perspective. The functionality will be determined by the most immediate need of the cooperative and its participants. Not all members of the cooperative may have immediate HIN needs or be able to contribute meaningful data. The initial participants in the HIN, and its initial functionality, will be determined by resources and availability of data from the participants.

A calculated approach to expanding the number and type of participants, their data contributions, and the functionality of the HIN will be accomplished with a phased implementation and incrementally increased functionality.

EXHIBIT IV-7

ALAMEDA COUNTY PROTOTYPE  
THE HEALTH INFORMATION NETWORK



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#### 4.1.1 Alameda County Systems Integration Plan and the HIN

The Alameda County Health Care Services Agency has made impressive conceptual **strides toward** the goal of its Systems Integration Program, which is the multiorganizational integration of systems. To capitalize on the efforts already underway, the **HIN** that will be developed to support the ACVPC could be integrated with or based upon the system developed in the Health Care Services Agency. The Alameda County HIN will be a giant leap forward for the county in realizing those goals. Information sharing and countywide identification of clients among agencies will be accomplished with the **HIN**, a common means to identify and determine what has been previously provided a client. **The HIN is** focused on the **ability to** provide the user a longitudinal record to capitalize on the efforts already underway of client. or patient, health care.

#### 4.1.2 The HIN Support Tool for the ACVPC

In the absence of the **HIN**, the cooperative could not effectively illustrate, with hard data, the overall cost-effectiveness of its integrated approach to health care purchasing and consequent improvements in health outcomes for the citizens of Alameda County. The **HIN** will perform many functions for all participating organizations, improving performance while reducing cost, and itself become a revenue source. The **HIN** will become an integral part of the participants' everyday functions and be viewed as a valuable resource. Initial HIN functionality must provide a benefit to the original participants as soon as possible to encourage its success.

#### 4.2 Participants in the Alameda County HIN

The **baseline** planning for the HIN should consider those entities **most** likely to become charter members from whom the most important data would **be** received, and to whom the HIN would have the greatest immediate value. Early planning sessions will identify all potential HIN participants, **just** as the planning for the purchasing cooperative **included** initial assessment of interest. The **HIN** could include participants that are not members of the purchasing cooperative, but this is not currently anticipated. Ranking criteria will be applied to potential participants and their data needs to determine the most important features and functions the **HIN** must include **at the outset**.

**For** example. it will be important to identify those participating organizations that represent the greatest number of enrollees, and therefore will bring negotiating clout to the purchasing cooperative; those which offer the most data and in the formats that most closely meet the requirements of the **HIN**, making initial and technically less difficult population of the data repository possible; and those which offer the existing electronic gateways to provider groups to facilitate communications and data sharing.

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### 4.3 Data Requirements of the HIN

As users become familiar with the capabilities of the HIN and avail themselves of the data, the demands on the availability and quality of data from the HIN will increase the demand for information. Users' expectations for the most current information and ease of access will become more important. The HIN will need **to set** standards about the timeliness with which **data are** made available to the different user groups. These standards can be reviewed over time to evaluate their adequacy and **determine** whether they meet the needs of the system's users.

#### 4.3.1 Initial Database Construction and Population

The charter members can provide HIN planners with the technical information about the data in their systems, what archived data are available, and general electronic connectivity specifications. This information will allow planners to decide what **data** are necessary to support the functionality of the HIN, which databases will be **required** to supplement the repository and ready the data for analytical software, and if there is sufficient value in available historical data for use in populating the databases.

As an example, sufficient eligibility data may be resident and available for conversion to the repository from each of the participants that analysis of demographics can begin for the ACVPC immediately and providers can determine eligibility of their patients on-line. Provider networks and associated claims networks or vendor systems of the participants may **be** ready to produce data immediately.

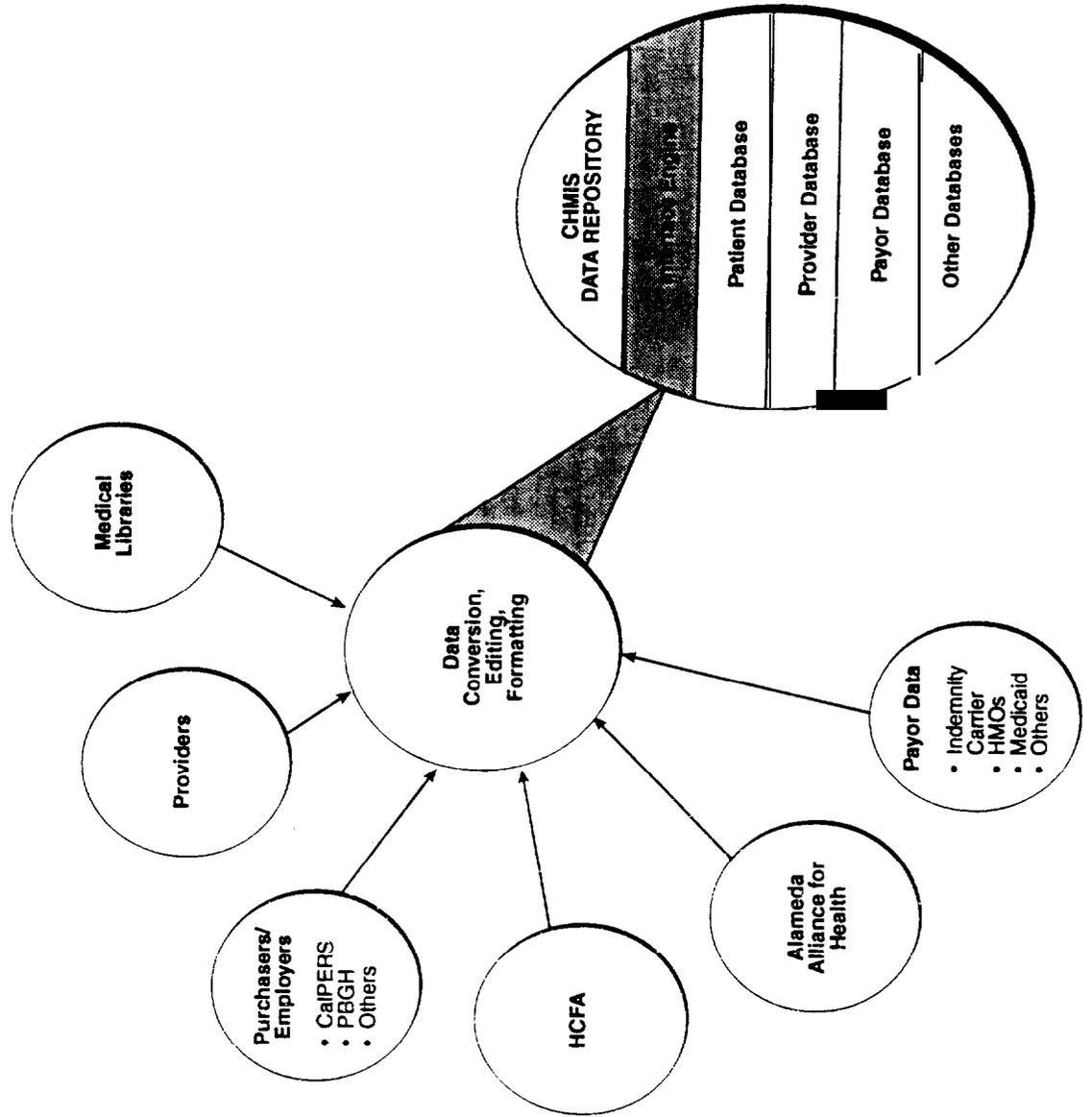
Types of data that can begin **immediately** flowing to the HIN and be housed in the repository include medications claims data from pharmacy networks in National Council of Prescription Drug Programs (NCPDP) format. Professional fee-for-service claims data, and possibly encounter data, from provider groups may be available through commercial insurer networks or electronic clearinghouses used by the providers or their payers. Some managed care organizations may have encounter **data** from their network professionals and facility providers that can be incorporated into the HIN. An illustration of **data** sources for initial database population is presented in Exhibit IV-8.

When it is determined what data can be accessed, and its anticipated volume, consideration of the hardware capacities and software capabilities in the areas of data validation and editing for quality control can commence. The next step is to determine what available **data are needed** to support initial functionality.

### 4.4 Functionality Goals of the Alameda County HIN

Realistic goals for the HIN must be set. These goals **must** consider what functions will produce the greatest benefit and support the ACVPC and the participants. As discussed in Section 3 above, the analytical capabilities of the HIN could be limitless, assuming all data elements for claims and encounters are available; the extent of the analysis would be dependent on the sophistication of the tool sets prepared **by** the HIN.

**EXHIBIT IV-8  
CONVERSION DATA**



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The goal of creating an HIN that is considered **by** user groups to be a valuable component of day-to-day operations will be realized through the identification and provision of useful functions. Items described in Section 3 above will be compared with the present capabilities of participants **and** network availability to user groups. Those functions that can be brought on early in the HIN development at a reasonable cost and that encourage daily use will be targeted for implementation in the earlier phases.

Initial functionality requires core elements: hardware, software, and communications network capabilities and interfaces. An **electronic data** interchange (EDI) translator engine, even with standardization of network and EDI protocols, is required to format data. The engine must provide internal audit capability. Software must be available that has **data** extraction, query, and analytical capabilities. Software must be able to track and report transaction revenue collection reporting.

As related earlier, there are many important functional items that can be included in a HIN and that should be part of the initial functionality of the Alameda County HIN. For example, decision support **system/executive** information system software optimizes the potential for **data** access, data analysis, ad hoc reporting, reporting of Federal data requirements, and offering of report cards on participating plans and provider networks. This software would allow *trend analysis*, which is important to the County in preparing for health delivery by utilizing “early warning” capabilities, which can allow public health planners to add and subtract services according to need.

These and other items will be used to form a matrix that illustrates functions that can be made available and their relative technical difficulty and cost and that can assign a priority for inclusion in the HIN. When developing the initial functionality of the HIN, there are important factors to be considered.

#### **4.4.1 Available Systems, Data, and Interfaces with Existing Systems**

The Alameda HIN must avail itself of the existing networks and data sources to the maximum degree. Not only is this approach cost-effective, it incorporates to the maximum extent possible the advantages of networks in place and the ease of incorporating current providers on those networks and increases the likelihood of vendor participation.

Certified transaction networks and pharmacy networks currently exist for claims submission. Additionally, commercial and managed care provider systems and electronic links are in use for various providers, Medicaid and Medicare carriers and intermediary **electronic** submission of claims and in some cases, transfer of funds and **electronic** statements of remittance.

At the time planning and design of the HIN take place, an identification and technical review of the standards and protocols in use by all participants to be solicited for participation in the HIN **will be conducted**. Accommodation of these various networks will be addressed with the abilities of the HIN software to convert or reformat data, and the technical communications interfaces issues resolved.

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The HIN strives for a “one system” solution, versus a hodge-podge of proprietary or vendor systems in use.

#### **4.4.2 Standards**

Electronic claims submission was the pioneer in electronic communication between provider and payer. Each organization that offers that process has grown to include two-way communications, through the transmission of statements of remittance, funds transfer, eligibility verification, claims status, and enrollment. These efforts have been within the payer organization or commercially pursued by vendors, but no one service or standard has emerged.

Nationally, multiple groups have formed that are working toward a standardization or record format to allow compatibility between systems and data exchanges. ANSI, WEDI, the Agency for Health Care Policy and Research, the American Society of Testing and Materials, Health Level 7, NCPDP, and NEIC, among others, are working toward the creation of national standards for EDI for administrative and clinical EDI datasets. The support of quality and outcomes initiatives, such as HEDIS, is predicated on data that can be adjusted to uniformity.

While national standards for data format, network protocols, and data integration are nearing the final form that all incoming data must eventually meet, some data must still be translated by the interface engine. Some support for back levels (older data formats) of data requires more processing and will be eventually phased out, although to support back levels at the outset in the creation of the HIN can encourage participation that would otherwise be missing.

#### **4.4.3 EDI Protocols**

Adherence to standard data formats fosters data interchange and analysis capabilities that will reduce cost and complexity in administrative and clinical transactions. A standard would allow increased communication between all payers and providers and simplify the claims submission and switching procedures.

Many EDI transactions have been standardized by ANSI, and additional transaction sets remain in development, as depicted in Exhibit IV-9.

It is anticipated that the HIN will require all submitters to meet the following standards:

- ANSI X12 835 for remittance data
- ANSI X 12 from hospitals and payers
- National Standard Format from physicians

EXHIBIT IV-9  
ANSI RECORDS AND COMMUNICATIONS STANDARDS MATRIX

SENDER	RECIPIENT					
	PROVIDER	PAYOR	PURCHASER/ EMPLOYER	MEDICAL SERVICES PROVIDERS	UTILIZATION REVIEW	GOVERNMENT
Provider	N/A	148, 837, 270, 271, 274, 275, 279	148, 270, 271, 276, 277	186, 850	186	N/A
Payor	270, 271, 274, 275, 835	N/A	148, 279, 838, 834	835	186, 279, 837	148
Purchaser/Employer	148, 270, 271, 276, 277	148, 279, 838, 834	N/A	N/A	N/A	148
Medical Services	106, 810	835, 837	N/A	N/A	186	N/A
Utilization Review	106	186, 279, 837	N/A	186	N/A	N/A
Government	N/A	148	N/A	N/A	N/A	N/A

N/A = not applicable.

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- NCPDP Version 3 from pharmacy networks
  - ANSI clinical data sets (or locally developed sets, if laboratory and X-ray data sets have not been developed at the national level)

Transitional support for back levels can be accomplished by reformatting of data before uploading to the HIN databases.

#### **4.4.4 Network Protocols**

The HIN must consider the protocols necessary to allow interface with existing private and vendor communication networks, to facilitate the two-way flow of data between the HIN participants. The HIN will offer TCP/IP and frame relay connections and an Internet Class C license.

#### **4.4.5 Service Capabilities of the HIN**

From the perspectives of the HIN participants, certain basic services must be available in the HIN, and training must take place so participants are educated on the use of the HIN. A customer service staff must be maintained to serve the ACVPC and the participants. Customer service functions include the following:

- Perform participant training functions
- Perform help desk functions for consumers, providers, and purchasers
- Track and monitor network and HIN response performance
- Ensure that all queries are processed, and maintain follow-up procedures for requests
- Provide technical assistance for system problems related to hardware, software, or network transactions
- Perform customer accounts receivable and payable functions
- Provide customers with information regarding the HIN data, including their status (fully restricted, restricted, public domain), and assist with the structuring of data report requests

The ACVPC can create and operate an HIN that supports the value purchasing of health care for public and private entities and create an environment in which analysis of care reaches unprecedented

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levels. This analysis will allow purchasers and health program planners to monitor quality of care and customize health benefits programs, leading to improvements in the health of county residents.

## 5. **OPTIONS FOR THE SOLUTION**

In formulating the solution for the ACVPC, we need to consider how best to finance the HIN and phase in its implementation. The following sections discuss the options for both HIN financing and implementation.

### 5.1 **Options for Financing HIN Development and Operations**

One of the most important aspects of planning an HIN is consideration of the various financing alternatives. Funding must be considered for both the development and operations phases of the HIN life cycle.

In order to understand the nuances of financing options, one must first have an appreciation of both the major phases of the HIN process. Each needs revenue. One also generates revenue and is likely to be a candidate for private capital. The phases are development and operations.

In the development phase, there is considerable work to be done. The basic steps required in the development and deployment of the system are as follows:

- Select and procure hardware platforms
- Specify and develop detailed software needs
- Select and implement database tools and interfaces
- Identify communications networks and interfaces
- Test the database and the system's security, functionality, and integrity
- Train, both classroom and hands-on, all user groups

These steps are required before any user can log on the system and transmit data to it for any of the various functions that the system will support.

In the operations phase, work to be expended will be significant. This phase will continue for years and will include the following types of activities:

- Routine operations activities such as file maintenance and backups
- Monitoring activities on the system, the database, and the communications network
- Interfacing with the user community on issues of functionality and data
- Accounting activities for user billings

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- Supporting data extracts for users, researchers, providers, and purchasers
  - Systems software maintenance and enhancement, including development of new or modified reports
  - Operations and distributions on standards system reports

The operations phase is the phase where service is provided and revenue is generated.

### **5.1.1 The Public Financing Option**

One option for financing an HIN focuses on the public sector. It uses public funding of both the development and operations of the I-EN. The HIN **would** be funded by a public or quasi-public entity. This entity could be one or a combination of the following; the Federal Government (as a demonstration program), the State of California, the County of Alameda, or the ACVPC (as a **quasi-public** entity).

This entity would have to present front-end investment funds to develop the HIN, purchase the hardware and software support products, and train the user community. Funds are usually available from foundations interested in pursuing ways to control health care costs while maintaining a high quality of care. The operations phase, after an initial ramp-up of users, should be funded out of transaction fees and sale of nonsecure data to private and public entities. We are confident that the HIN can be operated with no use of public funds. However, public funds savings realized from efficiencies made possible by the HIN **could** also contribute to support it. Foundation funding should be used primarily in the development stage of this endeavor and taper off as soon as the operations phase is under way.

### **5.1.2 The Private-Sector Financing Option**

A second option for financing the HIN focuses on the private sector. It provides private-sector funding of the development and operations of the HIN. There are private-sector firms that would develop and operate the HIN with no front-end investment on the part of the public sector in exchange of the for the right to operate. receive fees from users, and sell nonsecure data. Typically, these entities have access to capital for the development phase and would repay that capital investment from operating revenues over a five- to seven-year period.

### **5.1.3 The Recommended Financing Method**

We recommend that the ACVPC act as either a private or a quasi-public agent **and** develop and operate the HIN. We are confident that ACVPC can secure funding from both the private sector and foundations to develop the HIN and cover any negative cash flow that occurs during ramp-up of users. Operations can be funded from the transaction user fees and the proceeds from the sale of

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nonsecure data to health care purchasers, the public sector, the medical research community, and other interested parties.

## **5.2 Options for Implementation Methodology**

The implementation of an HIN system can take place under two basic scenarios: total and complete or phased. The system could be developed and then implemented simultaneously for all types of users and with all of its features. We refer to this type of implementation as the “big bang” method. It places a great degree of stress on both the implementers and the users. The other type of implementation is the “phased” method. It allows the developers and implementers to develop the system in an orderly, iterative manner and implement it in a like manner. It is also less intrusive on the user community.

### **5.2.1 The Big Bang Implementation Method**

The big bang implementation method is based on the idea that it is perhaps better to inflict pain all at once than in small, controlled portions. Given that system development and deployment is a fairly taxing and resource-intensive process, there are some who support the big bang method of implementation.

Developing and implementing in a total and complete fashion implies the following:

- That all aspects of the HIN will be simultaneously developed. Recalling the information presented in Section 5.1, this means that **all** the development tasks are performed in a relatively short timeframe. These tasks include (1) detailed software specification, design, and development (programming), (2) selection, procurement, and implementation of a hardware platform, communication network, database tools and interface products, (3) security, functionality, and unit as well as full system testing, and (4) training for all user groups.
- That all user groups will be simultaneously implemented. This means that the software that provides the functionality for all user groups, the network, and the user support staff will have to be ready for all comers at the same time. All of the aspects of operation that were outlined in Section 5.1 need to be ready. They are (1) routine operations activities such as file maintenance, backups, and facility monitoring, (2) user interfaces, services, and support activities (probably including a user hotline facility), (3) user and client accounting and billing, (4) consulting support for special needs of users, researchers, providers, and purchasers, (5) software maintenance, and (6) report distribution facilities.

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### 5.2.2 Phase Method of Development and Implementation

Given the ACVPC's need for an HIN as an integral part of its operations, and given the magnitude of the complete development of an HIN that can serve the entire county, we feel that the big bang method of development and implementation is not advisable and that the phased approach would better serve the user community.

Phasing development and implementation of the HIN implies the following:

- **Phased Development**-Will allow for priority components to be developed and tested first, with less critical items to be addressed after completion of the priority components. For instance, for all the components and functionality that need to be developed in a full-service HIN, a priority can be established for functionality that supports purchasers, providers, payers, and/or other users of the system. Based on that priority assignment, the development effort can address functional components in an order of priority that maximizes the immediate benefits of the HIN.
- **Phased Implementation**—Will allow the HIN to bring up associated groups so that the earliest user groups get full benefit from the system very quickly. Potential members of the ACWC present numerous cases where there is a logical association between the member and the provider community. These associated groups also exist within the payer community, with an indemnity-type health insurer having a close association with a preferred provider organization. It would make sense for all of them to join the HIN at the same time.

## 6. RECOMMENDED DEVELOPMENT PHASES

We believe that development of the ACVPC HIN should be phased as follows:

**Task 1: Hardware Platform Selection and Procurement**--This task needs to be completed before software development begins so that the hardware will be available for programming and testing and the language and other machine-relevant considerations are available for the programming staff.

**Task 2: Database Tool and Other Interface Tool Selection, Procurement, and Implementation** -Database and interface tools need to be selected early on in the development process. Specifics on which of them are selected are needed during the detailed software specification and development phase. Procurement should be phased to allow timely availability of the database and other potential interface products to the software design team. They have a direct bearing on the system's specification, programming, and testing procedures.

**Task 3: Detailed Software Specification and Development**-This major task should be phased to coincide with the order of implementation of the various users. There is one exception to this

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phasing. The entire database and all transaction layouts should be developed within the first phase so as to be available for access when testing modules that require elements within the database that are targeted for later development. The functionality required by the earliest-implemented user group **should** be developed first. The modules required to support this functionality should also be included in the first phase. Future phases should be defined in the same way.

**Task 4: Communications Networks Selection and Procurement-**This task has two parts, which can be phased differently. The network selection task should be completed early enough to allow system designers in Task 1 access to the network specifications. since these can affect their system design. The procurement task can be done later, as long as it is completed and available before the final system testing. Often, **communications** vendors will make a skeletal version of the network available to testers prior to **fully** implementing the network.

**Task 5: Testing of System Database, Security, Software Units, and Full System Functionality-**This task should be phased to coincide with the tasks above. Typically, software unit testing and database testing are conducted first. Security feature tests are phased next. Full operational system functionality testing is phased last.

**Task 6: Training for All User Groups-**This task is usually placed on the back burner in the systems development life cycle. We suggest that it be phased to begin about midway through the software development cycle and continue until all testing has finished.

## 7. IMPLEMENTATION

The HIN implementation has been broken into the following tasks and subtasks. A table follows the explanations of these tasks and illustrates the estimates of staff and time required to accomplish the tasks.

**Task 1: Information Collection and General Requirements Definition-Verify** and describe the providers, payers, and other participants and the associated technical specifications and capabilities of each. Update the information regarding entities in Alameda County already identified.

**Subtask 1.1: Develop Profile of Each of the General Types of Users-**Identify purchasing cooperative participants and potential participants and create a profile that describes the type of business, volume of related business, number of patients represented, type of benefit plans, and their data needs.

**Subtask 1.2: Complete List of All Transaction and Data Sources (Active Networks in Area) Based on Type of User—**From the profiles, identify the networks used or in place, by whom these are maintained, and the probable source of transaction data (network or mainframe) and categorize by type of user.

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**Subtask 1.3: Develop Detailed Candidate List of Users and Participants in General Functional Requirements Definition**—Identify and solicit potential users for participation. This marketing effort is to develop interest in the HIN and gain insight into what functionality will encourage participation.

**Subtask 1.4: Develop General Data Requirements for HIN (Transaction Types)**—Identify transaction data for capture and any data for initial database population. Identify what data standards are necessary and an indication of back-level support necessary.

**Subtask 1.5: Develop General Functional Requirements (Categories of Functional Support)**—Identify and document required functionality and anticipated technical interface requirements. Document outputs from the databases and the tasks the software must perform.

**Subtask 1.6: Secure Participant Agreements for Participants in the HIN**—Following the completion of the general design and functional specifications, secure participation agreements with the candidate list of users.

**Task 2: Develop Financing Approach and Sources**—Identify and estimate sources and amounts of funding available for the development and operations phases of the ACVPC HIN.

**Subtask 2.1: Identify Potential Development Funding Through Public or Private Sector Using Mechanisms as Follows and Develop Options for Financing Development Phase**—These mechanisms are:

- Federal/State
- County
- Foundation grants
- Private-sector funding as part of an overall development and operations initiative to permit the cooperative to charge network transaction fees and data charges for access and thereby recover development costs and generate a profit

Investigate and develop alternative funding approaches to obtain HIN development capital.

**Subtask 2.2: Develop Potential Operations Phase Funding Mechanisms as Follows and Develop Options for Financing the Operations Phase**—These potential operations phase funding mechanisms include:

- Government operation by State or county (using private-sector contract), with fees supporting operations based on transaction costs and/or access to data and with

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recovered operational cost savings from programs (Federal, State, and local) due to avoidance of data and staff duplication

- Private-sector operation funded by fees supporting operations based on transaction costs and/or access to data

Investigate and develop alternative funding approaches to obtain HIN operational phase funding.

**Subtask 2.3 Evaluate, Perform Economic Analysis, and Select Preferred Option-**From the above options, develop cost models for each alternative and present those **models to** the ACVPC for selection of the most advantageous financing method.

**Task 3: Develop System Specifications-**System specifications will be developed that consider the model CHMIS structures. Using source materials that are used as the foundation for CHMIS developments nationally, tailor to meet functionality goals of the ACVPC HIN.

**Subtask 3.1: Develop Detailed Data Specifications—**Subsequent to review and study of existing CHMIS models, as described by the Hartford Foundation and other private and public CHMIS initiatives, create data standards, record layouts, and **data** conversion and validity requirements specific to the needs of the ACVPC.

**Subtask 3.2: Develop Detailed Functional Specifications-**Develop detailed functional requirement specifications for data repository and individual logical database design and structure of interface components, hardware configuration, and requirements. Functionality required by software will be identified and documented.

**Subtask 3.3: Develop Hardware and Software Functional Specifications-**The completion of the hardware **and** software functional specifications is used as the groundwork to identify and review capabilities of available hardware **and** to identify software that will support the required functionality of the HIN. Hardware and software compatibility and management, ability to upgrade, and flexibility of control will be determined.

**Subtask 3.4: Develop Network Technical and Functional Specifications-**Identify and document the required network interface and specifications through review, based on anticipated volumes of data, participant conventions, transaction types, and existing networks. Document the **required** network interface specifications.

**Subtask 3.2: Develop Security, Privacy, and Contingency Specifications-**Create and document required **data** security and confidentiality measures and disaster recovery requirements for the HIN data and site security. The data security and confidentiality will be analyzed to allow protection from access **by** request or through a network. User authority and access levels will be created.

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**Task 4: Acquire System (Optional Task)—Options are** as follows:

- ACVPC in-house development and/or operations
- Request for proposals (RFP) for both development and operations
- RFP for development only, with a new RFP vehicle to decide operations vendor
- Sole source development and operations contract, with request for information (RFI) to qualify potential field of vendors to do the same
- Sole source development-only contract. with RFI to qualify potential field of vendors to do the same
- Sole source operations-only contract, with RFI to qualify potential field of vendors to do the same

**Subtask 4.1: Develop RFP and Evaluation** Elan-When financing options have been determined, and Tasks 1 through 3 are complete, develop (in concert with ACVPC) and write an RFP. The RFP will be constructed to accommodate the hardware, software, and functional design specifications as agreed upon with the ACVPC. The RFP will address both technical **and** cost considerations of the Cooperative.

An evaluation plan will be developed, also in concert with the ACVPC, that will allow the relative scoring of responses from both a technical and cost perspective. The evaluation plan will include the facility to weight particular categories to reflect the importance to the HIN and the cooperative.

**Subtask 4.2: Issue Request for Proposals-Publish** notice of any forthcoming RFP in the appropriate **trade** journals, identify potential bidders for direct solicitation, print, publish, and send or mail the RFP.

**Subtask 4.3: Evaluate Proposals; Rate, Rank, and Select Bidder or Bidders-Using** the evaluation plan developed in an earlier step, form a selection team for proposal evaluation and bidder selection. Review and analyze the technical and cost proposals received for mandatory compliance items **and** perform, with the ACVPC staff, a review of the technical proposals. Scores **and** weights will **be** applied and a selection for award **made**.

**Subtask 4.4: Negotiate Contract**—Officials responsible for the HIN will negotiate a contract with the successful bidder or bidders. Terms of the contract will be targeted at maximizing benefits to the community and minimizing funding **outlays**.

**Task 5: Develop System and Establish Service Functions-The** following tasks and subtasks describe the general steps required to initiate the development and operation of the actual HIN.

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**Subtask 5.1: Establish HIN Environment**-Many diverse tasks are required to establish the environment in which the HIN will operate. These are necessary for the implementation of the project:

- **Establish HIN Interface and Reporting Lines**-Establish communication protocols between I-IIN management and contractor or operations staff. Facilitate the necessary process to achieve the desired interface and reporting structure that will be the most effective. Meeting schedules and project status reporting issues are addressed and finalized in this step.
- **Finalize Hardware, Software, Network Standards, Designs, and Structures**—Create a **finalized** plan for the technical design and structure of the repository and the standards the technology utilized **will** be required to meet. Detailed functional specifications work will have been carried out in task 3 above, and final tweaking of the platform hardware, various database designs, interface structure, and software will be completed.
- **Site Planning-Design** and create a plan describing the requirements of an HIN site, identify potential sites that can provide a comprehensive working environment for the HIN repository and staff, and within the scope of financial and budget considerations, secure and locate an appropriate space.
- **Conduct Requirements Analysis and Produce Requirements Analysis Document (RAD)**—Conduct requirements analysis to define all parameters, requirements, and definitions for implementation. This procedure is intensive, with cooperation required from ACVPC authorities, hardware and software professionals, and potential HIN users. This requirements analysis will lead to the finalized detailed implementation plan and will allow the documentation of directives that promote the ultimate success of the HIN.
- **Prepare and Document Detailed Implementation Plan (DIP)-Distill** the project's requirements into a detailed implementation plan, based on the technical solution proposed. The initial DIP is created from the understanding of the project from the RFP (if any). the technical solution decided upon, and the RAD. This document is delivered after the conclusion of the requirements analysis task.
- **Develop and Finalize Configuration Management Approach and Process-This** approach will be finalized and implemented as a result of the hardware and software selection and the DIP. **Produce a** comprehensive configuration management approach to ensure that all system modifications bring **about** predictable results and ensure that

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system changes are properly identified, prioritized, and implemented and pass extensive quality assurance standards throughout affected areas of the HIN operations environment.

- **Develop Quality Assurance/Quality Control (QA/QC) Plan**-Specify tasks and activities necessary to control and assure the quality of the data repository system and the quality of the data in the repository. The QA/QC plan and procedure will be designed to protect the integrity of the database and the function of the repository software management.

**Subtask 5.2: Acquire Hardware and Develop Software**-Obtain the necessary hardware and procure and modify or develop software for the implementation activities:

- **Hardware Acquisition**—From previously developed functional specifications, research candidate hardware platforms based on capacity, upgrade ability, compatibility with software management tools, and the required HIN functionality. Solicit offers from candidate vendors and select vendor.
- **Software Development-Develop** or acquire and modify software to detailed specifications. The development or selection of software will consider the integration into the HIN as a whole. Software development will encompass hardware and data management, database creation and maintenance, interface routines, network monitoring, reporting functions and query support, and transaction accounting and financial reconciliation needs, among others.
  - Program:

Write the code to modify or create software to support required functionality.
  - Unit test:

Design test plans from system design specifications, documenting all possible test cases. Test data will be compiled and software executed with test data as input. The intermediate and end results are recorded and analyzed, with deviations from expected results noted as error, which are subsequently investigated, and the tests are repeated.
- **System/Acceptance Testing**—In this testing, the system as a whole is subjected to thorough testing. As in unit testing, test cases covering all possible situations are developed and input created against which to run the software programs. Errors are

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identified and corrected. Following the successful completion of acceptance testing, actual data are loaded to the repository to populate the databases. Acceptance testing is repeated with these volumes of live data, as an entire functional unit.

**Subtask 5.3: Prepare and Publish System Documentation-**Prepare and produce operations documentation specifications and develop and publish internal and external user manuals.

**Subtask 5.4: Develop Repository Basic Documentation-**Create and publish user manuals for participants and technical systems documentation.

**Subtask 5.5: Finalize Security Plans and Procedures-**Complete and document facility, system, data, and user security measures. These will include the assignment of user identification numbers, terminal numbers, and data access levels. The building access procedures and network software will be reviewed for completeness and documented.

**Subtask 5.6: Finalize Disaster Recovery Plan-**With ACVPC officials and site management, disaster recovery procedures will be agreed upon and finalized to ensure ongoing operations and data security in the event of a disaster.

**Subtask 5.7: Design and Develop Training Materials-**Prepare materials for training sessions with HIN user groups prior to the operational stage of the project and modify as necessary as an ongoing activity. These materials will be targeted to the type of user and be reviewed with ACVPC prior to publication and distribution.

**Subtask 5.8: Define and Establish All Service/User Assistance Capabilities and Procedures—**Publish standards for the HIN data repository that will be used to satisfy requests for data by all user groups. This informational material will be reviewed with the ACVPC prior to printing and publication. These materials may include cost information for data requests.

## **Task 6: Initiate Phase I and Users**

**Subtask 6.1: Identify and Enroll Users-**Identify and enroll user staff; obtain confidentiality agreements; assign passwords and security levels; where possible; load preliminary data files contributed by the participant organization; and update as appropriate. Included in this task is the acquisition of information required from the participant and users to complete the profiles maintained in a database for HIN operations management staff.

**Subtask 6.2: Train Users--**Conduct training sessions with HIN user groups prior to the operational stage of the project and as an ongoing activity. Training will be tailored to the specific types of users that are present within any participant organization. There will be targeted training conducted for those who send data, those who will be requesting data from the HIN, and those who will be

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responsible for the users' systems operations, including any technical liaison, professional, and management staff.

**Subtask 6.3: Test Functions and Features for Each User; Assign Passwords-**As new users are trained, communications interfaces and routine procedures are tested from the user site. Activate passwords and interfaces once training is complete.

### **Task 7: Initiate Later Phases and Users**

**Subtask 7.1: Select User Groups for Expanded HIN Participation (Incremental Business Plan)**—With the ACVPC, continue to market the HIN and solicit organizations for participation. Target organizations or types of user groups that can significantly expand repository data and groups that represent opportunities for sale of data will be identified and approached.

**Subtask 7.2: Design and Test Additional Functional, Network, and Data Capabilities-**With input from participants, the ACVPC, and HIN management, conduct ongoing planning to increase the types of data and the **functionality** of the HIN. Upgrades will be programmed, tested, and implemented, at the direction of the ACVPC.

**Subtask 7.3: Identify and Enroll Users-**Identify and enroll user staff; obtain confidentiality agreements; assign passwords and security levels; where possible, load preliminary datafiles contributed by the participant organization; and update as appropriate. Included in this task is the acquisition of information required from the participant and users to complete the profiles maintained in a database for HIN operations management staff.

**Subtask 7.4: Train Users--**Conduct training sessions with HIN user groups prior to the operational stage of the project and as an ongoing activity. Training will be tailored to the specific types of users that are present within any participant organization. There will be targeted training conducted for those who send data, those who will be requesting data from the HIN, and those who will be responsible for the users' systems operations, including any technical liaison, professional, and management staff.

**Subtask 7.5: Test Functions and Features for Each User-**As new users are trained, communications interfaces and routine procedures are tested from the user site. Activate passwords and interfaces once training is complete.

**Task 8: Operate System-**The mature, operational phase of the HIN implementation will be characterized by maintenance of the HIN systems and business operations and continued functional development activities.

**Subtask 8.1: Operate and Maintain the HIN Facility-**Maintain the HIN facility, technical, operations, and service staff at a level to support customer liaison activities.

**Subtask 8.2: Perform Cyclic Technical System Operations** Routines-Conduct and support routine, established maintenance and service functions to support the functionality goals of the HIN.

**Subtask 8.3: Perform Daily Service Tasks**-Conduct day-to-day tasks and activities involving the acceptance of data, network maintenance, customer service, and technical support functions, including the production of financial reports.

**Subtask 8.4: Perform Data Extraction and Support Other Liaison and Consulting Functions (Incremental Business Plan)**—Complete data extract requests and contribute to expansion of data repository contents and planning for expanded functionality. Contribute HIN technical and service expertise to ACVPC in the development of business opportunities for the HIN.

## 6.2: Implementation Phase FTE and Staffing Estimates

Task&&task	Staff Estimate	Time Estimate
Task 1. Information Collection and General Requirements Definition <ul style="list-style-type: none"> <li>1.1—Develop profile of each of the general types of users</li> <li>1.2—Complete list of all transaction and data sources (active networks in area) based on type of user</li> <li>1.3—Develop detailed candidate list of users and participants in general functional requirements definition</li> <li>1.4—Develop general data requirements for HIN (transaction types)</li> <li>1.5—Develop general functional requirements (categories of functional support)</li> <li>1.6—Secure participant agreements for participants in the HIN</li> </ul>	2 full-time equivalent staff (FTEs) (1 staff year)	Six months
Task 2. Develop Financing Approach and Sources <ul style="list-style-type: none"> <li>2.1—Identify potential development funding through public or private sector and develop options for financing development phase</li> <li>2.2—Develop potential operations phase funding mechanisms and develop options for financing the operations phase</li> <li>2.3—Evaluate, perform economic analysis, and select preferred option</li> </ul>	1 FTE (.25 staff year)	Three months

Task/Subtask	Staff Estimate	Time Estimate
Task 3. Develop System Specifications  3.1-Develop detailed data specifications 3.2— <b>Develop</b> detailed functional specifications 3.3— <b>Develop</b> hardware and software <b>functional specifications</b> 3.4— <b>Develop</b> network <b>technical</b> and functional specifications 3.5— <b>Develop</b> security, privacy, and contingency specifications	2 FTEs (one staff year)	Six months
Task 4. <b>Acquire</b> System (Optional)  4.1— <b>Develop</b> RFP and <b>evaluation</b> plan 4.2-Issue RFP 4.3-Evaluate proposals; rate, rank, and select bidder or bidders 4.4— <b>Negotiate</b> contract	1 FTEs (.5 staff year)	Six months
Task 5. Develop System and Establish Service Functions  5.1 -Establish HIN environment <ul style="list-style-type: none"> <li>· Establish HIN interface and reporting lines</li> <li>· Finalize hardware, software, network standards, designs, and structures</li> <li>· Site planning</li> <li>· Conduct requirements analysis and produce document</li> <li>· Prepare and document detailed implementation plan</li> <li>· Develop and finalize configuration management process</li> <li>· Develop quality assurance/quality control plan</li> </ul> 5.2— <b>Acquire</b> hardware and develop software <ul style="list-style-type: none"> <li>· Hardware acquisition</li> <li>· Software development</li> <li>· System acceptance testing</li> </ul> 5.3— <b>Prepare</b> and publish system documentation 5.4— <b>Develop</b> repository basic documentation 5.5— <b>Finalize</b> security plans and procedures 5.6— <b>Finalize</b> disaster recovery plan 5.7-Design and develop training materials 5.8— <b>Define</b> and Establish All <b>Service/User</b> Assistance Capabilities	2.5 FTEs (2.5 staff years)	Twelve months

Task/Subtask	Staff Estimate	Time Estimate
Task 6. Activate Phase I Users 6.1 -Identify and enroll users 6.2—Train users 6.3—Test functions and features for each user; assign passwords	3 FTEs(1.5 staff years)	Six months
Task 7. Activate Later Phases and Users 7.1 -Select user groups for expanded HIN participation (incremental business plan) 7.2—Design and test additional functional, network. and data capabilities 7.3-Identify and enroll users 7.4—Train users 7.5—Test functions and features for each user	2 FTEs (2 staff years per calendar year)	Ongoing
Task 8. Operate System 8.1—Operate and maintain the HIN facility and Operations 8.2—Perform cyclic technical system operations routines 8.3—Perform daily service tasks 8.4—Perform data extraction and support other consulting functions (incremental business plan)	3 FTEs (three staff years per calendar year)	Ongoing

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**APPENDIX A**

**FEDERAL WAIVER OPTIONS FOR ALAMEDA COUNTY**

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## APPENDIX A

### FEDERAL WAIVER OPTIONS FOR ALAMEDA COUNTY

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Over the past several years the most effective mechanism for States and counties to modify certain aspects of their health care delivery systems, especially the Medicaid program, has been through Health Care Financing Administration (HCFA) waivers. The ways in which implementing HCFA waivers, either Section 1115 research and demonstration waivers or Section 1915(b) program waivers, has improved the accessibility, quality, and cost-effectiveness of medical care have not gone unnoticed. The permissibility of using managed care concepts in the waiver programs has been the reason these improvements in the health delivery system have been realized.

Now many States and counties want to expand use of managed care techniques to improve coordination, accessibility, and cost savings in other service areas, specifically social services and other categorical programs. However, to gain that flexibility, waivers have to be obtained.

This appendix shows how HCFA waivers could be used to modify the Medicaid program and expand accessibility to previously uninsured populations and how social services and other categorical programs could be better integrated and funded through the use of waivers. The Institute for Health Futures project team views these strategies as longer range options than the immediate priorities of value purchasing and an information network. For this reason, this discussion is presented as an appendix: we would be glad of the opportunity to develop these thoughts further in subsequent phases of the Alameda County health care reform initiative.

#### **1. FEDERAL WAIVERS CAN PROVIDE FLEXIBILITY IN FINANCING AND OPERATING MEDICAID PROGRAMS**

A detailed description of the operational and financial flexibility that a Section 1115 research and demonstration waiver permits within the Medicaid program is given below. For the sake of comparison, we have also provided a description of Section 1915(b) program waivers, which are less broad,

While Medicaid block grant legislation now pending in Congress would provide some of the flexibility allowed by a Section 1115 waiver, passage and implementation of that legislation is not guaranteed in the short term.

Waivers permit States the flexibility to deviate from Federal Medicaid statutory and regulatory requirements that cannot be altered through the Medicaid State plan amendment process. However, different types of waivers provide different degrees of flexibility. Section 1115 of the Social Security Act allows States to operate managed care programs that do not comply with Federal statutory requirements. Section 1915(b) of the Social Security Act allows States to waive fewer Federal statutory requirements. A Section 1915(b) program waiver would allow the county to waive

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specified Medicaid program requirements, while a Section 1115 research and demonstration waiver would grant broader authority. Exhibit A-1 compares the provisions of 1915(b) and 1115 waivers. The major differences between the two types of waivers are:

- Objectives-Each waiver has a different objective and focus and is intended for programs with differing purposes:
  - Section 1115 waivers are research and demonstration waivers that allow HCFA to study the policymaking implications of revisions to the Medicaid program. They are awarded solely at the discretion of the Secretary of Health and Human Services. An 1115 waiver can be granted if the Secretary deems that the proposal has implications for national Medicaid policies. These projects generally involve a long lead time and a lengthy approval process. HCFA requires all 1115 waivers to be cost neutral for the Federal government over the duration of the project.
  - Section 1915(b) waivers allow a limited number of Medicaid requirements to be waived. The waivers (1) are frequently used to establish **capitation** and selective contracting arrangements; (2) do not carry scientific evaluation requirements; and (3) entail a faster approval process. HCFA requires that all 1915(b) waiver programs be cost-effective.
- **Degree of Waiver Authority**-Each type of waiver permits different degrees of authority, freedom, and innovation in implementing new Medicaid delivery programs.
  - Section 1115 waivers can provide a considerable amount of freedom and flexibility, depending upon how the waiver is written. Section 1115 waivers allow the expansion of coverage to those not eligible for Medicaid, alterations in the Medicaid benefit package, or a change in the Statewide **application** of the program.
  - Section 1915(b) waivers are more restrictive in nature and are often used to limit recipient freedom of choice in specified ways. For example, Section 1915(b) program waivers allow States to require recipients to enroll in **HMOs** or other managed care arrangements. Section 1915(b) waivers also allow a State to contract selectively with managed care plans.
- **Eligibility Criteria**-Section 1115 waivers can provide Federal matching funds for populations that cannot otherwise be covered by Medicaid.
  - Section 1115 waivers allow income and other eligibility criteria to be loosened so that previously ineligible people may **qualify** for Medicaid. With few exceptions, HCFA-approved 1115 waivers extend Medicaid coverage to poor adults under age 65 who otherwise would not qualify for this coverage.

EXHIBIT A-I

COMPARISON OF SECTION 191 **5(b)** AND 1115 WAIVERS'

1915(b)	1115
Mandatory enrollment or provider selection	Same
Federally <b>qualified HMOs</b> can lock in recipients for up to 6 months; other <b>HMOs</b> can lock in recipients for 1 month only	Lock-in provisions can be extended to 1 year
State can <b>limit recipients' choice</b> of providers (i.e. State can contract with only managed care plan); however a choice of at least two delivery systems is required	Same
Special populations or <b>geographic</b> area can be targeted	Same
	Can extend eligibility beyond Medicaid population
	Can use DSH payments for services other than hospital care
	Can modify mandatory cost-based reimbursement for <b>FQHCs</b>
	7 % 5 - b - t : -
	Can guarantee recipient enrollment for up to 0

\* This list identifies **major** Medicaid provisions that **States have waived** for managed care programs

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- Section 1915(b) waivers do not grant the authority to add ineligible enrollees and receive accompanying Federal matching dollars for Medicaid.
  - **Enrollment Arrangements**--Federal regulations include limits on the period when Medicaid eligibles can be required to receive care at a designated facility or health plan (“locked in”). Each of the waivers stipulates recipient and provider enrollment arrangements:
    - An 1115 waiver can allow States to lock beneficiaries into a health maintenance organization (HMO) for as long as one year.
    - Section 1915(b) waivers allow States to require that beneficiaries remain in an HMO for one month, except in the case of a federally qualified HMO, in which a six-month lock-in is allowed. A 1915(b) waiver can also allow a State to make a default assignment of eligible beneficiaries who do not initially choose a plan.
  - **Payment Arrangements**--Section 1115 waivers and Section 1915(b) waivers have **different** implications for the use of disproportionate-share hospital (**DSH**) funds and how various types of facilities are reimbursed.
    - A Section 1115 waiver allows the use of DSH funds for purposes other than paying hospitals for inpatient care. Under this waiver, a local government can develop creative ways to obtain and use DSH funds for the provision of ambulatory services and to expand eligibility to the uninsured.

A Section 1115 waiver allows the Secretary of HI-IS to suspend cost-based reimbursements to Federally Qualified Health Centers (**FQHCs**).

Both 1915(b) and 1115 waivers allow a State to essentially sidestep the Federal Boren Amendment. This Amendment requires States to establish payment rates for hospitals, skilled nursing **facilities**, and intermediate care facilities for the mentally retarded (**ICF/MR**) that are sufficient to cover the costs that economically and efficiently operated facilities incur in providing care. Under a Section 1115 waiver, however, it is the health plans, not the State, that set payment rates with providers. States having an 1115 waiver **often** propose that any savings achieved under the program be used to expand eligibility or to shift the program’s emphasis away from the provision of inpatient hospital care and toward the delivery of primary care services.<sup>1</sup>

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<sup>1</sup> Sara Rosenbaum and Julie Darnell, *Medicaid Section 1115 Demonstration Waivers: Approved and Proposed Activities as of February 1995*, George Washington University Center for Health Policy Research, Washington, DC, 1995.

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- 19 15(b) waivers do not **allow** the use of DSH funds for any purpose other than inpatient hospital care. In addition, a 19 15(b) waiver does not allow the Secretary to waive mandatory cost-based reimbursement for FQHCs.
  - **Project Duration-The timeframes** for projects in Section 1115 and Section 19 15(b) waiver applications differ in their objectives and purpose:
    - Until 1993, Section 1115 waivers were limited to a five-year timeframe. Reforms published in the *Federal Register* in 1994 allow 1115 waivers to be of a “sufficient duration to give new policy approaches a fair test.” Large-scale statewide demonstrations are generally approved for a five-year period. All 1115 waivers granted since the reforms are for a duration of five years or less. The waivers are renewable at the discretion of the Secretary of HI-IS
    - Section 19 15 (b) waivers are typically granted for a two-year period and can be renewed for an **indefinite** period of time **if they** are successful. The renewal of a waiver generally depends on the cost-effectiveness of the program.

## 2. **RATIONALE FOR A SECTION 1115 RESEARCH AND DEMONSTRATION WAIVER**

An 1115 waiver could **allow** the county to use Federal Medicaid funds to cover some of the uninsured population that it presently cares for with unmatched funds. This expansion of coverage would protect any loss of Federal matching **funds** as savings are achieved through Medicaid managed care. An 1115 waiver could also be used to provide a lock-in of more than one month if the city plans to form a nonfederally-qualified public HMO. Other reasons to pursue an 1115 waiver include:

- Development of a disproportionate-share hospital payment strategy would allow redistribution of funds away **from** inpatient hospital care and toward primary care or to provide care for the uninsured.
- It would allow better management of the chronic care needs of the non-AFDC population, as is planned with Maryland’s 1115 waiver.<sup>3</sup>
- It would allow the county to obtain Federal matching funds for its Federal Public Health Service 330 dollars.

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<sup>2</sup> *Federal Register*, September 27, 1994, p. 49249

<sup>3</sup> Maryland’s Medicaid High-Cost User Initiative was developed to identify high-cost, high-risk Medicaid recipients and refer them to a system of care appropriate to their needs. In Maryland, 10 percent of the Medicaid recipients account for 70 percent of the program’s costs; 6 percent of the patients incur 60 percent of the costs. In order to provide flexibility to the project, the Center for Health Program Development and Management at the University of Maryland, Baltimore County, and the State’s Department of Health and Mental Hygiene were granted a Section 1115 waiver in July 1995.

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Exhibit A-2 describes the potential benefits of an 1115 waiver to Alameda county

### 3. **LOS ANGELES AND TENNESSEE PROVIDE EXAMPLES OF HOW 1115 WAIVERS CAN BE USED TO OPTIMIZE THE USE OF FEDERAL DOLLARS**

HCFA has granted 13 States 1115 waivers, most of which allow the broadening of Medicaid eligibility requirements; all rely on the use of managed care. (Exhibit A-3 provides a matrix of approved waivers.) In addition South Carolina received a conditional 1115 waiver from HCFA but has suspended its implementation. Section 1115 waivers are pending for 11 States and Los Angeles County. (Exhibit A-4 provides a matrix of pending Section 1115 waivers.) In addition, at least two other States—Maryland and New Jersey—are in the process of preparing Section 1115 waivers.

Two waiver proposals—one pending and one operational—provide several key examples of how waivers can be used to increase a Medicaid program's flexibility and to optimize the use of Federal matching funds.

#### 3.1 **The Los Angeles County Example**

The Los Angeles County Health Department has applied for a Section 1115 waiver from HCFA to help it address a 1995-96 budget shortfall of \$655 million. Currently, the Department's financing is overwhelmingly—about 95-percent—oriented toward hospital-based services, with a heavy reliance on Federal DSH payments. The waiver is intended to allow the Department to shift funds away from hospital-based services so that more primary care services can be provided. The waiver will specify a cap on the county's Medicaid growth rate. The transformation may result in county hospitals losing inpatients to private sector hospitals; however, the county will have access to a funding source to increase its outpatient care to the uninsured. Specific waiver provisions include:

- **Federal Matching Funds for Outpatient Care**—Nearly two-thirds of the patients who receive care in Los Angeles County's outpatient clinics receive unsponsored care. The county's Section 1115 waiver will provide Federal matching payments for outpatient services delivered to the uninsured at county clinics, contract clinics, and county hospital outpatient departments. The cost of this aspect of the waiver program is estimated at \$40 million. Federal matching funds will not be available for undocumented aliens.
- **County Funds for Outpatient Care**—In California, DSH funding is calculated based on an individual facility's share of the total statewide inpatient days of care provided to Medi-Cal and uninsured patients. If a facility reduces its inpatient days, it loses these revenues to a competitor. The DSH aspect of the waiver will allow the county to reduce its own inpatient days and transfer its DSH money to expand outpatient care.
- **Capped Federal Medicaid Spending**—A Section 1115 waiver program must be budget neutral to the Federal government. The growth in Federal Medicaid spending

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## EXHIBIT A-2

### POTENTIAL BENEFITS OF SECURING A SECTION 1115 MEDICAID WAIVER

- Can allow the county to receive Federal matching funds for dollars spent to care for uninsured residents now receiving uncompensated care funded by unmatched county funds
- Can *allow* the county to use **disproportionate** share hospital funds for **primary** care and other types on non-inpatient hospital services
- Can lock in a favorable base year for Federal reimbursement rates
- Can provide incentives for a **shift** to outpatient and preventive care, with corresponding reductions in unnecessary expensive hospital-based services

**EXHIBIT A-3**

<b>APPROVED 1115 WAIVERS AS OF MARCH 28, 1996</b>			
<b>State</b>	<b>Approval Date</b>	<b>State</b>	<b>Approval Date</b>
<i>Arizona</i>	<i>1992</i>	Oklahoma	October 1995
Delaware	May 1995	Ohio	January 1995
Florida	September 1994	<i>Oregon</i>	<i>March 1993</i>
<i>Hawaii</i>	<i>July 1993</i>	<i>Rhode Island</i>	<i>November 1993</i>
Kentucky: 2nd waiver/amendment	October 1995	<i>Tennessee</i>	<i>November 1993</i>
Massachusetts	April 1995	Vermont	July 1995
<i>Minnesota</i>	<i>April 1995</i>		

**EXHIBIT A-4**

<b>PENDING 1116 WAIVERS AS OF MARCH 28, 1996</b>					
<b>State</b>	<b>status</b>	<b>Waiver Submission Date</b>	<b>State</b>	<b>Status</b>	<b>Waiver Submission Date</b>
Alabama	Pending	July 1995	Missouri	Pending	June 1994
Arizona	Amendment is pending (expansion of its existing 1115)	March 1995	New Hampshire	Pending (Highly problematic)	June 1994
Georgia	Pending	September 1995	New York	Pending	March 1995
Illinois	Pending, expecting HCFA approval within the next two weeks.	September 1994	Texas	Pending	August 1995
Kansas	Pending	March 1995	Utah	Pending	July 1995
Louisiana	Pending-HCFA did not approve the financial proposal	January 1995			

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over five years for the Los Angeles County Department of Health Services will be limited to its Federal base spending in 1994-95 plus an inflation factor agreed to by the Department and HCFA. Over the past five years, the growth in Federal Medicaid spending in county facilities has been nearly 20 percent, in contrast to a statewide growth rate of about 10 percent, of which half is due to caseload **growth**. Much of the growth for these facilities has been due to DSH expenditures, which are projected to be flat for the foreseeable **future**.

HCFA is still considering the Los Angeles waiver application, but its approval has been assured by President Clinton. Under the proposed waiver program, the Los Angeles County Health Department may be able to achieve these results by the end of the five-year demonstration program:

- Expansion of outpatient and preventive care through cost-effective public-private partnerships
- Reductions in inappropriate use of county hospital emergency rooms, preventable hospital utilization, and ultimately, the number of hospital beds
- Redesign of the county health system from a centralized, hospital-based system to a decentralized, integrated system with an emphasis on ambulatory, primary, and preventive care services
- Reorganization of the payment structure for county inpatient and outpatient services, with financial incentives for cost efficiencies
- Development of a better funding base for indigent health care
- Simplification of eligibility criteria and financing for Medi-Cal patients and uninsured indigents

### **3.2 The TennCare Example**

HCFA approved Tennessee's Section 1115 waiver for **TennCare** in November 1993, and the program was launched in January 1994. This rapid implementation was due to a budget crisis resulting **from** Medicaid expenditures that had almost tripled over the six preceding years. The governor was committed to the program and felt the risks of rapid implementation outweighed those of a delay.

Prior to **TennCare**, the use of managed care in the Medicaid program was insignificant. In its first two years, **TennCare** covered 1.1 million participants monthly, up from 770,000 prior to the launch of the program. All participants are required to receive care through a State-approved managed care organization, including **HMOs** and preferred provider organizations (**PPOs**). The program's eligibility criteria are broader than those proposed under most other Section 1115 waivers.

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Specific **TennCare** waiver provisions include:

- **Expanded Eligibility**—**TennCare** has enrolled over 400,000 uninsured, non-Medicaid-eligible State residents out of a total pool of about 700,000, largely with Federal financial participation. In removing categorical and asset restrictions to expand Medicaid eligibility, the State instituted cost sharing for some categories of new enrollees. The State is scheduled to expand the program to mental patients beginning April 1, 1996.
- **DSH Funds for Outpatient Care**—The **TennCare** waiver allowed the State to incorporate DSH payments into the budgetary Limits established on the program. This approval effectively severed the relationship between DSH payments and inpatient hospital care and allowed the funds to be used to finance the care provided to persons newly eligible for Medicaid.
- **Expanded Benefits**—Under **TennCare**, the State removed Medicaid service limits on many types of care and expanded other programs. For example, Medicaid's 14-day limit on inpatient hospital coverage was lifted and Early and Periodic Screening, Diagnostic and Treatment services were expanded. Dental benefits were also expanded to enrollees under age 21.
- **Change in Federal Matching**—The **TennCare** waiver allowed the State to combine Medicaid funds with State funds for indigent care programs (including the State share of various Federal block grants), public hospital charity care expenses, and other State, local, and private sources in order to maintain a high Federal matching rate.<sup>4</sup>

Since the implementation of **TennCare**, the State has achieved the lowest percentage of uninsured residents in the country at 5.8 percent, surpassing the previous leader, Hawaii, which has a rate of 5.9 percent. **TennCare** officials announced in February 1996 that its goals of increased preventive care and decreased emergency services are being achieved. Officials cite the following results for **TennCare** enrollees under age 21:

- Emergency room visits have declined from 900 visits per 1,000 people in 1993 to 360 per 1,000 people in 1995,
- Primary care visits have increased 20 percent since **TennCare** was implemented

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<sup>4</sup> *Managed Care and Low-Income Populations: A Case Study of Managed Care in Tennessee*, Mathematica Policy Research, Inc., Washington, DC, 1995, p. x.

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- Inpatient hospital days have declined from 490 per 1,000 people in 1993 to 265 per 1,000 people in 1995.<sup>5</sup>

#### 4. **NEW JERSEY'S PROPOSED SECTION 1115 WAIVER PROGRAM TRULY REFLECTS MARKET INTEGRATION, LEVERAGE, AND PURCHASING POWER**

The State of New Jersey has two health reform programs in place. One is Health Access New Jersey, a subsidized insurance program for the uninsured, which was established pursuant to the State's 1992 Health Care Reform Act. The other is a Section 1915(b) waiver program in which approximately 95 percent of the Aid to Families with Dependent Children (AFDC) and the AFDC-related New Jersey Care populations in selected counties would be enrolled in health maintenance organizations. Through approval of a Section 1115 research and demonstration waiver, the State wants to move forward in its Medicaid managed care efforts, expand health care coverage, and improve the efficiency and quality of the health care delivery system. The Section 1915(b) waiver program would be incorporated under the Section 1115 waiver program.

As with Los Angeles, Tennessee, and other States that have sought Section 1115 waiver programs, New Jersey wants to use the waiver as a mechanism to optimize Federal dollars and:

- Use the savings achieved **from** managed care to purchase health care for the uninsured and other populations
- Use Federal matching **funds** for dollars spent to care for uninsured residents now receiving uncompensated care **funded** by unmatched **funds**
- Redirect the use of some DSH money away from inpatient services to primary care and other noninpatient hospital services
- Use some DSH money for purchasing coverage for the uninsured
- Provide incentives for a **shift** to outpatient and preventive care, with corresponding reductions in unnecessary and expensive hospital-based services

The innovative way the State proposes to include not only acute/medical care but also behavioral health and long-term care in its managed care system reflects integration, linkage, and coordination among various providers. The managed care strategy this waiver program proposes aims at providing a seamless and continuous means for the Medicaid and uninsured populations to receive a comprehensive array of accessible health care. The following explains how each of the three components are to operate within the program:

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<sup>5</sup> *BNA's Managed Care Reporter*, Bureau of National Affairs. Washington, DC. February 14, 1996, p. 156

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- **Acute/Medical Care**—The 1915(b) waiver population in the demonstration counties and the other 17 counties' AFDC and AFDC-related residents would be enrolled in the Section 1115 program. Through use of Federal matching funds, DSH dollars, and managed care savings, program **eligibility** would be expanded to two tiers of eligibles. One tier would be those currently eligible for Medicaid and individuals and families with **family** income at or below 75 percent of the Federal poverty level (FPL) who do not qualify under existing rules. The other tier would be an expansion population. uninsured adults and **families** with incomes up to 250 percent of the FPL. Enrollment of these persons would be limited to available dollars and would include the Health Access participants. Also, eligibility for medical assistance would be replaced with a gross family income test, and no asset test is proposed for either tier.
  - **Behavioral Health Care**—The State would contract with one or more managed care organizations (**MCOs**) for the provision of mental health and substance abuse services. The **MCO** would be reimbursed on a capitated basis using a risk corridor arrangement. To avoid disrupting the current client/provider relationships, the **MCO** would contract with existing community agencies currently providing services to persons with mental health and substance abuse problems. The two benefits packages that would be offered would not be institutionally biased and would include many community-based services. One package would be for seriously mentally ill adults, and the other would be a basic benefits package.

Coordination and integration between the acute/medical **HMOs** and the behavioral health **MCOs** is vital for this waiver program. Enrollment in a HMO would automatically result in enrollment in the MCO. Care managers for both of the plans would exchange treatment information, and a linkage/referral system between the providers would be developed. A joint grievance system would also be implemented. The State does not view its acute/medical care and behavioral health care programs as separate systems.

- **Long-Term Care**—Long-term institutional and home- and community-based services would also be provided under a managed care framework. Eligibility for the **long-term** program differs from eligibility for the acute/medical care portion. Long-term care services would be delivered through two types of capitated plans. Elderly individuals could choose between a comprehensive HMO, one that serves patients of all ages, and a specialty HMO, one that provides care primarily for the elderly and disabled.

One of the unique features of New Jersey's proposed waiver is its strategy to encourage more **HMOs** to serve the waiver populations. The S&E would use its market leverage in purchasing State employee health benefits. The State would build in an incentive whereby in order to provide benefits to State employees, the HMO would also bid to provide benefits to the waiver populations.

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## **5. POPULATIONS POTENTIALLY AFFECTED BY A SHIFT TO MANAGED CARE**

Under an 1115 waiver, savings accrued from managed care and from value purchasing could be used to expand the Medicaid eligibles and cover persons now cared for in the indigent care system with unmatched dollars.

### **5.1 Current Medicaid Eligibles**

In January 1996, HCFA approved the California Department of Health Services' Section 1915(b) program waiver application. The waiver describes a two-plan model that requires Medicaid beneficiaries in each of 12 counties to choose between a comprehensive, locally developed (initially by the county government) managed care plan (termed the "local initiative plan") and a commercially operated HMO (termed the "mainstream plan"). Alameda County was one of the 12 counties selected for participation in this program. More than 203,000 of Alameda County's population are Medi-Cal beneficiaries. Approximately two-thirds of those Medi-Cal eligibles are in the AFDC group, and the remainder are in the Supplemental Security Income (SSI)-related groups. Since December 1995, the AFDC Medi-Cal population began to voluntarily enroll in the Alameda Alliance for Health, the local initiative plan. It is anticipated that the mainstream plan will begin enrolling Medicaid beneficiaries in Spring 1996. At that time Medicaid beneficiaries will be required to either enroll in one of the two plans or be enrolled in one.

### **5.2 New Medicaid Eligibles**

If Alameda county officials elect to seek a Section 1115 waiver, they could expand the Medicaid population to include persons who could qualify for Medicaid today if the county were to take full advantage of existing Federal statutes (e.g., people covered under Section 1902(r) of the Social Security Act). Federal matching dollars would be available for these newly eligible persons. Under an 1115 waiver, other persons may be added to the Medicaid population, but Federal matching dollars may not be available for all of them, since their incomes or assets may be too high to qualify for Medicaid benefits under existing Federal statutes and regulations.

### **5.3 Indigent Persons**

Estimates of the number of indigent persons in Alameda County range from 300,000 up to 375,000. This group may include working, uninsured people and their dependents and unemployed people and their dependents who do not qualify for publicly sponsored programs. In the current health care delivery system, these individuals most likely receive uncompensated care at acute-care, long-term care, and psychiatric care facilities and at specialty clinics and outpatient centers.

Based on the experience of Tennessee and other States, we estimate that a large percentage of this population could be provided with health insurance coverage under an 1115 waiver program. As in TennCare, premiums and copayments could be charged on a sliding scale.

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## 6. BEHAVIORAL HEALTH CARE HAS UNIQUE REQUIREMENTS IN A MANAGED CARE PROGRAM FOR MEDICAID

Alameda county has historically provided a broad array of behavioral health care (mental health and substance abuse) benefits to its Medicaid population, including inpatient, outpatient, and residential treatment benefits. In designing a managed care program for this population, several options can be considered:

- Benefits could be part of the overall benefits for which an **MCO** would **be at** risk (as in the proposed New Jersey Section 1115 research and demonstration waiver program)
- Benefits could be “carved out” and managed separately by a behavioral health organization, which would be at risk
- County facilities could **be** combined with those of the BHO to best utilize the strengths of each. This could be either a full- or partial-risk arrangement.

### 6.1 State Examples of Behavioral Health Carveouts

Many States with either Section 1115 research and demonstration or 1915(b) program waivers are carving out behavioral **health** care benefits. The following States are improving how their behavioral health care is provided:

- Colorado, Florida, Iowa, Nebraska, Ohio, and Washington have carved out behavioral health care benefits.
- After nearly two years of operating its program with behavioral health care benefits being integrated with all other benefits, Tennessee is now moving toward a total carveout.
- Rhode Island has carved out behavioral health care services for the seriously and persistently mentally ill (SPMI) and seriously emotionally disturbed (SED), although any needed laboratory services or medications are covered in-plan by the **MCOs**. The State still covers **carveout** services on a fee-for-service basis.
- Massachusetts has a **carveout** program for mentally ill Medicaid recipients who choose primary care case management over a health maintenance organization. Mentally ill Medicaid recipients in an HMO are not included in the carveout.

These States have come to recognize that behavioral health care requires a separate management structure. Although there is no consensus on the best approach to this, nearly all **of them use a** BHO to manage their behavioral health care benefits.

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Carveouts also provide the States considerable flexibility to integrate other funding sources for the behavioral health care population. They can allow States to combine block grant, State, local, and other funding to target specific services or populations, This reduces the likelihood of fragmentation associated with multiple funding.

Another consideration in a State's decision whether to carve out behavioral health care benefits is that many MCOs carve out these benefits of their own volition, through subcapitation contracts with BHOs. Although this may appear to be in concert with a complete carveout, States have found that they have reduced influence in how such subcontracts are structured and operated. Consequently, States have found it difficult to ensure access to needed services that are culturally appropriate for a Medicaid population. For example, Rhode Island has found it necessary to levy additional requirements on its MCOs related to network composition, service limitations, and other factors in order to expand access beyond the SPMI and SED populations. It is too soon to tell whether this remedy will be sufficient.

States have paid particular attention to behavioral health care benefits partly because of the disproportionate occurrence of behavioral health disorders in the Medicaid population and because of their increasing cost. States are keenly aware of the increase in the cost of other medical conditions when behavioral conditions are under-treated or not treated at all. Given the States' overall goal to constrain the growth in Medicaid expenditures, the special attention being accorded behavioral health care seems well founded.

## **6.2 Including Substance Abuse Treatment in a Behavioral Care Carveout**

There are differing views on whether substance abuse treatment should be included in a behavioral health care carveout. Substance abuse treatment providers and advocates worry that substance abuse will be overshadowed and usurped by larger mental health interests. This should not be of particular concern provided that traditional substance abuse treatment modalities are required within the range of services to be made available by a BHO.

There should be no question, however, that substance abuse treatment should be included, if for no other reason than to address comorbidity. In Epidemiologic Catchment Area studies sponsored by the National Institute of Mental Health, investigators found that:

- 29 percent of those with a mental disorder also had a substance abuse disorder
- 45 percent of those with an alcohol disorder also had a mental disorder
- 72 percent of those with an "other" drug disorder also had a mental disorder

It is essential, therefore, that substance abuse be included in any **carveout** arrangement in order to assure appropriate treatment.

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## 7. **FEDERAL WAIVERS COULD BE THE MECHANISM FOR INTEGRATION OF FUNDING AND OPERATION ASPECTS OF SOCIAL SERVICE AND OTHER CATEGORICAL PROGRAMS**

In the early 1970s categorical Federal health care programs were set up and designed so that poor and vulnerable populations would receive necessary services. Categorical programs are those that receive a specified dollar amount to provide certain services to a defined group of eligible persons. Each one operates independently **from the** other and has its own funding, governing bodies, operational policies and procedures, and staff. However, from the beginning of their development, the issue of integrating many or all of the programs to make them more efficient and effective has been raised repeatedly. Recently, the possibility of their integration has been gaining more consideration and credibility, because of the favorable impact that similar changes have had in the health care environment. Depending upon the degree of intended integration, Federal waivers may be required.

## 8. **PROGRAM INTEGRATION COULD BE THE WAY TO SOLVE EXISTING SERVICE DELIVERY PROBLEMS**

Confounding factors such as administrative and service duplication, confusion in accessing **care, lack** of continuity of care, payment inconsistencies and duplications, and transportation obstacles make providing cost-effective and efficient patient care extremely difficult and unrealistic when each of the categorical programs is operated and funded independently. The fragmented infrastructure that was designed to ensure that comprehensive, responsive services are available to vulnerable populations has certainly been less than optimal. The undercurrent of discontent over these problems and the proposal of program integration as a way to solve some of them have existed over the years, but they have not been voiced loudly enough to be taken seriously. Two main reasons why the voices of program integration promoters have historically remained muffled are:

- Supporters of program independence maintain that the vulnerable populations would suffer if they **were** deprived of certain guaranteed services provided by each of the independent programs
- A few **local** level attempts at program integration have been unsuccessful

However, the environment has recently changed. Program funding has become more restricted, the level of services that need to be provided has increased and become more complex, and the number of persons needing assistance has increased. The way categorical services are administered and delivered must change in response to these conditions. Proponents of program integration may now be successful if they try again. Timing is ripe for a new mechanism that will enable these vital services to continue to serve the needs of the vulnerable populations.

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## **9. INTEGRATION OF PROGRAMS SHOULD INCLUDE BOTH HEALTH AND SOCIAL SERVICES**

The greatest improvements in health status, particularly among the vulnerable populations, does not come **from** providing more or more accessible health care services alone, but rather **from** addressing some of the underlying causes of poor health, such as inadequate nutrition, housing, family living arrangements, education, and job opportunities, lack of transportation, and other factors. The more comprehensively a system can address medical needs along with these indirect causes through coordinated or integrated services, the more the overall health **status** and welfare of vulnerable populations can be elevated. In addition, education and participation of families is a vital component of service integration. Not only is improved comprehensiveness and continuity of care achieved when integration of medical and social services occurs, but overall cost savings can be derived as well

### **9.1 Managed Care Concepts can Promote the Integration of Health and Social Services**

Managed care strategies have been successfully **used as** a means to provide more cost-efficient, accessible medical care to the commercial care, and now the Medicaid and Medicare, populations. Through expanding the use of managed care principles (including **capitation**) beyond the traditional realm of medical care to include social services and other categorical programs, continuity of care for these vulnerable populations can be enhanced even more. These populations typically have multiple health and social problems (e.g., **substance** abuse, transient housing, lack of transportation) that need to be addressed simultaneously. By having both medical and social service needs provided for in one managed care system, the total package of care becomes more streamlined and coordinated, which in turn has a favorable impact on the patient's health status and the financial, administrative, and operational aspects of the managed care system itself Exhibit A-5 shows how categorical program providers could be incorporated into a managed care system.

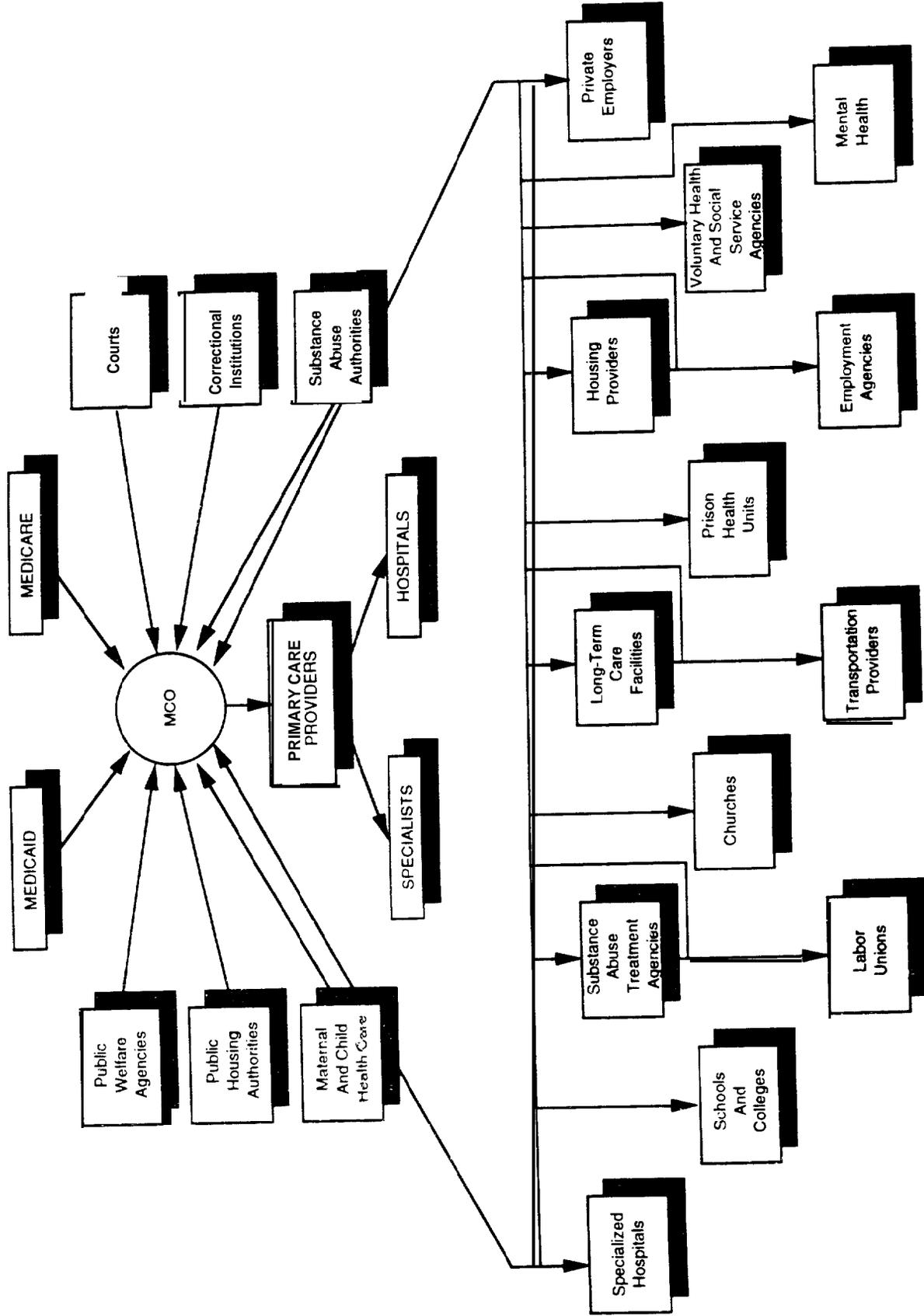
**As** a community-oriented entity, the managed care system should include the services most in need of greater access and integration. The goal of collaboration between health and social services would be to design a system that meets the needs of the people it serves in a new, more efficient and cohesive way, one tailored to its community. Members of the managed care organization would have better access to services that are equal to **or** better than those that they were receiving before the services became integrated. Compliance with performance standards and outcomes would be imperative for **all** services provided in the integrated system.

### **9.2 Purchasing of Social Services can Also Be Integrated**

Not only can the provider side of the equation be improved by integration of social services and other categorical programs with medical services, but the purchaser side as well. Instead of having separate funding for each of the programs, they can be pooled. Pooling of categorical program funds for collective purchasing and operational flexibility may require Federal waiver approval from the Department of Health and Human Services. A single organization could **be** developed, such as a purchasing cooperative, through which the pooled funds to purchase the specific services would flow.

EXHIBIT A-5

HEALTH AND SOCIAL SERVICES HUB



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The participants in the alliance would negotiate the best rate and purchase the best-integrated package of medical and social services.

### **The Role of the Alameda County Value Purchasing Cooperative**

The Alameda County Value Purchasing Cooperative (ACWC) can serve as the channel through which many or all of the social services and other categorical program funding streams flow. In the initial phases, membership of the ACWC would consist of health care purchasers. Subsequent to their participation, purchasers of social services and other categorical program services can then be phased in. Dollars that support programs providing services for vulnerable populations can be redirected into the cooperative, which would use its market leverage to negotiate favorable rates. Such programs include:

- Community health clinics
- Communicable disease
- Correctional institutions
- Family planning clinics
- Foster care
- Homeless programs
- Maternal and child health programs
- Migrant health programs (currently, Alameda county does not receive rural/migrant health funding)
- Public housing
- Substance abuse programs
- HIV/AIDS programs

If this funding **rechannelling** is to be successful, the individual programs must understand the principles behind **collective** purchasing and how they and their targeted populations will benefit under such an arrangement. In addition, it must be clear to the programs that they will not lose their operational autonomy in delivering services.

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## **The Role of the Alameda County Health Information Network**

Financial advantages accrue through purchasing of social services and other categorical services through the cooperative, not only because of the inherent collective strength and bargaining power of the number of participants, but also because of the value and leverage that having quantifiable data brings during rate negotiations. The ACWC could mandate that all providers supply uniform patient, provider, and health status data. The Alameda County Health Information Network (HIN) would be the repository to house and provide the requested data. The HIN could be designed or enhanced so that it is a data repository not only for medical information, but also for financial and patient information valuable to social service, probation, public housing, maternal and child health, substance abuse, and other categorical programs.

As stated previously, the greatest improvement in health status does not come from providing more or more accessible health care services alone, but rather **from** addressing some of the underlying causes of poor health. By having access to both medical and social service-related data about a patient through the HIN, a more comprehensive **profile** of an individual can be ascertained and a more tailored treatment package can be designed geared toward improving his or her overall health status.

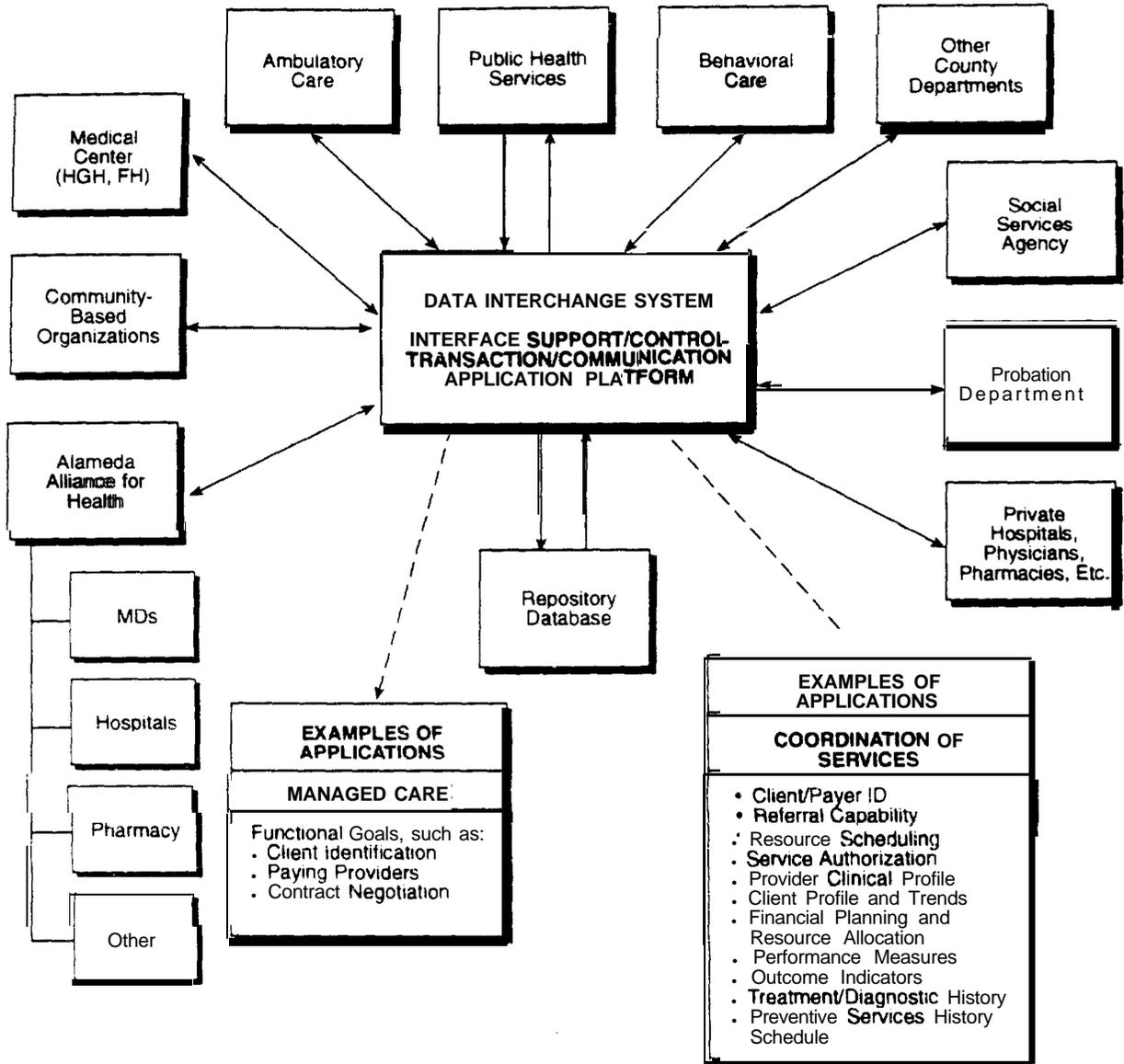
Alameda County has already acknowledged the need for and utility of a centralized data repository for a comprehensive array of data (from and for the Alameda Alliance for Health, social services agencies, public health entities, community-based clinics, probation offices, and other agencies). Exhibit A-6 shows how the county envisions the system integration program. The HIN that the Institute for Health Futures proposes in this paper could either partner with or be integrated with it.

### **10. THROUGH WAIVER PROGRAMS, ALAMEDA COUNTY HAS BEEN MOVING FORWARD IN INTEGRATING ITS CATEGORICAL AND SOCIAL SERVICES PROGRAMS**

Alameda County has been in the forefront of understanding the ideas behind managed care, implementing managed care programs, and including the Medicaid population in such arrangements. It has also been examining ways in which to expand managed care concepts beyond the traditional medical/acute care umbrella to other services that indirectly affect the health status of its residents. Supporters of services integration have been examining ways to improve the performance of categorical programs and social services.

in spite of the interest in and enthusiasm for the reform of care delivery, the leadership of the county acknowledges that **full** integration of health and social services is a large undertaking and that an incremental progression towards this goal is appropriate. Integration on both the provider and purchaser sides is feasible, and the county has already started moving in these directions. The county also acknowledges that Federal waivers are required to make significant changes in the funding and operations of programs to truly make a difference in the delivery of services and the health status of the people it serves. The following three waiver programs are examples of how Alameda County is moving forward in this area.

**EXHIBIT A-6**  
**ALAMEDA COUNTY**  
**SYSTEM INTEGRATION PROGRAM (SIP)**



SOURCE: Alameda County Medical Center, Status Report on Preliminary Vendor Evaluation, February 20, 1996.

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## **Empowerment Zone/Enterprise Community Initiative**

The City of Oakland has won the first Federal waiver under the Clinton Administration's Empowerment Zone/Enterprise Community initiative. The Oakland Community Building Team (CBT) Demonstration Project will allow the city to develop innovative programs to bring economic self-sufficiency and revitalization to the most distressed parts of the city. Areas can develop community-specific initiatives to address the unique needs of the targeted populations. Oakland was granted \$3 million in Social Services Block Grants to operate the CBT and plans to **provide** stipends for **welfare** recipients. Participants will work on **community** service projects and receive practical **job** experience and training, as well as formal education. Sponsors for the projects and job training will be community organizations. This program stresses public/private partnerships and collaborative efforts among **community** constituents. In addition, this program will have a single funding source for many services. There is flexibility and minimal restriction on how to use the dollars. This program reflects how social services program integration impacts the purchasing side of the equation.

## **Behavioral Health**

Under the State of California's freedom of choice waiver, Alameda **County began** moving its SSI-linked seriously and persistently mentally ill population out of the fee-for-service environment and into the managed care arena. In the first phase of this mandatory enrollment program, Alameda County has focused on the inpatient setting and will begin mandating that outpatient service be rendered through managed care in 1997.

## **Foster Care**

Alameda County could be following in the steps of New York and 13 other States that have submitted applications to the Department of Health and Human Services for waivers of **regulatory** requirements so they can experiment with new approaches, primarily managed care approaches, for better integration and delivery of several social services programs. On a smaller scale, the county has already submitted a waiver that would permit "blended" **funding** of foster care services using Federal dollars. The waiver would also relax many of the **restrictions** on how those dollars could be used. Program directors of various foster care services could develop new ways of service coordination and innovative approaches to improve the emotional well-being of the child through enhanced community and family participation.