The Neighborhood Health Plan and the Community Medical Alliance: Integrating Systems to Expand Clinical Programs for Medicaid Enrollees with Special Needs

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Introduction

The Neighborhood Health Plan (NHP), in collaboration with the Health and Disability Working Group at the Boston University School of Public Health, received a planning grant in 1999 from the Center for Health Care Strategies to develop and document new approaches to care delivery for Medicaid enrollees with chronic illnesses and disabilities. Our primary activity was to study the integration of the Community Medical Alliance (CMA) program, a managed care plan for 500 enrollees with severe disabilities and chronic illnesses, into Neighborhood Health Plan, a Medicaid managed care plan.

CMA has a unique orientation to care delivery for the most medically complex subset of the Medicaid population in Massachusetts. Studying this integration process provided an unprecedented opportunity to learn from health care reform in action, as NHP adapted components of the CMA model for a larger Medicaid population.

NHP was founded by the Massachusetts League of Community Health Centers in 1987 to foster community health center access to the emerging managed care market, particularly in light of the expansion of Medicaid managed care. At the start of this study, NHP had recently merged with CMA. During the period of the study, NHP underwent a second merger with Harvard Pilgrim Health Care (HPHC) and became the vehicle for serving HPHC's 35,000 Medicaid enrollees. As of December 31, 1999, NHP had a total Medicaid membership of over 96,000 people distributed as follows:

TANF and TANF-related	80,785 members
SSI disabled	8,219 members
Long term unemployed	7,890 members

During the planning grant, we interviewed key informants, reviewed NHP materials, and attended clinical leadership meetings. We used this information to document a baseline description of the essential features of the NHP/CMA care delivery system in 1999 and to track changes in care delivery as NHP incorporated the CMA programs, philosophies, and strategies and developed new care management programs.

Our work resulted in several key findings about barriers to change and strategies to address those barriers. We also outlined the challenges NHP faces as it continues its merger with CMA and makes changes in its clinical delivery system.

The Challenges of Integration

One of the most important findings was that as the NHP/ CMA integration unfolded, NHP needed to create new infrastructure to support its clinical programs. Some of these infrastructure changes included a health risk assessment process, revisions to the referral and authorization system, and a new structure for provider network management. As a result of these changes, NHP has been able to create a new continuum of care management programs for enrollees with special health needs.

Health Risk Assessment

In the CMA program, enrollees with disabilities are identified and assessed prior to health plan enrollment, making post-enrollment contact and care planning relatively easy. For all other NHP enrollees, the plan has no contact with members prior to enrollment. The limited information received at enrollment is a barrier to contacting members to conduct a health risk assessment or even to select a primary care provider. NHP is responding to this challenge by implementing a two-tiered health risk assessment process for all new enrollees with the goal of reaching as many individuals as possible.

Referrals and Service Authorization

Within CMA, care management and service authorization are performed by the member's primary care team. These providers are very familiar with the member's needs. Authorizations are fed into a reasonably flexible claims payment system. In NHP, with 100,000 members, the care management and authorization functions are more remote and performed by individuals who are not as familiar with the specific members. The staff time spent processing referrals and authorizing services is essential in order to ensure that claims are paid. However, this presents a barrier to care coordination, because the same people perform both the referral and authorization function and the care coordination.

NHP is responding to this challenge by streamlining and automating the referral and authorization system. First, all referral and authorization policies and procedures were reviewed to eliminate authorization requirements for services that are rarely denied or have minimal financial impact on the plan. Second, an Internet-based referral and authorization system, CHCNET, was implemented. CHCNET allows primary care sites to obtain referral numbers over the Internet that are directly entered into the NHP claims system in order to authorize payments. CHCNET has reduced the time required to process referrals and authorizations by two-thirds at participating sites.

Provider Network Management

For the CMA programs, the plan works very closely with a designated provider network. Provider contracts include specifications about participation in multi-disciplinary team meetings, on-call and coverage responsibilities, and working with nurse practitioners as primary care providers and care coordinators. NHP's provider network is significantly broader than the CMA network, and contract specifications are more generic, as is appropriate for a larger plan. In addition, NHP members constitute only 5 to 10 percent of any given primary care provider's patients. This is a barrier to insuring provider buy-in, which is the cornerstone of any effort to restructure the delivery of care.

NHP is addressing this barrier by developing the Partnership Program. This program is a collaboration between NHP and selected high-volume primary care sites to increase the capacity of primary care sites to restructure care. The primary care sites agree to convert their Medicaid primary care case management membership to NHP in order to create a critical mass for clinical innovation. The sites identify two to three clinical goals, and

NHP provides technical assistance to help the sites meet these goals. All of the Partnership sites are working with NHP to explore the feasibility of assuming more risk for their members and developing enhanced on-site care management capacity.

Continuum of Care Management Models

The CMA care management model is a highly intensive, hands-on model with nurse practitioners at the hub. The model includes home visits, 24-hour access to a knowledgeable clinician, mental health and substance abuse consultation, and support services. This model is neither appropriate nor necessary for most of NHP's members. However, the NHP traditional case management model, combining referral and authorizations with plan-based case management, is not sufficient to meet the needs of NHP's members with complex disabilities or chronic illnesses. Over the past year, NHP has experimented with variations on both the CMA and NHP care management models to create new options.

NHP currently operates several different care management programs, ranging from a traditional case management/utilization review model to disease management, intensive case management, and specialized clinical programs. The continuum of care management programs can be viewed as a triangle. At the base are the plan-wide, plan-operated programs for a broad spectrum of NHP enrollees. These include a general case management program, a program for high-risk pregnant women, an asthma disease management program, and an intensive program for high-cost cases.

At the tip of the triangle are specialized clinical programs for small groups of highly complex enrollees. They are diagnosis or population-specific and include the CMA programs for enrollees with AIDS, adults with severe physical disabilities, children with serious emotional disturbances, and medically fragile foster children. These programs are generally operated through contracts with closely affiliated group practices/health centers and a high level of collaboration between the plan and the provider.

In the middle of the triangle are models of care management based at high-volume or high-cost primary care provider sites. These programs are neither plan-wide nor diagnosis or population-specific. They represent a middle-ground approach to care management, with a more focused approach than the plan-wide programs, but less clinical intensity than the CMA programs. They serve a more diverse, but slightly less medically complex enrollee population than the CMA programs.

Plan-wide, Plan-operated Programs

The model for plan-wide clinical services at NHP combines case management, utilization review, and referral and authorization functions within a single department, the Clinical Services Department. NHP employs nine nurse case managers who follow up on high-risk members or requests for case management services. Each case manager has an assistant known as a support coordinator. The nurse case managers have expertise in

rehabilitation, HIV, and pediatrics, and someone is on call 24 hours per day/7 days per week. Historically, NHP has operated both a general case management program and a program for high-risk pregnant women.

A third plan-wide program is asthma disease management. Asthma is one of the top health issues for NHP's members. A study of 1997-1998 data indicates that between 9 and 10 percent of NHP enrollees have asthma. Sixty percent of these are children, and 40 percent are adults.

NHP began to develop an asthma disease management program in February 1999. The broad goals of the program are to improve clinical management of the disease and reduce costs for preventable emergency room visits and inpatient hospital admissions. NHP's role in the program is to support its provider network in improving care through the following activities:

1. Producing reports on the utilization of services by NHP members with asthma stratified by primary care site;
2. Removing barriers that prevent timely access to care; and
3. Arranging and financing additional patient education.

Clinical Programs for Special Needs Populations

Organizationally, the relationship between CMA and NHP works as follows:

- Administrative staff mainly work directly for NHP. These staff are employed by the various NHP departments, including member services, provider relations, program development, claims payment, behavioral health, and quality management.
- A core group of clinical staff, including many of the nurse practitioners, behavioral health consultants, case managers, and clinical program supervisors, work for a clinical group, CMA, Inc., that is exclusively affiliated with NHP.
- Some of the core clinical staff work for other group practices or health centers that are part of the NHP provider network.

Severe Physical Disabilities Program

Origins: The physical disabilities program was established in 1992 as a partnership between CMA and Boston's Community Medical Group (BCMG), a private practice of nurse practitioners and physicians who provide primary care and care management for individuals with severe physical disabilities.

Eligibility criteria: To be eligible for this program, individuals must require personal care services and have functional quadriplegia, or have paraplegia and other complex medical conditions/substance abuse disorders or mental health diagnoses. The eligibility screening is tied to an enhanced capitation rate for this population. Individuals who are dually eligible for Medicaid and Medicare were allowed to enroll in this program at the time of the CMA/NHP merger. Currently, they are no longer eligible for enrollment (Medicaid decision).

Enrollment: Two hundred twenty-five members in the Greater Boston area.

Clinical management: Clinical management is provided by BCMG. The main care managers are nurse practitioners who provide primary care in collaboration with the enrollee's primary care physician. The primary care provider is usually an internist, but may also be a physiatrist. Nurse practitioners provide services in enrollee's homes, including primary care, follow-up care, response to new problems, monitoring chronic conditions, problem-solving mental health and addictions issues, and patient education. In addition to the nurse practitioners, the program also includes a designated medical director, a physical therapist, a durable medical equipment specialist, a mental health specialist, an addictions specialist, and support staff to facilitate referrals, authorizations, and transportation.

Provider network: Enrollees in this program have access to NHP's entire provider network. However, the main primary care provider network for this program is BCMG and the Department of Physical and Rehabilitative Medicine at Boston University Medical Center. There are also special contracts with durable medical equipment, mental health, and addiction treatment providers.

Special benefits: Arrangement of transportation, assistance with problem-solving related to durable medical equipment, and provision of home-based primary and acute care services are three very important benefits of this program. In addition, NHP uses a much broader definition of medical necessity for speech, physical, and occupational therapy than is commonly used by plans that serve a commercial or TANF population.

Financing: NHP receives an enhanced, risk-adjusted capitation rate for these enrollees.

Challenges: Challenges include expanding this program to other parts of the state. This requires determining where there is a sufficient volume of eligible enrollees to replicate the model, as well as where providers are located who are willing to serve this population in a home and community-based setting.

AIDS Program

Origins: The CMA AIDS program began enrolling members with advanced AIDS in Greater Boston in 1992 under a special contract with Medicaid.

Eligibility criteria: Medicaid's eligibility criteria are very complex and require a comprehensive clinical assessment of the stage of illness prior to enrollment in NHP. These criteria are tied to a risk-adjusted capitation payment to NHP. Prior to the merger of CMA/NHP, individuals dually eligible for Medicaid and Medicare were allowed to enroll in the program. Now they are no longer permitted to join (Medicaid decision).

Enrollment: Two hundred eighty-five individuals with AIDS are enrolled in the program; seventy-five in western Massachusetts and the remainder in the Greater Boston area. In the year 2000, the program expanded to Central Massachusetts.

Clinical management: Clinical management is provided by CMA, Inc. The main care managers are nurse practitioners that provide primary care and HIV specialty care in collaboration with the enrollee's primary care physician. The primary care physician is either an internist or infectious disease specialist. Nurse practitioners provide services in enrollee's homes, including primary care, follow-up care, response to new problems, monitoring chronic conditions, problem-solving mental health and addictions issues, and patient education.

In addition to the nurse practitioners, the program includes a designated medical director, a mental health specialist, an addictions specialist, and support staff to facilitate referrals and authorizations. The presence of the mental health and addictions specialists helps to support communication between medical and behavioral health providers, and also helps support the nurse practitioners in their primary roles of care coordinators.

Provider network: The provider network for this program is mostly a subset of NHP's overall network with specialties in HIV care. For example, three health centers that are central to NHP's general network also have specialized HIV programs, and most of NHP's tertiary care hospital network has infectious disease clinics. In addition, the program contracts with specific providers for infusion therapy, mental health, and addiction treatment.

Special benefits: Acupuncture treatment, massage therapy, adherence support, home-based HIV care, and assistance in coordinating transportation are special benefits for this program.

Financing: NHP receives an enhanced risk-adjusted rate for enrollees with advanced AIDS, but no risk adjustment for enrollees with HIV or less advanced AIDS.

Challenges: Challenges include expansion to other communities and reviewing the model of service delivery in light of changes in HIV treatment and health outcomes.

Mental Retardation Program

Origins: NHP has a small program that began in 1996 for individuals with developmental disabilities and/or mental retardation. CMA developed this program in collaboration with the Massachusetts Department of Mental Retardation.

Eligibility criteria: Any adult with developmental disabilities or mental retardation is eligible for this program, as long as they have Medicaid and no other health coverage (such as Medicare). Prior to the CMA/NHP merger, this program also included individuals with other disabilities and complex needs who were not eligible for the

special CMA capitation rates. Now the general disabled population remains in the mainstream NHP program.

Enrollment: Twenty-seven enrollees in the Greater Boston area.

Clinical management: Clinical management is provided by a nurse practitioner in CMA, Inc. It includes home visits, primary care in the home, staff training at group homes, 24 hr/7 day on-call services, help with making appointments, transportation, referrals, evaluation of service plans, and monitoring medical problems. The nurse practitioner also facilitates service authorization.

Provider network: The NHP provider network is used, although there are some specialized mental health providers who were recruited into the network to serve this population.

Financing: There is no special rate for these enrollees.

Challenges: The major challenges for this program are:

- To expand program eligibility to include dual eligibles (Medicaid and Medicare), since most people referred to the program are dually eligible.
- To determine the appropriate rates for Medicaid and Medicare capitations for these enrollees.
- To determine the appropriate staffing and administration for this program: Should the program be moved from CMA, Inc. to the Clinical Services Department of NHP and be made available to a broader population? Would nurse case managers be sufficient for this program?

Mental Health Services Program for Youth (MHSPY)

Origins: The MHSPY program began as a collaborative effort of Harvard Pilgrim Health Plan (HPHC), Medicaid, and the Massachusetts Departments of Social Services (DSS), Mental Health (DMH), Education (DOE), and Youth Services (DYS). The development of MHSPY was funded by a Robert Wood Johnson grant to HPHC. The program is designed as a three-year pilot to integrate medical, mental health, social support, and non-traditional services for children with serious emotional disturbances within an established system of care. Under the terms of the grant, all primary care is provided by physicians at Harvard Vanguard Medical Associates, physician practices that formed the basis for the original HPHC staff model health plan.

Eligibility criteria: To enroll in the program a child must be between the ages of 3 and 18, eligible for Medicaid, a resident of Cambridge or Somerville, and eligible for, or receiving services from, DMH, DSS or DYS, or receiving special education services in school. The child must meet level of function criteria that indicate being at risk of placement in a residential institution. Most important, the child's family must agree to actively participate in the program.

Enrollment: Enrollment into MHSPY began in March 1998. According to the terms of the grant, no more than 30 children may be enrolled in the program at one time. Thus far, a total of 43 children have entered the program, and there are currently 15 children on the waiting list. Potential enrollees are referred to the program by participating state agencies. The enrollment coordinator, employed by Medicaid, screens referrals to ascertain eligibility status, and then sends the referral to a team composed of staff from MHSPY and involved agencies. This team reviews and prioritizes the referrals for enrollment.

Clinical management: Clinical management is provided by MHSPY, under the direction of the program's medical director (a psychiatrist), as well as by the primary care physician. A steering committee with representatives from the five state agencies meets monthly to oversee the program administratively and ensure interagency collaboration.

Provider network: Primary medical care is provided by primary care providers at Harvard Vanguard Medical Associates. All other services can be received from any provider whether or not the provider is in the HPHC network. Providers also include people who do not have traditional credentialing. For example, MHSPY uses the services of a Haitian male therapist who is not licensed to receive third party payments. His skills, ability to speak Creole, and ability to serve as a male role model made him important to the program.

Special benefits: Benefits include the standard Medicaid package as well as other services MHSPY deems valuable. For example, one MHSPY client was frequently late for school because she went to sleep late at night and had trouble rising in the morning. MHSPY reimburses her 20-year-old neighbor to help her maintain more regular sleep habits and thus attend a full day of school. Another client was found to be extremely musically talented. MHSPY seeks to emphasize children's strengths, and so now pays for music lessons. Funding from the other state agencies enhances the opportunity to provide this type of alternative service. While NHP carves out mental health benefits, MHSPY integrates mental health and medical care.

Financing: NHP receives an enhanced capitation rate for these enrollees that includes Medicaid funding as well as funding from the other state agencies involved.

Challenges: The main challenges for this program have been associated with migrating operations and systems from HPHC to NHP. Future challenges include expanding the program to accommodate the waiting list and finding additional primary care provider capacity.

Medically Fragile Foster Child Program

Origins: "Special Kids ♥ Special Care" is a CMA program for medically fragile children in foster care. This program is the joint effort of NHP, the Massachusetts Department of Social Services (DSS), and Medicaid. Initiated by DSS, planning for the program began in February 1999, and enrollment began on December 12, 1999.

Eligibility criteria: To be eligible for the program, children must need skilled nursing services and have full foster status. Many children are technology dependent. DSS identifies children and initiates the application process but has had great difficulty locating eligible children. This is due in part to the limited number of children who meet the strict medical and legal criteria and in part to difficulties locating the children through the DSS data system. Most referrals have come from nurses employed by DSS who have been responsible for coordinating medical care for these children.

Enrollment: Twenty-one children have been enrolled in the program to date. The program started in the Boston area and is now expanding to other parts of the state.

Clinical management: Day to day clinical management is provided by the CMA, Inc. pediatric medical director and a CMA, Inc. pediatric nurse practitioner. The nurse practitioner works with the primary care physician to coordinate care. The nurse practitioner takes first call for new problems; manages durable medical equipment vendors, home health, and private duty nursing; and facilitates coordination with the school system.

Regular meetings are held to coordinate clinical and administrative operations with Medicaid and DSS. They include a monthly steering committee meeting with CMA, Inc. management and clinicians, senior NHP staff, and staff from Medicaid and DSS. Clinical case review team meetings include staff from DSS, Medicaid, and CMA, and offer a forum in which clinical issues, such as changes in service level, can be reviewed.

Provider network: The network for this program is extremely flexible. NHP will contract with any provider with whom the child has a pre-existing relationship. Since the merger with HPHC, most of the children's providers are already part of the network. However, if they are not, NHP will contract with them. Providers are paid an enhanced rate for the types of primary care services most commonly used by these children: certain types of outpatient visits, case management, telephone consultation, and home and hospital visits.

Financing: NHP receives an enhanced, risk-adjusted capitation rate for these enrollees. However, the risk-sharing arrangement between NHP and Medicaid is such that NHP bears no risk for the first two years of this project, so the capitation payment serves largely as a cash flow mechanism.

Challenges: Challenges include bringing very different systems together, overcoming turf issues, and finding sufficient numbers of eligible children in a geographic area to justify the infrastructure costs of clinical management. NHP and DSS are very complex systems that knew little about each other before beginning this program. Attention to developing relationships, trainings, and other forms of education, as well as respecting the expertise of the DSS nurses, has helped to diffuse concerns about the impact of managed care on caring for these children. In addition, program expansion is difficult due

to the small numbers of eligible children and difficulty identifying these children within the DSS system.

Middle Tier Care Management Programs

During the planning year, NHP initiated nine new primary care site-based programs. Six of these programs are part of the Partnership Program, an initiative developed by NHP to align the goals, incentives, and care outcomes for both NHP and participating community health centers. Three additional programs that focus more exclusively on care management for special needs populations have been established at non-Partnership sites. Together, these nine programs represent the middle section of the care management triangle at NHP.

The Partnership Program

The Partnership Program is designed to establish the mutual goals for selected primary care sites and NHP of enrollment growth and quality improvement, while at the same time building economies of scale and creating new marketing and service opportunities. One of the key features of the Partnership Program is that participating health centers "roll over" their Medicaid primary care case management enrollees into NHP. This gives the health center the critical volume of NHP membership to consider the development of new clinical programs and financial arrangements.

Other expectations of health center partners include:
- A commitment to NHP as the managed care plan of choice;
- A commitment to develop common medical management strategies with NHP; and
- A commitment to share the financial responsibility for the entire benefit package to the maximum extent feasible.

NHP's contributions to the Partnership include:
- Information system support such as CHCNET, an Internet-based referral and authorization system;
- New financial arrangements;
- Technical assistance, for both operations and clinical programs;
- Marketing/communications support; and
- Financing an outreach worker to help uninsured patients obtain Medicaid.

Health centers were informed of the Partnership Program in April 1999 through the release of a "Partnership Program Proposal," which outlined program requirements and commitments. In October of 1999 the first four health centers were selected to participate in the program. In the spring of 2000 two additional centers joined the program.

Each health center is pioneering the plan-wide asthma disease management program and has identified one or more clinical initiatives as part of the Partnership Program. The clinical initiatives include:

- Reducing emergency room utilization and increasing urgent care and primary care capacity
- Establishing an HIV program
- Increasing on-site specialty sessions
- Defining the case manager role for the prenatal care program
- Developing programs for prevention and early identification of diabetes and HIV

Other Primary Care Site-Based Programs

The Brightwood Health Center in Springfield, Massachusetts is collaborating with NHP to implement an innovative primary care and care management program for NHP enrollees on SSI. CMA, Inc., NHP's clinical affiliate, employs a nurse who works on-site at Brightwood in a team approach with Brightwood's primary care providers, behavioral health providers, and social workers to provide case management services. The timetable for converting the primary care case management members to NHP is longer at Brightwood than at the other Partnership sites. The plan is for NHP to continue reimbursing Brightwood on a fee-for-service basis until the model is fully operational and a new historical cost base can be determined.

NHP is also collaborating with two high-volume, high-cost teaching hospital primary care programs to implement care management for NHP members with chronic illness, disability, and complex medical, psychiatric, and social needs. NHP, through CMA, Inc., funds a nurse practitioner to work in a team approach with physicians at each of these teaching hospital outpatient clinics. The nurse practitioners collaborate with the primary care provider to develop and implement care plans, triage new problems, conduct home visits as needed, take first call at night and on weekends, and coordinate medical and behavioral health services and social supports.

In the three programs described above, the primary care team has service authorization responsibility and authority. The nurse or nurse practitioner has after-hours call responsibility and makes home visits as needed, enhancing access to care for high-risk enrollees. In these ways, the new programs are similar to the CMA programs. However, the target population for these programs is broader than for the CMA programs and includes enrollees with a wider spectrum of disabilities and chronic illnesses. In addition, because these programs are site-based, the NHP case managers work with primary care site-based physicians, behavioral health providers, and social service staff, rather than setting up a separate infrastructure for these services within NHP or CMA, Inc.

Challenges

NHP has encountered many challenges in working with its provider network to implement site-based programs. The biggest challenge encountered in the past year was

the integration of HPHC members and network providers into NHP systems. Many other NHP priorities took a back seat to this massive operation.

Operational challenges were also encountered with the existing network. Potential health plan partners were concerned about converting members from the Primary Care Clinician (PCC) program (Medicaid fee-for-service) to NHP because of the time and money required to process authorizations and claims. Claims can be submitted to the Massachusetts Medicaid program electronically, but NHP still requires paper. Plans are underway to facilitate electronic transmission. The implementation of CHCNET has started to alleviate some of the concerns regarding referrals, but the claims submission component is not yet operational.

The availability of good clinical information in a timely and usable format was another challenge. There is a potential wealth of relevant information, but it is contained in a claims payment system. It has taken substantial time and resources to convert this information to reports that may be useful for clinical action.

Finally, financial obstacles have played a role in slowing down the Partnership Program. Some health centers are concerned about converting membership to NHP because Medicaid fee-for-service payments may be more attractive than the primary care capitation paid by NHP for a particular site. Although this circumstance does not apply to every primary care site, it is of particular concern to those health centers operating on the margin because even a slight change in revenues could create serious financial difficulties.