Care Network
of Alabama, Inc.

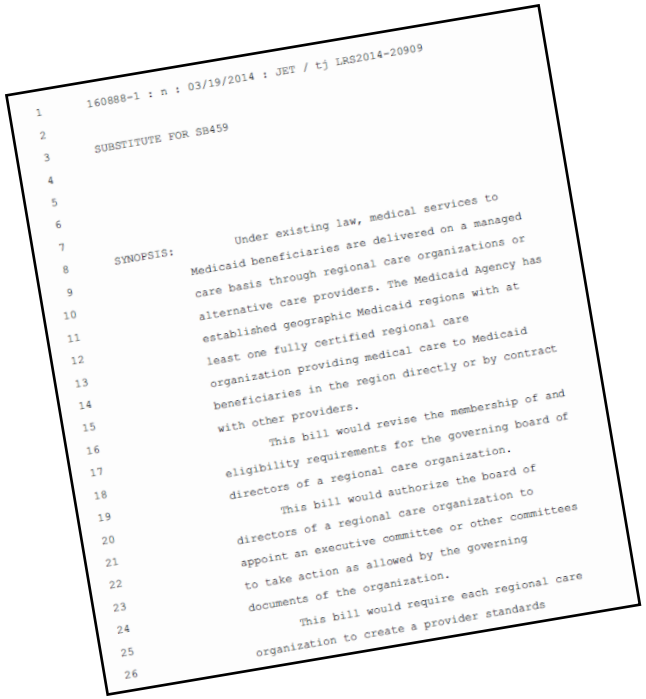
Regional Care Organization and Patient Care Network Overview

January 2015

RCO HISTORY AND BACKGROUND

Establishing Regional Care Organizations

- **In May 2013, the Alabama Legislature passed legislation outlining a reform plan for Alabama Medicaid, which Governor Bentley signed into law.**
- **The law authorizes Regional Care Organizations (RCOs) to provide benefits to Medicaid beneficiaries through a capitated financing model that establishes a set amount per patient that Alabama Medicaid will pay the RCO.**
- **In April 2014, the Alabama Legislature amended the RCO legislation.**



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SUBSTITUTE FOR SB459

SYNOPSIS: Under existing law, medical services to Medicaid beneficiaries are delivered on a managed care basis through regional care organizations or alternative care providers. The Medicaid Agency has established geographic Medicaid regions with at least one fully certified regional care organization providing medical care to Medicaid beneficiaries in the region directly or by contract with other providers.

This bill would revise the membership of and eligibility requirements for the governing board of directors of a regional care organization.

This bill would authorize the board of directors of a regional care organization to appoint an executive committee or other committees to take action as allowed by the governing documents of the organization.

This bill would require each regional care organization to create a provider standards

The Legislation addresses:

- Governance
- Risk & Reserve Requirements
- Regions & Medicaid Contracting
- Beneficiary Eligibility & Enrollment
- Provider Contracting & Network Adequacy
- Appeals
- Anti-Trust
- Use of “Alternative Care Providers”
- Quality Assurance Committee
- Transitional Care Management Services
- Future Studies on LTC and Dental Services
- Implementation Timeline

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Why establish RCOs

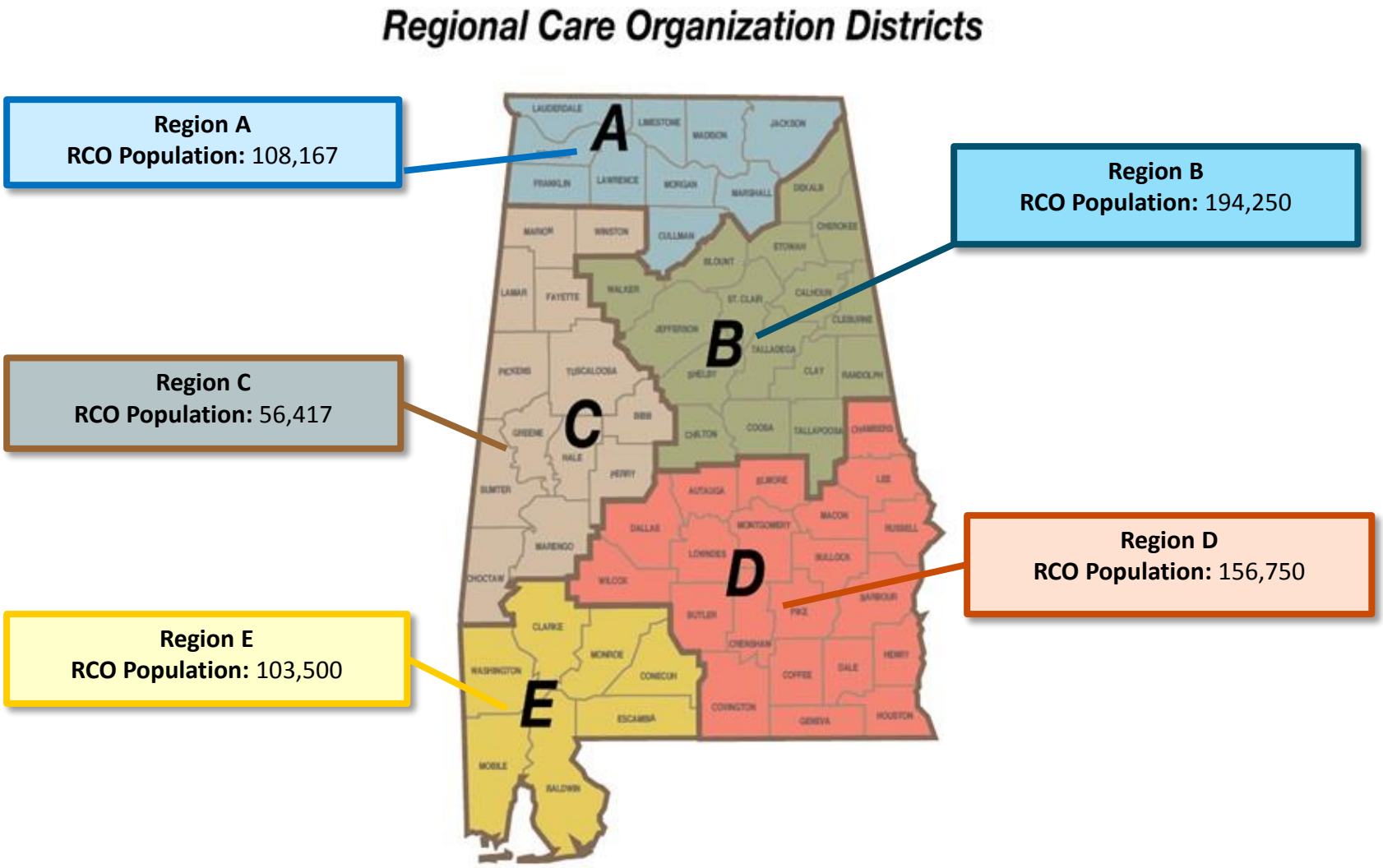
Expected improvements over current Medicaid program:

- ✓Better care
- ✓More efficient
- ✓Less costly

RCO Requirements

- ✓Serves only Medicaid beneficiaries
- ✓Will not be deemed an insurance company under state law
- ✓Must have a governing board of directors and citizen's advisory committee that meet specified requirements
- ✓Must be incorporated as an Alabama non-profit

RCOs Organized in 5 Regions Across the State



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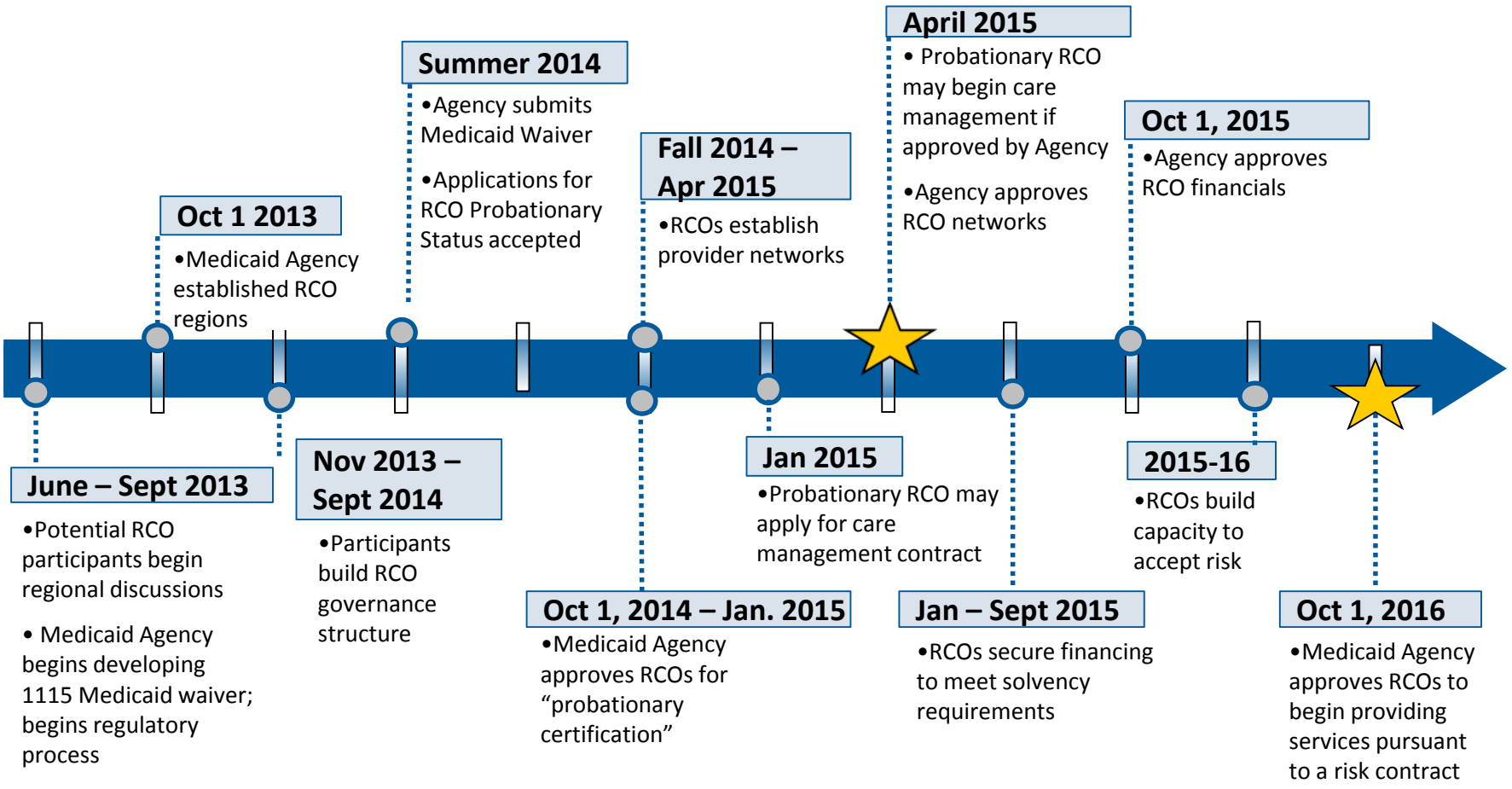
RCO Implementation Timeline



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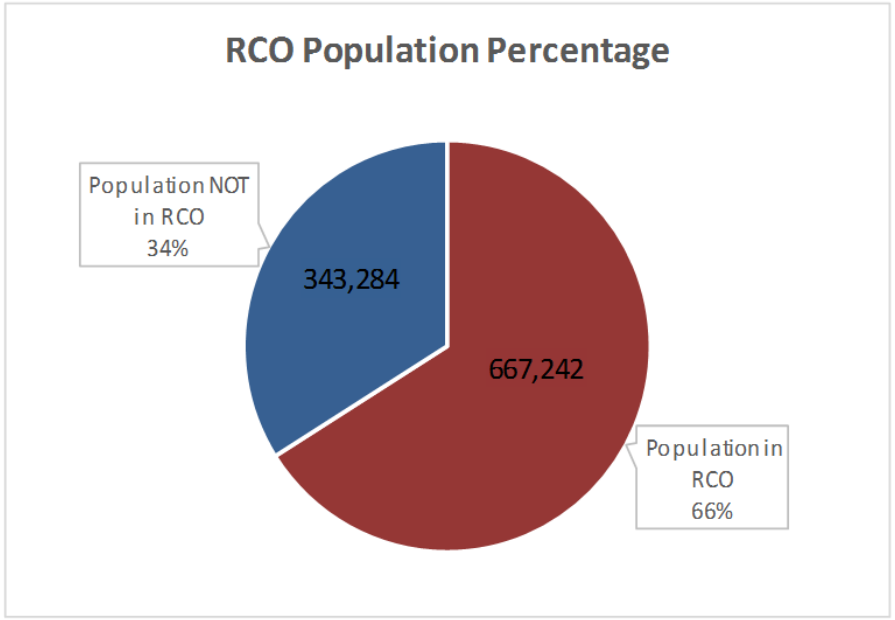
Who's Covered by the RCO?

2/3 of Alabama's Medicaid Population in RCO Years 1-3



Not Covered

- Dual eligibles
- Foster children
- Hospice patients
- ICF-MR recipients
- Nursing home/institutional recipients
- Plan 1st recipients
- Home/community-based waiver patients

Covered

- Aged, blind & disabled
- Breast and cervical cancer treatment program
- Medicaid for Low Income Families
- SOBRA children and mothers

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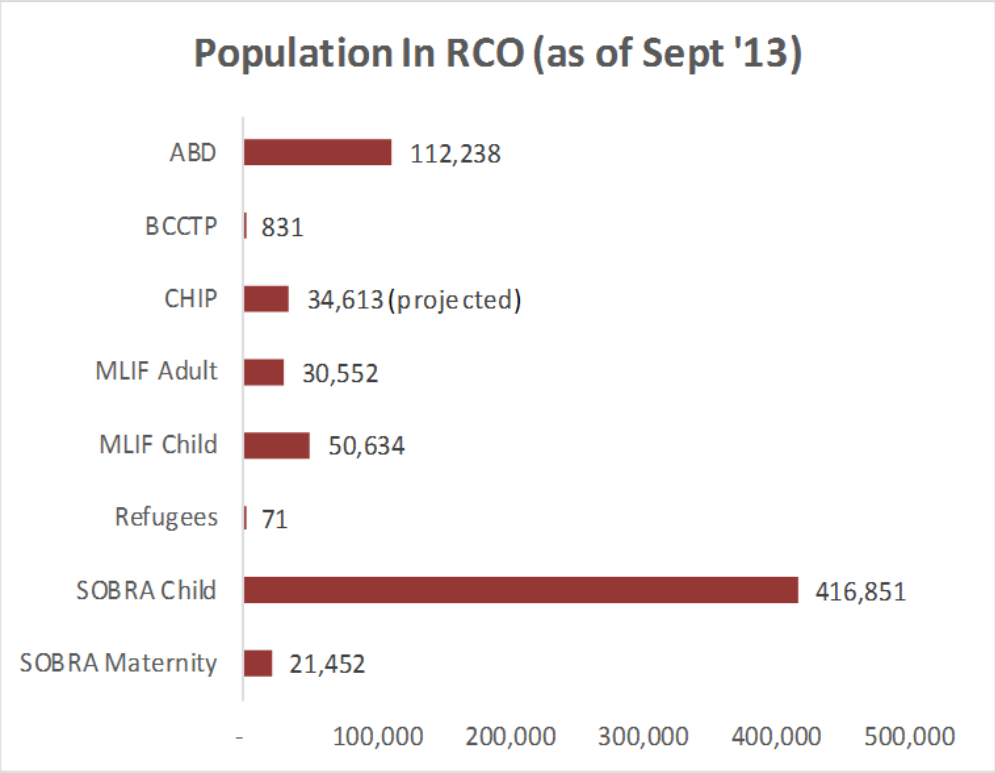
Who's Covered by the RCO?

75 % of RCO Recipients are Children



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RCO ORGANIZATION

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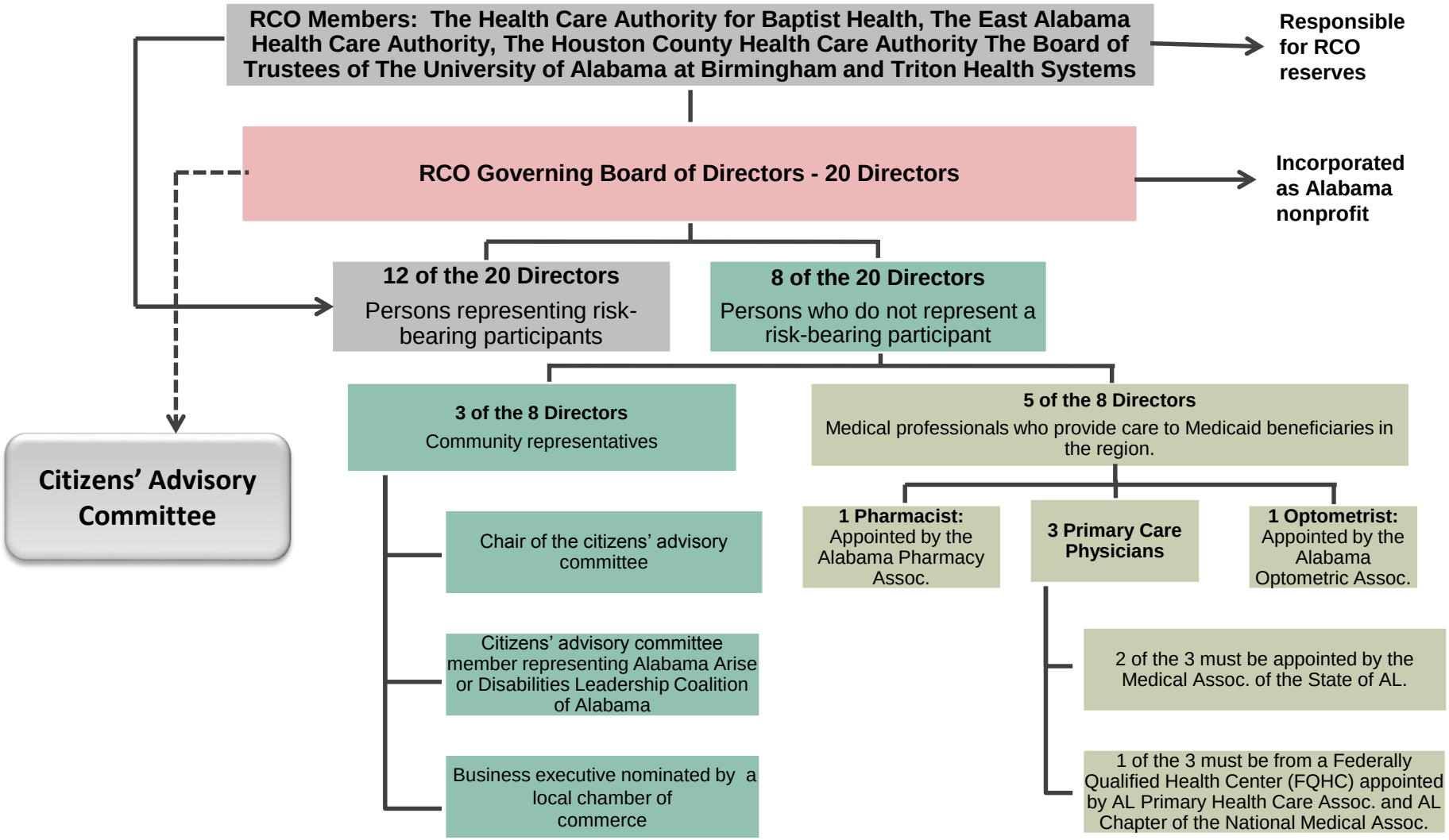


RCO Board: 12 Risk Bearing Members

- **The Health Care Authority for Baptist Health, An Affiliate of UAB Health System**
  - Russell Tyner
  - Katrina Belk
  - Robin Barca (rotating appointee)
- **The East Alabama Health Care Authority**
  - Terry Andrus
  - Sam Price
- **The Houston County Health Care Authority**
  - Ron Owen
  - Derek Miller
  - Ralph Clark (rotating appointee)
- **Triton Health Systems, LLC**
  - Brad Rollow
  - Cardwell Feagin
- **The Board of Trustees of The University of Alabama for The University of Alabama at Birmingham**
  - Will Ferniany
  - Don Lilly

RCO Board: 8 Non-Risk Bearing Members

- **Medical Association of State of Alabama appointees**
  - Dr. Winston Ashurst
  - Dr. Beverly Jordan
- **FQHC appointee**
  - Dr. Nasser Samuy
- **Pharmacy Association appointee**
  - David Darby
- **Chamber of Commerce appointee**
  - Jimmy Lunsford
- **Optometry Association appointee**
  - Bill Tillman
- **Citizens' Advisory Committee Chairman**
  - Jerry Haynes
- **Alabama Arise or Disability Leadership Coalition representative**
  - Kathy Vincent

Citizens' Advisory Committee Members

1. Anita Archie: Montgomery County
   - Chief of Staff to Mayor Todd Strange
2. Barbara Boyd: Lee County
   - Consumer Representative
3. Dr. Ritu Chandra: Russell County
   - Pediatrician
4. Tanisha Copeland: Houston County
   - Consumer Representative
5. Samuel Crawford: Houston County
   - Retired Fire Fighter/Fire Chief
6. Jerry Haynes: Lee County
   - Administrator/Pediatric Clinic of Opelika
7. Denson Henry: Dallas County
   - Vice President/Henry Brick
8. Vernon Johnson: Dale County
   - CEO/Dale Medical Center
9. Dr. Tonya Lyles: Chambers County
   - Pediatrician
10. Mary Patillo: Chambers County
    - Consumer Representative
11. Stacia Robinson: Montgomery County
    - Business Owner/The BeneChoice Companies
12. Kathy Elmore Sawyer: Montgomery County
    - Nominated by Disabilities Leadership Coalition
13. Dr. Lee Scott: Houston County
    - Pediatrician
14. Dr. Terry Vester: Chambers County
    - Family Medicine Physician
15. Kathy C. Vincent: Montgomery County
    - Nominated by Alabama Arise

CURRENT STATUS

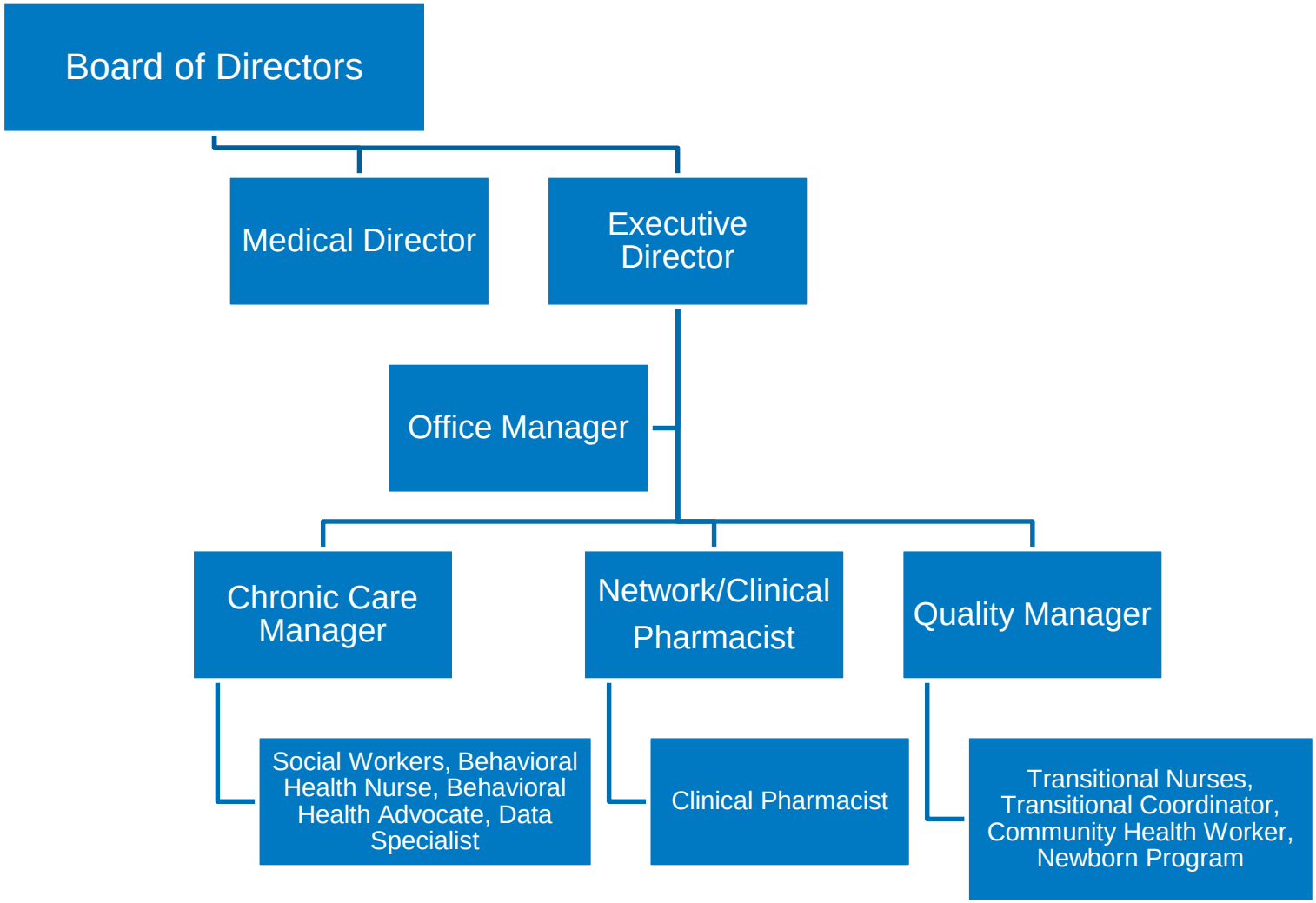
Current RCO Status

- Care Network of Alabama gained probationary approval **Dec. 18, 2014**
- Request for proposal issued for health home contract **Dec. 29, 2014**
- Letters of Intent from RCOs sent to Medicaid providers **Jan. 5, 2015**
  - 10, 796 letters sent
  - > 249 Patient First primary providers
- Return LOIs for both RCO and health home commitments **Jan. 15**
- RCO network adequacy assessment by Medicaid **April 1**
- Health home care management to begin **April 1**

PATIENT CARE NETWORK

- **The goal of the network is to:**
  - Improve health outcomes for Alabama Medicaid Patient 1st Population
  - Help primary care providers effectively manage patients with chronic conditions
  - Improve communication across care settings
  - Empower the patient to self-manage their conditions
  - Reduce the costs of care

- Currently serve Medicaid Patient 1st patients in seven counties: Bullock, Chambers, Coosa, Lee, Macon, Russell and Tallapoosa
  - 81% of patients are pediatric
- 57 physicians currently enrolled representing 34 practices
- 27 Employees / 25 FTE's


Board of Directors
Medical Director
Executive Director
Office Manager
Chronic Care Manager
Network/Clinical Pharmacist
Quality Manager
Social Workers, Behavioral Health Nurse, Behavioral Health Advocate, Data Specialist
Clinical Pharmacist
Transitional Nurses, Transitional Coordinator, Community Health Worker, Newborn Program

Home Health Population

- Region D has 77,000 health home eligible enrollees
- In current network we have approximately 15,700 Health Home Patients
- 68% Health Home patients are Pediatric
- 32% Health Home patients are Adult

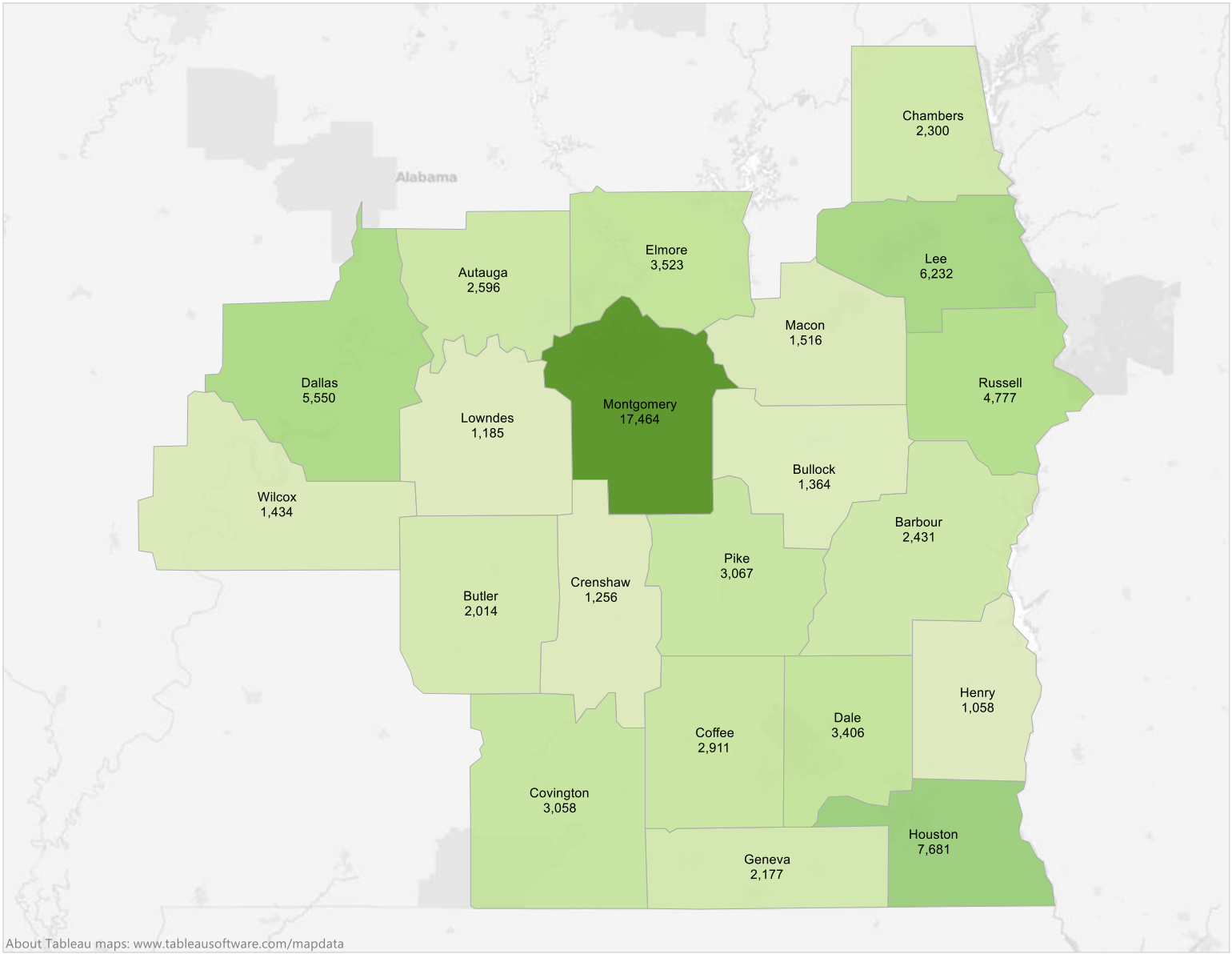
CMS Guidelines

- Eligibility for Health Home Services
  - Two or more chronic conditions
  - One chronic condition and risk for a second
  - A serious and persistent mental health condition

Health Home Diagnosis:

- Mental Health
- Substance Abuse Disorder
- Asthma
- Diabetes
- Heart Disease
- Obesity
- HIV
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Sickle Cell Anemia
- Transplants
- Hepatitis C Virus

Region D Health Home Patients



CNA Services

- Care Management
- Transitional Nursing
- Behavioral Health Care Management
- Pharmacy Support
- Nutrition Education

Care Management

Each Primary Medical Provider practice is assigned a social worker case manager or a nurse case manager

Case Managers:

- Help identify patients with high-risk and chronic conditions
- Provide education to patients about their chronic conditions
- Provide on-going patient support to make sure they attend physician appointments and take medications as prescribed
- Visit patients in their home to assess for other needs
- Assist patients in accessing resources for identified social needs

Care Management

- Categorizes patient contact by need of contact frequency.
  - **Heavy** – weekly contact by case manager
  - **Medium** – monthly contact by case manager
  - **Light** – contact at least once per quarter
- Re-evaluates status every 90 days

Transitional Care Services

- The network currently partners with six hospitals in our network area to transition patients from the hospital to home and then to their primary medical home.
- Transitional Care Coordinator visits patients in East Alabama Medical Center daily and communicates with staff at other hospitals regarding discharge instructions and patient needs.
- The transitional care nurses visit patients during their hospital stay, when possible, and then conduct an in-home visit within five days of discharge.
- Transitional care nurses follow patients for 30 days post-discharge. At end of 30 days patient file is closed or if additional services are identified, patient is referred to social worker case manager.
- Primary purpose of the home visit is medication reconciliation and to make sure the patient has a scheduled follow-up appointment with their primary care provider.

Behavioral Health

- Staff are embedded in the area Mental Health Centers. The goal of this program is to bridge the Mental Health consumer into Primary Care as well as assist consumers with appointment access into mental health.
- Obtains medication recommendations from Psychiatrists at Mental Health Center for our Primary Care Physicians who are managing psychotropic drugs for their patients with mental health diagnoses.
- Provides case management to Network patients with severe mental illness in addition to other Health Home diagnoses.

Pharmacy Support

- Pharmacists complete medication reconciliations for network patients and communicates with primary medical providers.
- Pharmacist rounds on inpatients at East Alabama Medical Center to identify medication concerns before patients are discharged.
- Pharmacists are liaisons between community pharmacists, primary medical providers and the Alabama Medicaid Agency.

Nutrition Education

- Registered Dietitian provides education in patient homes and primary care physician offices
- Education provided on diet for the following conditions: high cholesterol, hypertension, iron deficient anemia, failure to thrive, obesity, Type 1 and Type 2 Diabetes, pancreatitis and underweight
- Group education in summer-camp format has been provided in three counties for children identified as high risk due to BMI or diagnosis

Network Resources

- As an Agency of the East Alabama Food Bank, CNEA is able to provide food to patients in need
- The Network has budgeted resources for transportation and help arrange transportation for patients so they can attend their physician appointments
- Resources are budgeted to help patients with items to assist with medical care, but not covered by Medicaid (adult diapers, special needs bottles, socks and shoes for patients with diabetes)

Network Resources

- Medicaid provides the networks access to data to identify high risk and high cost patients
  - Stubblefield report
  - Network Metrics
  - Inpatient/ED monthly reports
  - High Cost Pharmacy reports

Medical Management Meetings

- Meet Quarterly with Providers to discuss initiatives
  - Asthma
  - Diabetes
  - Flu Vaccine
  - Immunizations
  - Pediatric Hypertension

Physician Comments

" I will say that having Christina in house has been invaluable. She is able to do things that I used to have to do like calling people before important appointments in Birmingham to make sure they have a way to get there, but she is much more effective at doing this than I was. Her relationship with mental health has also been valuable, as it was previously difficult to know if patients were even being seen there. I have definitely had a couple of kids with chronic illnesses lately that were not getting proper care until I got her involved."

Brooke L. Taylor, M.D.

"The support of the Care Network staff has been invaluable in taking care of patients that are either difficult to manage or fall through the cracks. Even if it were a break-even money proposition, I think it is still useful because it helps us take better care of our patients by coordinating care, fulfilling needs we were not aware of, or preventing unnecessary emergency department utilization. I was a skeptic, but I don't think I can say enough about it."

Richard L. Glaze, M.D.

Patient Success Story

- 54 year old – African American Male – Diabetes and Heart Disease
- Referral reason
  - High Service Utilization
  - Non-compliant with diabetes and hypertension medication
  - DKA inpatient stays in the ICU
- Transitional Nurse/Social Worker Case Manager
  - Home visits – provided education and encouragement regarding medication compliance
  - Downloaded patient's glucometer readings at pharmacy to review glucose levels
  - Regular communication with patient
- 12 month cost January 2013 Stubblefield report
  - **$19,545.53**
- 12 month cost August 2014 Stubblefield report
  - **$3,853.58 – no inpatient or ED visits in previous 12 months**

Patient Success Story

- 61 year old– African American Male – CHF/Hypertension
- Referral reason
  - High Service Utilization – IP and ED visits
  - 8 or more prescriptions
- Transition nurse
  - Home visits – identified that patient is illiterate and cannot read instructions on his medication
  - Patient lives alone – has friend who can help transport patient to physician appointments
  - Provided patient with pill box – CNEA staff refills pill box weekly
  - CNEA staff helps patient to schedule MD visits
- 12 month cost January 2013 Stubblefield report
  - **$10,394.58**
- 12 month cost August 2014 Stubblefield report
  - **$3,362.14 – no inpatient/ED visits in over 12 months**

What are the costs of these services for the primary care physician and for the patient?

- There is no cost to the provider or to the patient.
  - The primary care physician contracts with the network and the network provides care management services free of charge to their Patient 1st Medicaid patients.

How to become a part of the network:

- Must be an Alabama Medicaid Patient 1st Provider
- Sign patient care network contract with Care Network of Alabama, Inc.
- Sign a letter of intent to contract with the RCO – Care Network of Alabama, Inc.

Network Contacts

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- Kim Eason – Executive Director – kim.eason@carenetwork.org
- Julie Wells, MSW, LCSW, CDE – Chronic Care Manager – julie.wells@carenetwork.org
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