

Care Management/Coordination of Carve-Out Services

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BACKGROUND

In January 2005, Governor Schwarzenegger proposed expanding mandatory managed care for people with disabilities beyond the eight counties served by County Organized Health Systems. The California HealthCare Foundation (CHCF) viewed the Governor's proposal as an opportunity to foster a constructive dialogue among health plan representatives and consumer advocates, to improve the quality of care for people with disabilities and chronic conditions, and to establish better methods of measuring and monitoring health plan performance.

After conducting a two-month feasibility study, CHCF contracted with three consulting groups to develop a set of comprehensive performance standards and measures for health plans serving people with disabilities. The project focused primarily on the acute care needs of adults between the ages of 22 and 64 who qualify for Medicaid based on eligibility for SSI. The project consultants were also charged with identifying strategies for better coordinating services that are "carved out" of the health plan contracts, such as institutional and community-based long-term care, California Children's Services (CCS), alcohol and substance abuse treatment, and mental health. Issues pertaining to children and seniors were addressed as they relate to non-CCS services, care coordination, and the transition into and out of the Medi-Cal program.

The consulting team reviewed federal Medicaid managed care rules and requirements and researched best practices of other state Medicaid managed care programs that serve similar populations. The team also analyzed data from a sample of Medi-Cal fee-for-service claims and reviewed the current Medi-Cal health plan contract, and relevant California statutes, regulations, and policies. The team facilitated an extensive process to solicit public input and feedback in eight areas: enrollment and member services, network capacity, accessibility, benefit management, care management, quality improvement, performance measurement, and coordination of carve-out services. This public input process included workgroups with more than 100 California representatives from consumer organizations, health plans, health care providers, the California Department of Health Services, and other state agencies, such as the

Department of Rehabilitation, the Department of Managed Health Care, the Department of Mental Health, and the Department of Developmental Services. The team also met with a 28-member advisory group made up of a smaller number of the above California stakeholders and held a variety of Web-based, telephone, and in-person meetings to obtain feedback on the recommendations from interested parties who were not able to participate in either the workgroups or advisory groups.

Overall, the consultant team tried to ensure that the performance measures and standards recommended were responsive to people with disabilities and chronic conditions, and that they are enforceable, measurable, and reasonable in the overall context of the Medi-Cal managed care program. The recommendations were geared toward comprehensive standards that could be applied in a mandatory program. This reflected the consultant team's belief that in a mandatory program—where choice may be more limited, enrollment larger, and where plans have additional resources to invest in administrative infrastructure—more extensive standards and measures are practical, desirable, and potentially cost-efficient over time. The recommendations reflected the sometimes divergent views of the disparate stakeholders, who provided invaluable contributions and perspectives based on their experience. Ultimately, however, these recommendations reflect the opinions of the consultant team.

CARE MANAGEMENT

Case management and care coordination activities are essential for people with disabilities and chronic conditions who are enrolled in Medi-Cal managed care plans. Case management and care coordination use multidisciplinary team approaches and place the member at the center of care so that all medical, social, and personal needs are considered. The team involves a case manager or care coordinator who coordinates services among the participants on the multi-disciplinary team, with the member and his or her family/guardian.

A review of large states with Medicaid managed care programs and states with significant enrollment of people with disabilities in Medicaid managed care showed that most require some level of plan-based care management. In fact, provision of these services in a coordinated, systematic manner is a defining difference between full-risk managed care and other forms of managed care such as primary care case management,

in which responsibility for managing members' care is left to the individual primary care providers.

The Medi-Cal contract in effect in 2005 contained few requirements in the area of care management, with primary responsibility for these activities resting with the primary care provider (PCP). However, many Medi-Cal MCOs provided plan-level care management services for members, primarily those with catastrophic or high-cost conditions. Thus, many of the recommendations would be new to the Medi-Cal contract, but may not represent new activities to the MCOs.

The seven case management and care coordination contract recommendations all focused on development of a plan-based, systematic process for managing care, particularly for members with chronic or catastrophic conditions. Almost all were considered priority recommendations. In addition, we recommended that DHCS and the health plans should develop an ongoing working group to evaluate emerging best practices in care management, such as the use of interdisciplinary teams, health information technology, and consumer-directed models.

Recommendation CM-CR-1, Priority 1 - Essential (contract change)

The MCO shall use the following definition for care management: "Care management includes identification and assessment of member needs, advocacy, facilitation and coordination of plan, carved-out and "linked" services (not covered under the Medi-Cal program but described in the contract as related social, educational, and other services needed by the member). The process should integrate the member's strengths and needs, resulting in mutually agreed upon appropriate services that meet the medical, functional, and medically-related social needs of the member.

Recommendation CM-CR-2, Priority 1 – Essential (contract change)

The MCO shall provide care management for members who are identified through the care management assessment mechanisms as having the need for greater care management than can be provided by the PCP. The MCO shall maintain procedures for providing care management, with the following elements included:

- Written description of the activities and responsibilities that are part of the care management process, including procedures for monitoring the coordination of care provided, including but not limited to

medically necessary services delivered in and out of the MCO's provider network;

- Annual review and evaluation of the program description with approval by the MCO's governing body;
- Process for obtaining input into the development of the MCO's care management program and annual evaluation, including input from members (families/caregivers, as appropriate) and providers;
- Standardized procedures/description/methodology for identifying members for care management, including a process for self-referral;
- Description of the qualifications of people who will act as care managers, the approach for having sufficient staff available/monitoring case loads, and the appropriate methods for using a multi-disciplinary team;
- Description of the components of a care plan, including how it is developed and reviewed;
- Process for collaborating with carve-out programs to develop and distribute a quarterly contact list;
- Process and standards for oversight of care management activities delegated to a subcontractor or delegated medical group;
- Process for obtaining member input on satisfaction with individual care manager services;
- Information systems to support monitoring/management of care plans, the care management program, communication and information sharing among care managers and providers;
- Process to regularly update care plans based on changes in the members' medical or social status; and
- Process to obtain information on recommendations made by nurses staffing after-hours advice lines.

Recommendation CM-CR-3, Priority 2 - Important (contract change)

The MCO shall use qualified care managers, including licensed (or certified) registered nurses, social workers, rehabilitation counselors/therapists, physician's assistants, physicians, or other appropriate qualified individuals. Care managers preferably have practice and experience meeting the needs of people with disabilities and chronic conditions and receive appropriate training.

Recommendation CM-CR 4, Priority 1 - Essential (contract change)

The MCO shall maintain procedures for identifying members for care management, which should include the following mechanisms:

- Member, family member, caregiver/guardian's request;
- Referral from a specialist or PCP, or other provider (e.g., regional center, CCS provider);
- Referral from internal MCO staff (e.g., member services, complaints and grievances);
- Presence of an external care manager;
- Regular reviews of utilization and claims/encounter data, ER visits, lab, pharmacy scripts, DME, transplant request, and hospitalizations;
- Routine mining of claims/encounter data with algorithms established by the MCO;
- Triggers identified as being risk factors during initial screening of new members or during a later assessment (e.g., chronic homelessness/living arrangements, receipt of in-home supportive services, safety concerns, presence of a caregiver, enrollment in a county behavioral health program, enrollment in a community-based long-term care or contact with that system, regular visits to multiple specialists, presence of a cognitive impairment/certain conditions, missed appointment or referrals);
- Participation in multiple disease management programs (or identification of multiple conditions that could qualify for disease management); and
- Auto-assignment (of people in certain aid codes) to a PCP, which may indicate a concern with continuity of care.

The MCO shall provide a written explanation of the reason the member was not placed in care management when the request was made by a member or his/her representative, or provider, and provide those reasons to the family/provider.

The MCO shall maintain a process of communicating the initiation and closure of the care management process to the member and PCP.

Recommendation CM-CR-5, Priority 1 - Essential (contract change)

The MCO shall maintain procedures for developing care plans for members who are identified through the care management assessment mechanisms as having the need for greater care management than can be provided by the PCP. The care plan shall be developed by the care manager in collaboration with the PCP, treating specialists, interdisciplinary team (if indicated), and member (and his/her representative, if desired) that takes into account the following elements, as appropriate for each member:

- Health status and risk for secondary disabilities or complications;
- Clinical history;
- Age;
- Diagnosis/diagnoses;
- Functional and/or cognitive status;
- Mental health;
- Language/comprehension barriers;
- Cultural/linguistic needs, preference or limitations;
- Level of intensity of care management;
- Immediate service needs;
- Use of non-covered services;
- Barriers to care;
- Follow-up schedule;
- In or out-of-network care;
- Family members/caregiver/facilitator resources and contact information (if appropriate);
- Local community resources;
- Psychosocial support resources;
- Access/availability of needed medical equipment/accessible medical equipment;
- Assessment of progress, including input from family if appropriate; and

- Accommodation needs (e.g., appointment time), alternative formats (e.g., Braille, large print, disks, audio, electronic) and auxiliary aids and services.

The care plan shall be implemented and routinely monitored to ensure continuity of care. Information in the care plan should be made available to the member and PCP upon request. Additionally, the care plan shall be periodically evaluated to ensure that it continues to meet the member's needs. The MCO should have established criteria for discharge and transitioning members from care management.

Recommendation CM-CR-6, Priority 3 – Ideal system

The MCO shall have policies and procedures that address the following aspects of the disease management program:

- Identification of diseases and conditions to be addressed by the MCO's disease management program through several methods, e.g., claims analysis;
- Identification and stratification of members who may be appropriate for enrollment in disease/multiple chronic conditions management;
- Coordination with the PCP/medical home;
- Coordination/linkage with care management;
- Communication with the member; and
- Strategies for providing disease management for members with multiple chronic illnesses or conditions.

Recommendation CM-CR-7, Priority 1 - Essential (contract change)

The MCO shall submit policies and procedures describing how it will assist members in coordinating out-of-plan services, particularly for people who receive services from programs carved out of the capitated managed care program.

COORDINATION OF CARVE-OUT SERVICES

In the current Medi-Cal system, many services (e.g., specialty mental health, alcohol and substance abuse treatment, dental, California Children's Services, long-term care, home- and community-based waiver

services, and chiropractic) needed by members with disabilities are carved out of the MCO's responsibility and are provided instead by specialty providers who are reimbursed through fee-for-service Medi-Cal. The number and variety of services carved out of the Medi-Cal managed care program in California create the potential to leave members at risk for being lost between systems, with consequential negative impacts on care.

Due to the fragmentation between certain carve-out services and the health plans, the burden for coordinating services often falls on the beneficiaries and their families and the current system of carve-out services has created numerous coordination challenges for members. Through the workgroup process, we learned that there was significant confusion over identification of the appropriate party for claims payment, which can cause services to be denied or slowed. There was also a perception that several California Health and Human Services Agency (CHHSA) departments did not have strong oversight of carve-out providers or meaningful internal coordination.

The Medi-Cal MCO contract in effect in 2005 required that MCOs include information about carve-out services in the member services guide, develop and maintain procedures for referral and coordination of care to carve-out providers, and execute a memorandum of understanding (MOU) with certain carve-out providers (e.g., specialty mental health providers). However, a lack of clarity around the coordination responsibilities of various organizations, poor information sharing, and inadequate state oversight of carve-out service providers appeared to lead to challenges in achieving care coordination in many other areas of the health system.

The recommendations regarding carve-out services aimed to ensure that Medi-Cal members with disabilities and chronic illnesses had a seamless and easy-to-navigate system for coordinating between MCO and carve-out services (assuming that the current Medi-Cal program design for carve-out services did not change). The recommendations were based on a focus on the provision of member-centered care, an expectation of mutual responsibility and accountability for coordination of carve-out services across state, local agencies, the MCOs, providers, and the members themselves, and an understanding that agencies need to exchange information and data smoothly to coordinate systems of care.

Recommendation CCO-SR-1, Priority 1 - Essential (contract change)

The legislature should require the CHHSA departments with oversight of the carve-out service system to develop and execute a reciprocal, state-level, interagency MOU. Each department providing a carve-out service will be required to submit an annual MOU compliance report to the legislature. The MOU should contain, at a minimum, the following provisions:

- Coordinating care among providers: CHHSA departments with oversight of providers of carve-out services shall engage in ongoing auditing activities of these providers to ensure that the required level of coordination of care (as noted in the local-level MOU) is occurring.
- Sharing clinical information: CHHSA departments that contract with and have oversight of providers of carve-out services shall share with the MCO historical, member-level claims data regarding MCO enrollees who are receiving Medi-Cal funded carve-out services (as permitted by confidentiality laws and regulations) to ensure the MCO has the information to coordinate care across the carve-out system.
- State-level accountability: CHHSA departments that contract with and have oversight of providers of carve-out services must designate a staff person who is responsible for ensuring the provisions of the state-level MOU are followed.
- Responsibility for paying for services: DHCS and CHHSA departments that contract with and have oversight of providers of carve-out services must develop a service matrix that lists all Medi-Cal funded carve-out services and notes the correct payer: MCO or appropriate carve-out provider (see “Clarify Payment Responsibilities” below).

The state legislature should review all state laws that restrict the sharing of health care-related information between state agencies and appropriate partners. If barriers are found, the legislature should explicitly allow the health care-related information to be shared among state agencies and appropriate partners.

Recommendation CCO-SR-2, Priority 3 - Ideal system

CHHSA, in cooperation with the appropriate partners, shall develop a local level MOU that shall contain, but not be limited to, the following elements:

- Establish the basic elements of care coordination. Develop requirements for activities needed for coordination of carve-out services to ensure that each organization will have the same expectations for responsiveness. For example, the MOU should establish response time requirements for inquiries from carve-out system partners (e.g., any phone call about a shared member should be returned within 24 hours), and establish a process to inform carve-out system partners about the correct staff contacts (e.g., supply carve-out partners with updated contact lists of agency staff on a quarterly basis).
- Interagency team development. Establish and delineate the responsibilities of a local interagency team initiative to assist in coordinating care.

Recommendation CCO-SR-3, Priority 1 - Essential (contract change)

CHHSA shall identify and clearly delineate the appropriate party for claims payment.

CHHSA should use the following mechanisms to communicate payment clarification:

- Service matrix. CHHSA shall develop and maintain a state-level internet-based service matrix that lists all carve-out services and notes the appropriate payer. The state should work with all appropriate partners in the development of the service matrix and ensure that the information is widely distributed. The matrix shall be a part of the state-level MOU and be inserted into the MCOs' and carve-out providers' contracts.
- Web site. CHHSA shall develop and maintain a Web site designed to present policy clarifications specific to payment issues. The site should have an area designed to accept questions and post responses. This site should be open and available to anyone to review. It would serve as a single information point for members, MCOs, and providers to access managed care and carve-out payment policy information.