Framing the Issue

Care Coordination Advisory Committee

August 22, 2018

Framing the Issue

There is no single comprehensive set of care coordination standards across the multiple Medi-Cal delivery systems. This project began as an effort to look at this issue specifically for Medi-Cal managed care. However, we also hope this project can inform ideas for the broader Medi-Cal delivery system.

Care Coordination in Managed Care Plan (MCP) Contract/All Plan Letters (APLs)

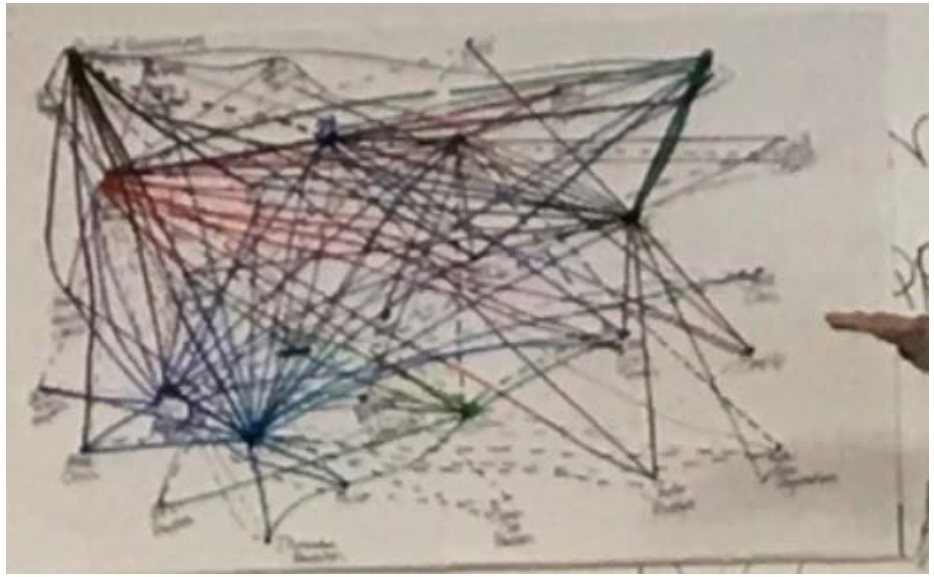
- Utilization management, continuity of care, complex case management, discharge planning and authorizations standards
- Preventive services
- Disease management and condition-specific standards of care
- Person-centered planning
- Identify health education and cultural linguistic needs
- Required assessments/screenings
- Required referral types and mandated Memorandum of Understanding (MOU) with other delivery systems (e.g. mental health, California Children's Services (CCS), regional centers)
- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies
- Health Homes Program requirements

Care Coordination Functions in MCP Contract and APLs

- Varies by aid code and plan (e.g. Senior Persons and Disabilities (SPDs))
- For care coordination components – outside administrative functions and assessments; lacks actionable requirements, instead uses broad terms/concepts
- Case management focuses on actions of the provider and lacks required actions of the plan
- “Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified…”
  - Focus is around coordination of services outside the MCP contract

Framing the Issue

As you would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care.



Mapping of local care coordination network for individuals with complex medical needs, who are chronically homeless or housing unstable and have BH needs. Mapping done with hospital partners, housing providers, MCP, MHP in San Bernardino County

Carved Out Services

Below is a list of examples of benefits or services carved-out of Medi-Cal Managed Care Plans but not intended to be an exhaustive list as carve outs vary by plan model and county

- Specialty Mental Health
- Substance Use Disorder Services
- Dental
- Long Term Care
- Home and Community Based Services
- California Children's Services
- Targeted Case Management
- High cost pharmaceuticals
- High cost procedures like transplants
- Local Educational Agency (LEA) Services
- Tuberculosis-related services
- Developmental Disability services
- Various populations and/or geographical areas

Framing the Issue

Case Study

Jackie Bender,
California Association of Public Hospitals and Health Systems (CAPH)

Goal of Care Coordination Project

Through internal and external stakeholder engagement, DHCS will explore whether a core set of standards and expectations regarding appropriate care coordination activities and requirements can be developed within and among all the Medi-Cal delivery systems. In addition, this project will look at the current structure of the delivery system and assess opportunities for improvement, potentially as a part of the upcoming renewals of our 1115 and 1915b Waivers.

Mechanics of Care Coordination

DHCS will look at all components around care coordination:

- Population health management
- Wellness, prevention and screenings
- Assessments of risk and need
- Case management and care management
- Transitions in care
- Fragmented delivery system
- Data Sharing and Integration
- Member and provider communication
- Governance and community activation
- Workforce and training
- Monitoring through meaningful metrics

Framing the Issue

- Evaluate existing statute, regulations, contract language, policy letters, and health assessments regarding Care Coordination through a systemic assessment
- National perspective and best practices, etc.
- Evaluate current care coordination practices through onsite visits and key informant interviews – plans, counties, providers, consumer advocates, etc.
- Create an internal DHCS Care Coordination workgroup
- Document key coordination and transition points, factors that influence better care coordination and factors that have a negative impact on care coordination

Advisory Committee

- Create a short-term Care Coordination workgroup to discuss findings of the department and formulate recommendations
- Workgroup would be comprise of: MCPs, counties, providers, consumer advocates, sister departments and internal DHCS staff

Final Summary Paper

- Draft a concept paper with roadmap for enhancing care coordination in Medi-Cal Managed Care
- Re-engage workgroup to vet paper
- 30-day Public Comment Period

Potential Implementation Activities

- Internal DHCS staff training
- External partners training(s) and/or webinar(s)
- Waiver renewal planning (1115 and 1915b)
- Statute/Trailer bill changes, if necessary
- Contract changes and updated policies and procedures through contract deliverable process
- APL/DPLs/INs
- Technical Assistance Guides (TAGs) and Clinical Implementation Support Guides (CISG)
- Monitoring and compliance plan
- Quality metrics

Questions?

Site Visit Learnings


CARE COORDINATION
OUTREACH
Areas served by interviewees

Site Visit Learnings

Main Components

- Evaluate carved-out services
- Build a care coordination framework/strategy
- Funding flexibility

Evaluate Carved-Out Services

- Separate funding streams create duplication of services, reporting requirements, administrative overhead, quality metrics, compliance oversight, etc. and competing for the same provider resources instead of mobilizing all toward one goal.
- Complicated funding sources makes for bifurcated care coordination – “when everyone is responsible, no one is responsible”.
- Humans are not “categorizable”.

Evaluate Carved Out Services

- Multiple delivery systems reduce plans ability to do proper risk stratification and case management due to a lack of data availability and layers of confidentiality mostly driven by carve outs
- Staff and resources dedicated to just coordinating carve-outs; not a lack of governance but fuzzy roles and responsibilities
- Cost to the system and beneficiary

Evaluate Carved Out Services

- Trust matters in large transitions; strategy around trust building will be necessary for success of carving-in services
- Entities should be using nationally used clinical guidelines to authorize services (e.g. not “medical necessity criteria” built to separate mild/moderate from specialty mental health)
- Need to consider the role county departments play in carved-out services and how they would remain integrated into the systems

Evaluate Carved-Out Services

There needs to be a plan for sharing state level data with managed care plans to improve care coordination across delivery systems, and/or the state should provide clear direction/instruction regarding privacy rules to local entities to allow for better local data sharing.

Care Coordination Framework

Need care coordination framework/strategy to appropriately meet the needs of all Medi-Cal members-- including our complex patient population-- while focusing on administrative burden reduction on our providers and plans. The only way to better self-manage and have upward mobility, is to address the social determinants of health.

- Model of Care
- Standardization
- Assessment Fatigue
- Evaluate the Delivery System
- Eligibility Concerns Impacting Outcomes

Care Coordination Framework
Model of Care

- Ensure needs of all members are met through disease prevention and education
- Ensure we are meeting the behavioral, developmental, physical, and oral health of all members
- Care coordination needs should be derived from data driven risk and need stratification
- Complex Case Management or Care Management that is individualized/personal and meets the member where they are:
    - Point of Services Care Management (inpatient and outpatient)
    - Community Based Care Management
- Address social determinants of health, focus on reducing disparities or inequities
- Ensure proper care coordination through key transitions in care, especially to the most vulnerable members
- Delegated entities must be held accountable for all requirements of any new model of care

Care Coordination Framework Standardization

- Policy alignment, when possible with Department of Managed Health Care, National Committee for Quality Assurance (NCQA), Medicare, Covered CA
- Look into benefits of NCQA accreditation for plans and delegated entities
- In general, where there are existing practice guidelines, don't re-invent but defer to such entities such as U.S. Preventatives Services Task Force, American Academy of Pediatrics Bright Futures
- Make care coordination more predictable across all plans with standard definitions and population health management requirements at state level
- Provide direction on plan oversight of delegated entities around complex case management and/or care management

Care Coordination Framework Assessment Fatigue

In addition to DHCS required assessments and care plans, health plans and providers conduct their own case management assessments to assess risk level/ need and build individual care plans for members. As does Mental Health, Substance Use Disorders, Department of Developmental Services, In-Home Supportive Services, etc. This has created massive assessment and care plan duplication within the system.

- Focus on risk stratification, only build care plan for high risk members; don't build aid code-driven policies
- Members, providers and plans are experiencing extreme assessment fatigue and don't feel it is yielding better outcomes
- Reduce/Redesign State required assessments: Initial Health Assessment (Staying Health Assessment/Individual Health Education Behavioral Assessment), Health Information Form/Member Evaluation Tool, Health Risk Assessment, Ages and Stages Questionnaire-3, Universal screening for Early Intervention/Developmental Disability
  - NCQA requires additional assessments
  - Providers require additional assessment/screenings
- Assessments should be linked to resources; shouldn't ask questions if there isn't a clear path to services, resources or benefit
- Better identify community assets and resources and provide such information to the members and providers

Care Coordination Framework
Evaluate the Delivery System

- Review fee-for-service (FFS) Only and Voluntary FFS Aid Codes or Geographical Areas
- Review exemptions for opting into FFS
- Evaluate populations that are currently outside managed care (e.g. foster care)

Care Coordination Framework
Eligibility Impacting Outcomes

- Incorrect contact information impedes plans' and providers' ability to do outreach and properly engage members
- County-to-county transfer delays
- High-need jail re-entry enrollment
- Find better eligibility solutions for homeless, e.g. regional model, as opposed to county-limited eligibility
- Ability to change managed care plans month-to-month

Funding Flexibility

- Managed care rate setting based on combination of individual health plan costs and county average.
- Explore ways to add outcomes focus in rate-setting
- Explore shared savings model or Pay-for-Performance models
- Explore aligning directed payments to larger strategic plan
- Federally Qualified Health Center (FQHC) payment reform and alignment within larger strategic plan for quality

Funding Flexibility

Review benefit to ensure we can meet the need of members or explore in-lieu of services

- The adults needing long-term supportive services are becoming younger and younger
- No sustainable options in the community for board-and-care
- Wrap-around services in the community to get people out of institutions and into the community
- Historically, health plan complex case management is clinically focused and doesn't address the social needs/barriers of members, especially members experiencing homelessness
- Tracking of data is driven by what is reimbursed

Services Requested

- Respite or recuperative care
- Sobering centers
- Jail Re-entry coordination
- Psychosocial aspects of care, including non-clinical care coordination like Community Health Workers (CHWs)/peer support
- Home and community-based services like habilitation, private duty nursing, congregate living facilities, support services provided in a licensed residential facility (short-or-long term), minor home repairs and adaptive equipment
- Housing liaison services
- Mobile triage team – street-based care team
- Patient health coach
- Specialty consults
- Community paramedics (EMS)
- Personal care services (if member can't self-direct IHSS, or to supplement IHSS or until IHSS is in place)
- Meals (home-delivered)

Questions?


TIME FOR
LUNCH
TIME FOR

Guiding Principles

- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals
- Build a data-driven population health management strategy to achieve full system alignment
- Meet the behavioral, developmental, physical, and oral health needs of all members
- Focus on assessing and addressing social determinants of health
- Focus more on value
- Focus more on outcomes
- Look to eliminate or reduce variation across counties and plans
- Support community activation and engagement
- Improve patient and provider experience
- Lower cost trends or reduce overall cost

Model of Care

"Population medicine is the design, delivery, coordination, and payment of high-quality health care services to manage the Triple Aim for a population using the best resources we have available to us within the health care system. Much of the efforts today such as the Accountable Care Organization, risk stratification methods, patient registries, Patient Centered Medical Home, and other models of team-based care are all part of a comprehensive approach to population medicine…Effective population management will require new partnerships among providers and payers, integrated data support, redesigned IT structures, a focus on non-traditional health care workforce, new care management models, and a shift from fee-for-service delivery to bearing financial risk."

http://www.ihi.org/communities/blogs/population-health-population-management-terminology-in-us-health-care

Current Care Coordination Requirements for MCPs

- Coordination of services for all medically necessary services, including preventive services, delivered both within and outside the plan's provider network
- Guidance varies regarding expectations of care coordination and, roles and responsibility of coordinating in and out of plan services
- Varies by aid code or plan type
- No overall plan risk stratification process
- Lacks focus on data driven systems
- Multiple components but lacks overall framework and strategy
- Allows for great variation by plan

Process-Focused Requirements

- Utilization Management (including Drug Utilization Review)
- Continuity of Care
- Authorization Standards
- Referral types and mandated MOUs with other delivery systems
- Immunization Registry Reporting
- Policies and Procedures for Out-of-Plan Coordination

Care Coordination

- Basic and Complex Case Management
- Medicare Coordination
- Discharge Planning
- Targeted Case Management
- Disease Management Program
- Risk Stratification and Assessment (SPD and Pregnant Women only)
- IHA, IHEBA, HIF-MET, HRA

Key Care Coordination Points

- 1915c Homes and Community Based Services (HCBS) Waivers
- Across various periods within the lifespan (pediatric, adults, geriatric)
- Benefit transfer-moving a benefit from FFS to Managed Care
- Between patients/informal caregivers and professional caregivers
- CCS, services for children with special health care needs
- Chronic Conditions
- Coordination of benefits/other health coverage
- County/plan transfers
- County programs: 1:TCM, 2) Public Health programs like Ryan White, STDs, TB, etc.
- Discharge to home or facility: 1)IP MED/Surg and IPU, 2) Out of network transfers, post stabilization; 3)SNF
- Eligibility Changes: 1) Share of cost, 2) FFS to MC, 3) MERS
- Home Health, Hospice, Palliative Care and End of Life
- Jail/Prison Re-entry
- LEA
- Medicare Eligibility, duals
- Mental health: 1: mild to moderate, 2) transition between mild to moderate and Specialty Mental Health (SMH), 3) SMH, and 4) Cases that split between: eating disorders, dementia
- New diagnosis (e.g. pregnancy, cancer, diabetes, COPD, dementia)
- Out-of-network access (travel)
- Persons with developmental disabilities
- Pharm: In-patient/out-patient (Pharm D); medication management, carved-out medication
- Preventative services
- Provider transfers: 1) termination/block transfer; 2) continuity of care
- Regional Centers
- Social Determinants of health
- Social services: foster care, IHSS, SSI, WIC, etc.
- Transplants
- Transportation

Model of Care Framework

Population Health Management Strategy

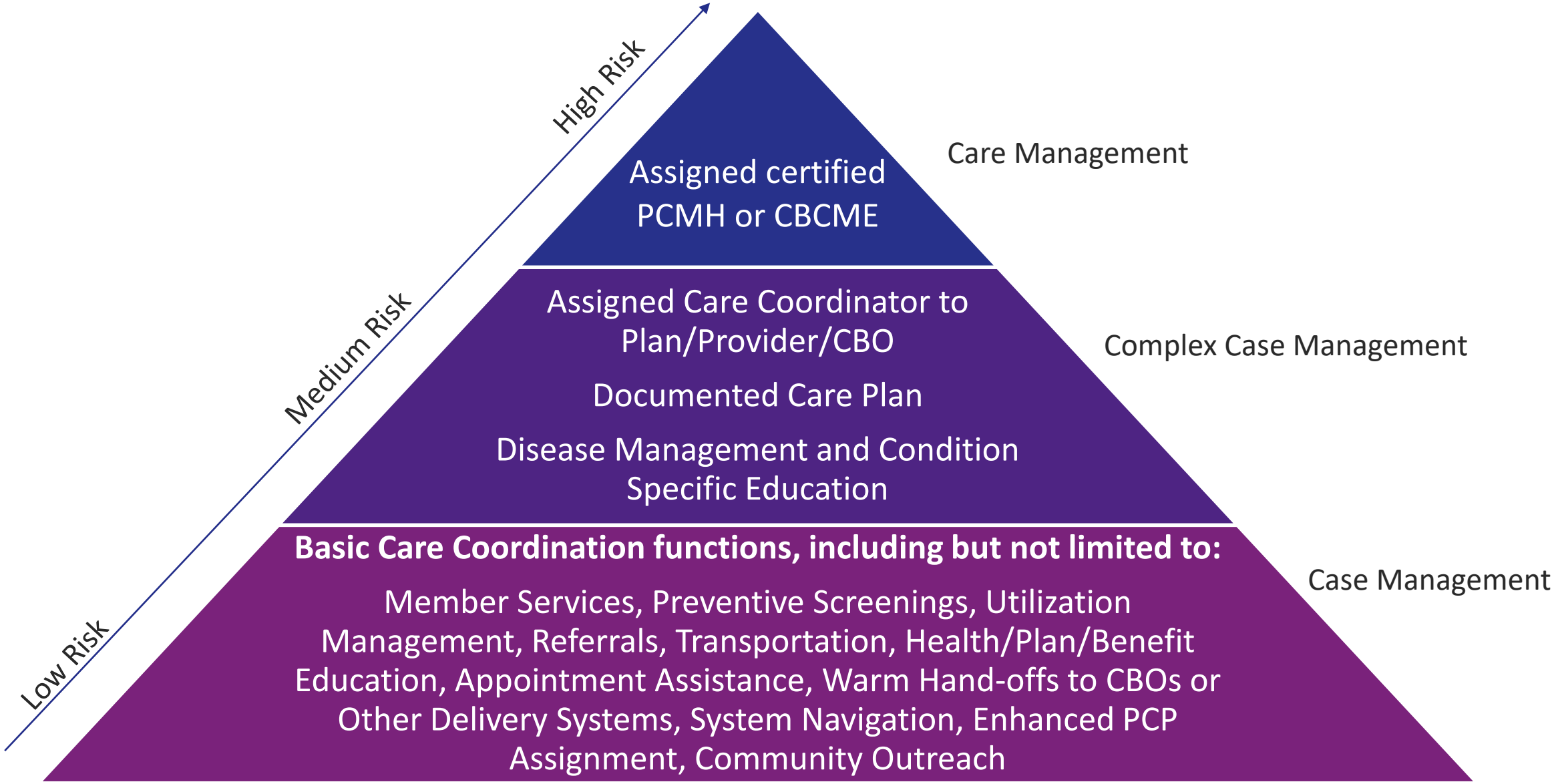
Risk stratification to identify risk and need of members to drive appropriate level of services and supports

Delivery system that uses data to drive targeted interventions and incentivizes value

Wellness, Education and Prevention

Complex Case Management and Care Management that addresses social determinants of health

Evaluate effectiveness and impact of strategy


High Risk
Medium Risk
Low Risk
Assigned certified PCMH or CBCME
Care Management
Assigned Care Coordinator to Plan/Provider/CBO
Documented Care Plan
Disease Management and Condition Specific Education
Complex Case Management
Basic Care Coordination functions, including but not limited to:
Member Services, Preventive Screenings, Utilization Management, Referrals, Transportation, Health/Plan/Benefit Education, Appointment Assistance, Warm Hand-offs to CBOs or Other Delivery Systems, System Navigation, Enhanced PCP Assignment, Community Outreach
Case Management

Factors that Influence Better Care Coordination

Accurate member contact information
Cultural awareness / identify disparities
Data sharing and integration
Funding Strategies: 1) Pay for Performance; 2) Value Based Payment models; 3) Shared Savings Models
Grouping populations by risk factors and aligning actions/resources appropriately
Health Education, Patient Engagement, Self-Management
Identifying Caregiver / Family Support
Integration of benefits within the same delivery system
Leadership Involvement and Governance
Leveraging Community Assets and Community Based Organizations
Metrics / Monitoring for Outcomes
Network Adequacy and Access to Primary Care - same day, after hours, urgent care
Person Centered Planning and Individual Care Plans, including relationship and trust with member
Personal Resources: phone, transportation, money, housing, food, etc.
Plan Integration: 1) Community; 2) County; 3) Inter-Organization; 4) Plan/MH Relationship
Preventive Health Screenings
Provider Training and Engagement
Registries and Patient Centered Medical Homes
Risk Stratification and Predictive Modeling
Team Based Care
Tracking assigned care coordinator and continuity of care coordinator
Workforce Development, Staff Training, Hiring, Retention (Community Health Workers)

Topics of Discussion for Committee

Identifying and Managing Member Risk and Need through Population Health Management Strategy

- Risk Stratification and Assess Members for Risk and Need
- Wellness and Prevention
- Transitions in Care
- Point of Care and Community Based Care Management
- Addressing Social Determinants of Health

Data Driven Solutions that Improve Quality Outcomes and Support Value Based Payment Arrangements

- Funding Flexibility
- Shared Savings Models
- Roles of 2020 1115 Waiver and MH 1915b Waiver

Reduce Variation and Complexity across the System

- Plan Accreditation
- Review FFS Only/Voluntary FFS Aid Codes or Geographical Areas
- Eligibility Concerns Impacting Care Coordination
- Pros/Cons/Challenges/Considerations for Carving-in Benefits to Managed Care

Committee Agenda Overview

August 22	• Framing the Issue and Model of Care Introduction
August 29	• Plan Accreditation, Prevention and Assessing Risk and Need
September 6	• Transition in Care, Point of Care and Community Based Care Management and Social Determinants of Health
September 25	• Organized Delivery Systems and Eligibility
October 5	• Funding Flexibility
October 29	• Benefits and their Delivery System