CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

April 27, 2018

Anastasia Dodson, Associate Director for Policy
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Subject: Proposed Medi-Cal Managed Care Quality Strategy Report

*Submitted via: publicinput@dhcs.ca.gov*

Dear Ms. Dodson:

The California Association of Public Hospitals and Health Systems (CAPH) appreciates the opportunity to submit comments on the Department of Health Care Services' (DHCS or the department) proposed Medi-Cal managed care quality strategy. In particular, we appreciate that the department is bringing together quality strategies from across multiple delivery systems into a single document for the first time. We believe this is the beginning of an important conversation to harmonize and streamline the requirements across systems as much as possible. Such harmonization could help reduce variation and improve the experience of Medi-Cal beneficiaries, plans, and providers as they work within and across delivery systems.

As you know, CAPH represents California's 21 public health care systems that are owned or operated by counties, special county hospital authorities, and the University of California medical centers (PHS) who deliver primary, specialty, emergency, and inpatient care through their hospitals, clinics, and physician networks to all who need it, regardless of ability to pay or circumstance. Many of our members also deliver services under or collaborate closely with the same county entities that operate other portions of the Medi-Cal managed care program, such as specialty mental health and substance use services. As core safety net providers to California's low-income population, public health care systems serve 2.85 million Californians and provide over 10 million outpatient care visits each year. They operate half of the state's top-level trauma and burn centers, and train more than half of the state's new physicians.

California's public health care systems are undertaking ambitious delivery system reforms that aim to improve the quality of care for all of their patients, including Medi-Cal managed care beneficiaries. Despite representing just 6% of all hospitals in the state, CAPH members operate in 15 counties where 80% of the state's population lives, and provide 35% of all hospital care to Medi-Cal beneficiaries in the communities they serve. The improvements in quality within public health care systems therefore have significant impacts on the quality of care delivered in the Medi-Cal managed care program as a whole.

For example, under the state's 1115 waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, public health care systems are using evidence-based quality improvement methods to achieve ambitious, year-over-year performance improvement targets on roughly 100 clinical measures. Federal funding for this program is contingent on meeting these targets. In addition, public health care systems are undertaking quality improvement efforts through the Quality Incentive Pool (QIP), a newly approved



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performance program for public health care systems in Medi-Cal managed care. The QIP will increase the amount of funding for public health care systems that is contingent on quality in four areas: primary care, specialty care, inpatient care, and resource utilization.

These quality improvement efforts under PRIME and QIP complement Whole Person Care, which aims to improve the health and well-being of high-risk, high-utilizing patients. The Whole Person Care program seeks in part to address the challenges inherent in having multiple delivery systems within the state and within each county, and works to overcome those barriers though data exchange, collaboration, and flexibility to expand services to address important social determinants of health, such as involvement in the jail system or lack of housing, to truly meet patients' needs. Across these programs,[1] public health care systems are reporting and undertaking quality improvement efforts on nearly 100% of the external accountability set, the measure set DHCS uses to hold plans accountable for quality.

Our comments on the managed care quality strategy are grounded in the experience of these program and more than a century of our members' experience in caring for our state's most vulnerable residents.

1. **Care Coordination Across Managed Care Delivery Systems**

CAPH appreciates that the state's strategy document marks the first time that the quality strategies across delivery systems are being combined. We are also encouraged by DHCS' parallel efforts to examine the challenges of care coordination within and between delivery systems through its care coordination site visits currently underway, with the objective of creating a core set of standards and expectations for Medi-Cal managed care health plans and their partners.

As CAPH's members have reflected, there is not one single approach to care coordination that fits all beneficiaries. In general, care coordination is best delivered closest to the patient. While some patients are self-sufficient and may just need short-term coordination to address an isolated acute episode, other patients need sustained care coordination over time, delivered by a trusted individual or team, often outside of the traditional clinical setting. For these patients, the coordination may involve providers across more than one delivery system, more than one level of care, and those that operate outside of the health system such as housing and benefits coordinators. In many ways, as the complexity of the coordination increases, so too does the documentation burden, so much so that providers and counties are discouraged from billing because it is overly onerous and may present audit risks. We appreciate that DHCS is taking these experiences into consideration as it develops standards for coordination. **We ask that any future care coordination guidelines or framework acknowledge the wide array of service models that may be needed within the Medi-Cal population; ensure appropriate but not onerous documentation and reporting requirements; and ensure providers are adequately reimbursed for the coordination they do, even when coordination takes place across delivery systems and funding streams.** CAPH looks forward to continuing to work with DHCS as future guidelines are developed.

2. **Importance of Continuous Eligibility in Medi-Cal**

National research indicates that Medicaid enrollees often experience gaps in their Medi-Cal enrollment, especially among non-disabled, non-elderly adults, and that this lack of continuity has impacts on quality

[1] Individual plans and public health care systems often have performance accountability arrangements on top of programs like PRIME and QIP, which include additional measures.

and health outcomes.[2] Data recently published by the state of California validates the national experience regarding breaks in enrollment: between October and December of 2016, 19% of completed renewals were discontinued from enrollment, and of those individuals, 83% were not re-enrolled in the subsequent 90-day period.[3]

Lack of continuous coverage is particularly concerning for individuals experiencing homelessness, who face structural barriers in the Medi-Cal program for obtaining and keeping their Medi-Cal coverage. Recent analysis by one California county found that among homeless individuals who started with Medi-Cal (100%), 31% had become disenrolled from Medi-Cal after a 24-month period, though they were still homeless and presumably still qualified for benefits. Of the initial group, another 13% had transferred to another county, only 55% of the overall starting group remained on Medi-Cal within the county. Homeless individuals may experience higher rates of non-renewal due to the fact that they likely are not filing taxes, and therefore are not known to the "federal hub" against which states can check to help process automatic renewals. These individuals are required to process a paper renewal, sent by mail to the beneficiary; for homeless individuals this is obviously a challenging means of receiving important communications.

Furthermore, this lack of continuity in Medi-Cal coverage and plan enrollment leads to missing data and an inability to monitor the quality of care delivered to this population. Plans are required to report numerous measures, as indicated in the quality strategy, including five quality metrics that have target performance rates (pages 16-18 of the draft quality strategy). All five of these measures, and most of the External Accountability Set measures, require some period of continuous enrollment in the plan, with many requiring 12-months or more. Thus the existing quality measures are only capturing information for individuals with stable enrollment, which means that critical insights into care for our most vulnerable patients cannot be made under the existing framework.

**As a way to begin examining the actual experience of breaks in enrollment in the context of quality, CAPH recommends that DHCS include continuous enrollment data as a component of plan quality dashboards and reports.** CAPH recommends publishing the length (in member months) of mandatory Medi-Cal managed care beneficiary enrollment, by aid-code grouping, county, and plan, with data broken down by statistically appropriate means such as quartiles. For instance, such data could illustrate that among non-elderly adult beneficiaries, the median length of enrollment for a given plan in a given county was 20 months, while the bottom quartile of beneficiaries were enrolled for 8 member months or less. In addition, DHCS should publish information about the reasons for disenrollment. It appears that DHCS used to publish monthly disenrollment reports,[4] but that the reports stopped in 2014. Data available on the Department's Open Data Portal includes some information about reasons applications are denied, but at a less granular level than what was previously available, covering only 3

[2] Ku, Leighton and Steinmetz, Erika. "Bridging the Gap: Continuity and Quality of Coverage in Medicaid." School of Public Health and Health Services, George Washington University. September 10, 2013. Available at http://ccf.georgetown.edu/wp-content/uploads/2013/09/GW-Continuity-Report-9-10-13.pdf. Accessed 4/26/2018.

[3] "California Eligibility and Enrollment Report: Insurance Affordability Programs." California Department of Health Care Services and Covered California. Reporting Period Oct. 2016 – Dec. 2016. Available at http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/ABX1_1CA_Eligibility_Enroll_Data_Oct-Dec2016.PDF. Accessed 4/26/2018.

[4] Reports from dates in 2014 and earlier are available at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDDisenrollments.aspx. Accessed 4/28/2018.

categories as opposed to the previous 29, and is county, but not plan, specific.[5] Continuous enrollment information at the plan/county level, combined with information about quality, is critical for understanding and supporting improved care for all populations in the Medi-Cal program.

### 3. Incorporating the Impact of Social Determinants of Health

According to the World Health Organization, the social determinants of health – issues such as poverty, lack of education, unstable or no housing, foster care history, jail involvement, hunger, and un- or underemployment – create disparities in care that can be avoided. The social determinants of health are:

> *the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.*[6]

There is widespread acknowledgement in the health services field that the social determinants of health have a negative impact on health, particularly among California's most vulnerable patients who are served by public health care systems. However, we are in the early stages of understanding how health care systems can leverage their resources to address these underlying issues and how to measure our success in those endeavors. Medicaid agencies, including in California, are experimenting with incorporating strategies to address the social determinants of health into their programs. Massachusetts, for instance, is experimenting with building social determinants measures into a risk adjustment model for plans, accounting for factors such as housing stability and neighborhood stressors, among other items.[7] In California through the Whole Person Care pilots, we are working to coordinate care across delivery systems, including health, mental health, and substance use services, and to bring partners together such as jail, housing, eligibility, and other social supports to address all the needs of the patient.

The movement to incorporate social determinants of health into health care services population and quality monitoring is still in its infancy. Enrollment, utilization, and quality data is not yet stratified, for example, based on housing stability, or linkage to other benefits like CalFresh. And relatedly, there is no systematic method in California of authorizing or tracking managed care plan investments in social determinants that could impact health outcomes. California should be a leader in addressing the social determinants given that approximately one-third of the state is enrolled in the Medi-Cal program, meaning there is widespread poverty in our state. **CAPH recommends that the state convene a group of experts that includes plans, safety-net providers, consumer advocates, and other subject matter experts to identify ways in which DHCS can support sustainable plan and provider investments in social determinants of health, what the anticipated outcome from this investment would be, and then ultimately how to incorporate social determinants of health into quality monitoring and oversight. This group should work together to leverage existing models underway in California and establish a foundation that can be strengthened over time.**

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[5] Medi-Cal Annual Renewals by County. CHHS Open Data Portal. https://data.chhs.ca.gov/dataset/medi-cal-annual-renewals-by-county. Accessed 4/26/2018.

[6] Word Health Organization. http://www.who.int/social_determinants/sdh_definition/en/. Accessed 4/26/2018.

[7] Breslin, Ellen and Lambertino, Anissa. "Medicaid and Social Determinants of Health: Adjusting Payment and Measuring Health Outcomes." Health Management Associates. July 2017. Available at https://www.shvs.org/wp-content/uploads/2017/07/SHVS_SocialDeterminants_HMA_July2017.pdf. Accessed 4/26/2018.

**4. Continue Building on Disparities Work**

CAPH is pleased that the department and plans are working to reduce health disparities in the managed care quality strategy, both through data collection and reporting, and through targeted performance improvement projects. This work is strongly aligned with efforts underway in California's 21 public health systems, which serve a diverse, low income patient population who are generally more at risk for poor health outcomes and often experience health disparities. All of California's public health care systems are undertaking concurrent and harmonized efforts to use data to identify and reduce specific health disparities. Through the PRIME program, public health care systems must capture granular population data, analyze that data to identify disparities, develop a plan to address a specific identified disparity, and execute that disparity reduction plan.

To date, PRIME has required systems to begin collecting sexual orientation and gender identity (SO/GI) data, and improve the collection and stratification of granular Race, Ethnicity and Language (REAL) data. Beginning in PRIME's third program year (July 2017 - June 2018), public health care systems began using the REAL data collected in the first two years to identify a specific disparity (e.g., blood sugar control, blood pressure control) for a specific population, and create a plan to reduce that disparity. Now that the plans have been developed, federal funding will be contingent on demonstrating year-over-year improvements in quality and health outcomes for the target disparity population and closing the gap between current performance and a high performance benchmark. This year-over-year target setting methodology should improve care and outcomes among the identified disparity populations as compared to the larger public health care system population, and thus will reduce the performance disparity between the two.

CAPH is encouraged that Medi-Cal managed care plans are undertaking similar efforts. We look forward to the inclusion of HEDIS measures stratified by demographic variables, and the individual plan performance improvement projects, in future EQRO reports. **In addition, CAPH recommends that DHCS publish the stratified HEDIS measures at the plan level to help make the data actionable and to support alignment of efforts at the plan and provider levels.** This information could help public health care systems, plans, and other partners align their disparity reduction efforts for a more effective, coordinated approach to disparities reduction at the local level.

CAPH appreciates the department's ongoing commitment to quality improvement in Medi-Cal managed care. As the department works to oversee quality within and across delivery systems, it will be important to continue streamlining programs, harmonizing where possible across delivery systems, and identifying which quality measures are the most impactful in order to support focused, meaningful quality improvement. If you would like to discuss any of the above recommendations, please feel free to contact us.

Sincerely,

Original Signed by

Jacqueline A. Bender
Vice President of Policy