Care Coordination Advisory Committee
October 29, 2018
Meeting Summary

The Department of Health Care Services (DHCS) held the final of six Care Coordination Advisory Committee meetings on October 29, 2018. The meeting was attended by invited committee members, staff from other state agencies and the Legislature, and members of the public. Jacey Cooper, Assistant Deputy Director of Health Care Delivery Systems facilitated the meeting, with support from other DHCS leadership and staff.

This meeting focused on Medi-Cal benefits and their delivery systems.

Meeting materials.

Discussion Summary

Jacey Cooper opened the meeting by summarizing the topic – the complex delivery system and numerous "carved-out" benefits, and the need to have a conversation around the pros, cons, and considerations around what is carved-out and what perhaps should be carved-in. She reminded committee members that the key "Guiding Principle" for today's conversation was:

> Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize towards common goals.

California Behavioral Health Directors Association of California (CBHDA) Presentation

Veronica Kelly from San Bernardino County and Dawan Utecht from Fresno County jointly presented on behalf of CBHDA. They discussed the types of behavioral health services that are provided by Medi-Cal today, including the sources of funding, the people who are served, and the services provided. While Medi-Cal managed care plans and Fee for Service (FFS) offer some behavioral health services, Veronica and Dawan explained the complex funding sources and programs that are the financial and programmatic responsibility of the counties. They presented four key strategies to achieve better outcomes in the behavioral health system:

1. *Promote regional approaches* to planning, administrating and delivering services
2. *Increase financial efficiency & effectiveness* by transitioning away from fee-for-service and toward value-based payment models
3. *Promote care coordination* by ensuring bi-directional access to physical and behavioral health, reducing barriers to care (potentially including the mild/moderate benefit), and building on the lessons of Whole Person Care and Health Homes Programs
4. *Support integration of mental health and substance use disorder services* by merging administration of the services and reducing siloes

A summary of the committee reaction and discussion to the presentation is below:

- Coordination of behavioral health services, and their connections to managed care, physical health, and social services, requires leadership, relationships, and the commitment of resources (full-time staff to attend meetings, etc).

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- Counties have a number of innovative approaches to serving clients and providing integrated physical, behavioral, and social services:
    - Partnerships with law enforcement, corrections, and courts
    - Partnerships with schools and foster care systems, development of child/family care teams
    - No-wrong-door approach to serving all clients in crisis, regardless of insurance status or type
    - Mental Health Services Act (MHSA) funds for prevention, early education, and housing
- Diversity of counties means that not all counties can offer the same spectrum of services to beneficiaries, and some counties have moved further towards providing integrated, high quality care.
- Counties are struggling to fulfill the responsibilities of serving as managed care plans. The administrative burden on both counties and their providers is very high.
- A regional model has some promising aspects to improve efficiency and serve clients who seek care in multiple counties, but the level of complexity may be challenging.
- Whole Person Care (WPC) and the Health Homes Program (HHP) offer promising practices on how to start thinking about moving towards a value-based payment model for county behavioral health services.
- There is a continuum of options for moving towards better integrated care, the choice does not have to be binary, as in carve-in or carve-out. For example:
    - As counties, local plans, and other partners are ready, they can move forward with more integrated partnerships.
    - A local carve-in could build on the strengths of both the plans and county, by assigning administrative functions to the plan but contract service delivery back to county providers.
    - The Oregon Coordinated Care Organizations offer another model, taking a regional approach with a single budget for behavioral and physical health.

Specialty Mental Health Services

Dina Kokkos-Gonzales, Chief, Mental Health Services at DHCS presented on Specialty Mental Health Services (SMHS) provided by county Mental Health Plans (MHPs) and the pros, cons, and considerations in thinking about carving those services in to managed care. The committee discussion on those considerations is below:

- The committee reached consensus about the value of the rehabilitative model counties use to deliver behavioral health services and the need to continue to support that model and the partnerships counties have developed to provide integrated care.
    - Ensuring ongoing contracting with county providers could both ensure the continuation of the rehabilitation model and provide continuity of care for beneficiaries.
    - Plans are moving towards considerations around social determinants of health and the rehabilitative model, although they have traditionally been built around

a medical model. There was acknowledgment that it is a cultural shift that requires a long-term commitment.

- Several committee members acknowledged that carve-outs and the FFS system are a challenge for beneficiaries with high-needs to navigate.
- Numerous committee members cited WPC as an important first movement toward better integration and better care, including providing the payment models that allow frontline staff to focus on clients rather than paperwork. Other committee members cited the need to look at these and other established best practices.
- There was significant discussion around the strengths and weaknesses of the plans and counties, and how to leverage each set of strengths under any new model:
    - Counties are able to work across their health, behavioral health, and other services (education, justice) to serve members with multiple needs. They often provide additional services outside of the traditional health care system to support beneficiaries. This type of coordination across services and wrap-around benefits should be protected.
    - Any move towards a carve-in should take into account the unique and specialized community providers in the county systems.
        - Washington State contracts offer a model, as they require contracting with certain providers, offer long periods of continuity, and other protections.
    - A plan representative noted that they can more flexibly use their resources to add services and contracts to make sure there is comparable access to services in every county.
- There was again a suggestion for a phased-in approach that can move deliberately, allow for partners to invest the resources to build the partnerships and infrastructure for integration.

Substance Use Disorder Services

Brenda Grealish Acting Deputy Director, DHCS, presented on substance use disorder (SUD) services delivered through the county, particularly Drug Medi-Cal and Drug Medi-Cal Organized Delivery System, and the pros, cons, and considerations in thinking about carving those services in to managed care. The committee discussion on those considerations is below:

- Several counties noted that while a lot of the conversation focuses on efforts around the opioid epidemic, county SUD services are broader and include treatment for alcohol and other addictions, as well as community engagement and prevention services, and not all of this work is captured in the data.
- A number of committee members discussed the challenge of understanding access in the current system: that there be a greater need for services outside the waiver, and that not all services delivered are captured in the claims data under the treat first, bill later model.
- Several committee members raised the issue of providers and workforce. SUD providers are different from mental health providers, and particularly must be specialized when

working with populations like youth, but that certification processes are new and more regulatory oversight might be good. One county noted it has been a challenge to get SUD providers up to speed on standards and utilization management.

- One plan noted that they already provide SUD services on the commercial side, but that there are nuances at the county level and a need to protect the county structure and model.
- The Oregon CCO model was again raised as potential model, as was the need to take a regional and phased approach based on the county and managed care infrastructure to any implementation plan.

Dental

Alani Jackson Chief, DHCS, presented on dental services, including FFS and dental managed care (DMC), and the pros, cons, and considerations in thinking about carving those services in to managed care. The committee discussion on those considerations is below:

- Committee members identified a key barrier, or challenge, to any carve-in as the differences between the dental and medical systems in terms of EHRs, billing codes, and quality measures.
- Committee members also identified the challenges with the DMC system that need to be avoided in any potential carve-in or integration effort: how DMC plans are siloed from the rest of the managed care plan benefit, and very low utilization/access rates.
- Several committee members discussed the potential to leverage FQHCs in integration efforts, as they often provide both medical and dental services to the same populations. This was identified as a potential area for a pilot.
- A health plan representative highlighted the potential benefits of a carve-in included having plan resources to ensure network adequacy and the ability to pull in additional resources from the medical side for specialized dental services.
- Two additional general challenges identified by committee members included the difficulty in finding providers in the FFS delivery system and the need for more outreach so that beneficiaries are aware they have dental benefits.

Long-Term Services and Supports: 1915(c) Home and Community-Based Services (HCBS) Waivers

Joseph Billingsley, Chief of the Integrated Systems of Care Division, Program Policy and Operations Branch, provided an overview of HCBS waivers and the pros, cons, and considerations in thinking about carving those programs in to managed care. The committee discussion on those considerations is below:

- There was general consensus from committee members that the waiver programs needed to be looked at individually, since they are different and serve different populations, and because they aren't all available statewide.
- Committee members also noted the need to be mindful about potential impacts to the community-based provider networks participating in the waiver programs.

- Suggestions for improving integration and coordination with waiver programs included educating the plans about the programs and encouraging them to authorize those services or make referrals.

Long-Term Services and Supports: In-Home Supportive Services (IHSS)
Joseph Billingsley, Chief of the Integrated Systems of Care Division, Program Policy and Operations Branch, DHCS and Debbi Thompson Deputy Director of the Adult Program Division from the Department of Social Services provided an overview of the In-Home Supportive Services (IHSS) program and the pros, cons, and considerations in thinking about carving the program in to managed care. The committee discussion on those considerations is below:

- A health plan suggested that an IHSS carve-in could maintain beneficiary self-direction (hiring, firing, educating their providers) and would give the plan the capacity to better leverage IHSS through referrals and assessments to prevent institutionalization and lower costs.
- A committee member suggested that there are ways to improve the partnership between IHSS and the plans that wouldn't require a full carve-in, given the complexity of the program.

Long-Term Services and Supports: Long-Term Care
Annalee Amarnath, Medical Program Consultant, Managed Care Quality & Monitoring, DHCS provided an overview of the long-term care benefit for skilled nursing facility (SNF) and sub-acute care services waivers and the pros, cons, and considerations in thinking about carving this benefit in to managed care. The benefit is already carved-in for County-Organized Health System (COHS) plans and in Coordinated Care Initiative counties. The committee discussion on those considerations is below:

- Several plans provided examples of the benefits of carving this benefit into managed care, including providing wrap-around supports for people in facilities and helping create transition plans from facilities back into the community.
- One plan also discussed how carving the benefit in can make it easier to transition a member from the hospital to a SNF if the member will need a longer than 60-day stay at the SNF, because they can work with the SNF to develop a longer-term transition plan to get the member back into the community so that their SNF stay is not indefinite.

Pharmacy
Harry Hendrix, Chief, DHCS, provided an overview of the pharmacy benefits that are carved-out of managed care, including blood factor, antiviral, SUD, and psychiatric medications, and the pros, cons, and considerations in thinking about carving those drugs in to managed care. The committee discussion on those considerations is below:

- Carving-in SUD drugs could help plans play a more active role in controlling opiate prescriptions, reducing ER utilization and health costs.
- If high-cost drugs are carved-in, rate setting will need to be reactive and able to adjust to changing costs.

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- There have been significant efforts to standardize and track data for some of the carved-out drugs, efforts that shouldn't be lost under any change.
- DHCS proposed carving all drugs out of managed care and providing the plans with real-time pharmaceutical data. The health plan committee members did not support this proposal, citing the difficulty of getting real-time data to track prescriptions, prevent overdoses, and manage and stratify risk.

Transplants
Annalee Amarnath, Medical Program Consultant, Managed Care Quality & Monitoring, DHCS provided an overview of the transplants that are carved-out of managed care and provided through FFS at centers of excellence (COEs) and the pros, cons, and considerations in thinking about carving those services in to managed care. The committee discussion on those considerations is below:

- Committee members flagged that COE providers have high volumes and specialization, which gives patients the highest likelihood of success.
- The health plans noted that they have experience covering transplants for commercial patients and contract with COEs in California and across the country, but that the Medi-Cal program may be better able to negotiate prices with the COEs.

Other County and CPE-Based Programs
In the interest of time, Jacey Cooper invited committee members to submit comments in writing.

Next Steps
DHCS welcomes any further public or committee comments through the end of the year. The next step in the Care Coordination Assessment Project will be conducting beneficiary focus groups and interviews. DHCS will be releasing the roadmap document for comment in 2019.