Care Coordination Advisory Committee
Meeting Summary: 8/29/18

The Department of Health Care Services (DHCS) held the second of six Care Coordination Advisory Committee meetings on August 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 the following topics:

- Plan accreditation, including a presentation from National Committee for Quality Assurance (NCQA)
- Assessing risk and need, and
- Preventive services and clinical screenings.

Key Discussion—please see meeting minutes for more detail and Committee comments:

- The meeting began with DHCS presenting findings from their site visits regarding accreditation. A summary is posted on the DHCS website.
- NCQA presented on its accreditation programs for health plans and delegated entities. NCQA described its value proposition as helping states, as purchasers and regulators of health care, to drive delivery system changes and streamline oversight, leaving room for the state to put more resources into improving quality. NCQA also reviewed its requirements and processes.
- Committee members asked questions of the NCQA presenters, many of which focused on what other states require from their health plans and delegates regarding accreditation.
- Following the NCQA presentations, the committee members had a broader discussion about the pros and cons of the state requiring NCQA accreditation, guided by the discussion questions at the end of the summary document referenced above. Key themes from the discussion:
    - Many plans are accredited or are seeking accreditation already, without a state requirement. They noted that it is a complex and resource-heavy undertaking that may be difficult for smaller medical groups/delegated entities.
    - Ensuring that improving quality, not increasing regulations and costs, was at the forefront of the discussion.
    - Some members felt that alignment and standardization under NCQA would be beneficial.
    - Interest in understanding what the overlap between NCQA and DHCS annual reviews would be, and how DHCS would address the gaps in NCQA requirements, specifically around basic care management.
    - Discussion around how carved-out services would be addressed through NCQA accreditation – some members shared their perspective on this issue as NCQA accredited plans.

  - Some members felt that requiring plans to be accredited would put pressure on delegated entities to move toward NCQA and lead to standardization across the entire system.
  - One member suggested first requiring plans to become accredited and then evaluating if delegates should be required to become accredited later.
- DHCS then presented on assessing risk and need, using this summary as a guide.
- Partnership HealthPlan of California presented an Assessment Library – a matrix of all the assessments they administer or interact with as a health plan.
- Debbie Thomson from the California Department of Social Services then presented on the In-Home Supportive Services (IHSS) Assessment, a functional assessment that looks at the abilities of a person to perform activities of daily living, not a medical assessment. The purpose of this presentation was to illustrate the data already being collected that could be leveraged to risk-stratify without developing and administering a duplicative assessment.
- Following the presentations, committee members discussed the topic, guided by the discussion questions in the summary document. Key themes were:
  - Emphasizing the need for timely, accurate, accessible data at the point of service.
  - The struggle with collecting data on Fee-For-Service beneficiaries, especially for dental providers working with special populations, such as pregnant women.
  - The need to assess the beneficiary's ability to self-manage their care, independent of their diagnoses/comorbidities.
  - The need to review information-sharing requirements between counties and health plans to ensure information from assessments is accessible to those who need it.
  - What should be asked on an assessment—should health plans ask about issues (e.g. housing need, other social services) that they may not be able to help with directly?
  - Need to understand provider's time restrictions and beneficiary choice when having this discussion.
- The committee then moved on to the final topic of the day, preventive services and clinical screenings, which began with an overview of the summary document. Committee members then discussed this topic, prompted by the discussion questions in the document. Key discussion points are below:
  - If a standard structure for providing a core set of preventive services and clinical screenings is required, it needs to be flexible in regard to time frame to allow for treatment of acute needs.
  - Must be evidence based.
  - Push back—hard to monitor every service provided in a delegated system. It is ultimately up to the provider to make a clinical decision.
  - Would need to account for the fact that some beneficiaries won't show up, no matter how hard the plan tries to get them into the doctor's office.

- Need to ensure that Early and Periodic Screening, Diagnosis, & Treatment (EPDST) is not lost in this—this is required whenever a concern is raised, not on a periodic schedule. Also need to look at EPSDT data as a powerful tool.
- Need to keep in mind not overburdening providers.

Next Steps for DHCS:

DHCS will consider all the committee comments and work to get materials for future meetings out to the committee as soon as they are ready.