Care Coordination Advisory Committee
Meeting Summary: 9/25/2018

The Department of Health Care Services (DHCS) held the fourth of six Care Coordination Advisory Committee meetings on September 25, 2018. The meeting was attended by invited committee members, staff from other state agencies and the Legislature, and members of the public. Mari Cantwell, Chief Deputy Director of Health Care Programs and Medicaid Director, DHCS and 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:

- Eligibility Barriers and Concerns
- Fee for Service (FFS) Only and Voluntary FFS Aid Codes/Populations or Geographical Areas

Meeting materials.

Discussion Summary

Mari Cantwell opened the meeting by asking members to think creatively about how to solve the challenges being discussed.

Eligibility Barriers and Concerns

Collecting Accurate Contact Information

DHCS Chief of Medi-Cal Eligibility Sandra Williams presented on how applicant information including contact and demographic information is collected and processed by county eligibility offices. Committee comments included:

- Emphasizing the importance of accurate telephone numbers. One health plan commented that even if they are able to track down a phone number for a member, there is no process for updating that member's contact information in the various databases that exist, and specifically in the Medi-Cal Eligibility Data System (MEDS).
    - A health plan suggested that pharmacies are more likely to have accurate contact information but there is no pathway for them to communicate that information to physicians and plans. Plans also suggested that they should be able to populate updated information in MEDS if the member authorizes them to do so.
- Many members also commented on the inability to update MEDS and add new fields noting that MEDS is an outdated system that needs to be overhauled.
- DHCS emphasized that in 2015, All County Welfare Director's Letter 15-19 stated that counties must partner with plans to develop processes to communicate beneficiary contact information changes and updates.
    - Some members emphasized the need for standardization across counties to enable efficient sharing and updating of beneficiary contact information.
- Members asked for demographic information to include disabilities, sexual orientation, and gender identity.

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County to County Transfers

DHCS presented on the county-to-county transfer process. Committee members had the following thoughts on addressing challenges with county-to-county transfers:

- There are significant IT challenges in solving any challenges that may arise if a member is changing counties.
    - CalHEERs requires some transfers to be handled manually and once someone drops off and reapplies for aid it is unable to release that person's original county of enrollment.
    - MEDS also creates a challenge in changing someone's county, especially for foster children and college students.
- Timeframes and processes for the county-to-county transfer process don't line up with the MCP-to-MCP transfer, which results in members spending time in FFS or with an out-of-county plan, creating continuity of care and access challenges.
- When beneficiaries transfer mid-month, but have already used benefits before moving, they can't be transferred to a new MCP until of the 1st of the next month due to capitation—but if a person has already used services they are likely to need more services. Can MCPs support a smoother transition? Can the state move to half month capitation? Can beneficiaries initiate the ICT, pick a new health plan, and initiate data sharing all at one time?
- There needs to be a process for beneficiaries to get services when they run into challenges with counties not releasing them to a new county in a reasonable amount of time.
- Committee members working in county behavioral health noted that it would be helpful to receive Short-Doyle data from the state, even on a six-month delay, as it would provide framework and background for diagnoses.
- It was suggested that permission to share data across the state and other organizations the could be included enrollment and renewals so that beneficiaries can sign-off on it yearly.

High Need Jail Reentry

DHCS presented on the challenges they have heard in regard to those needing to be enrolled in or reconnected to Medi-Cal following release from jail. Committee members provided the following comments:

- A major issue is having correct address for beneficiaries to send them their Medi-Cal card upon release. Would it be possible to process enrollment prior to release and hand the Medi-Cal card to them upon release rather than mailing? This would improve their ability to receive services and medication immediately upon release.
- Suspending Medi-Cal once they are in jail is a huge issue—would be helpful if they could stay enrolled and keep their same health plan to facilitate care post-release.
- There is a need to improve the information transfer both upon entry and release from jail to keep health plans informed.
- Consider putting this population in FFS for the first month of release so they can access services right away without moving into complex case management.

- The most difficult population to connect to care is those who do not go onto probation upon release—they become difficult to engage when they are not required to stay in contact with the county.

Continuous Enrollment

DHCS presented on the idea of moving towards continuous enrollment with an open enrollment period rather than allowing beneficiaries to change plans on a monthly basis. Committee members provided the following comments:

- Some members were concerned that a move to continuous enrollment would be harmful to beneficiary choice because it would default them into plans that they may not like or that may reduce their access to specialty services.
- Some members were supportive of having an open enrollment period, as the beneficiary can still change plans if they need to under specific exceptions and the plan is ultimately responsible for providing all medically necessary care for the beneficiary.
    - Continuous enrollment would enable the plan to provide ongoing comprehensive care coordination.
    - Continuous enrollment could align with Covered California policies.
    - Additionally, it would enable plans to better collect and report on HEDIS data.
- The committee offered some ways to mitigate these challenges such as:
    - Allowing for changes in the first 90 days for those defaulted into a plan.
    - Allowing exceptions if plans have quality or access issues.
    - Allowing exceptions if plan's formulary doesn't include a needed drug OR developing a state-wide formulary
        - Committee members associated with a health plan noted that this would make drugs a carve-out and negatively impact their purchasing power.

<u>FFS Only and Voluntary FFS Aid Codes/Populations or Geographical Areas</u>

Mari Cantwell presented current FFS and Voluntary FFS aid codes and populations and asked the committee for feedback in regard to which populations, if any, should be moved into managed care.

Many committee members noted that the FFS-only zip codes should be required to move to managed care, as county behavioral health plans are required to provide services in these areas and technology and increased populations have improved the ability of MCPs to provide care in these areas. Additionally, areas with provider shortages are often the best places to require managed care so that the plan can help build a network and be held accountable for ensuring access to services.

Members also called for consistency across counties and emphasized that beneficiaries eligible for both Medicare and Medi-Cal and those receiving long-term care should be required to enroll in managed care. If plans can hold the risk for long-term care, and the risk for both the Medi-Cal and Medicare (through Medicare Advantage) for these populations, they can help

provide complex care management. Plans can also help identify nursing facility beds for members who may otherwise be unable to be discharged from an acute inpatient facility.

Members agreed that California Children's Services (CCS) and foster care youth may be better served in FFS, but regardless the state should look at how to better serve these populations.