Organized Delivery Systems and Eligibility

Care Coordination Advisory Committee

September 25, 2018

Meeting Objective

The committee will discuss key components of DHCS' population health management strategy and will provide recommendations, direction, and advice concerning a core set of standards and expectations regarding appropriate care coordination activities and requirements for Medi-Cal delivery systems.

Today we will discuss:

- Eligibility Barriers and Concerns
  - Accurate Contact Information
  - County-to-County Transfers
  - High Need Jail Re-entry
  - Managed Care Continuous Enrollment
- Review Fee-For-Service (FFS) Only and Voluntary FFS Aid Codes/Populations or Geographical Areas

Guiding Principles

- Improve the member experience.
- Meet the behavioral, developmental, physical, and oral health needs of all members.
- 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.
- Focus on assessing and addressing social determinants of health and reducing disparities or inequities.
- Focus more on value and outcomes.
- Look to eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Accurate Applicant/Beneficiary Information

Accurate Applicant/Beneficiary Information

- Contact and demographic information are collected via the Insurance Affordability Program (IAP) application process within the California Health Eligibility & Enrollment System (CalHEERS) (also known as the www.CoveredCA.com portal) and the county Statewide Automated Welfare System (SAWS).

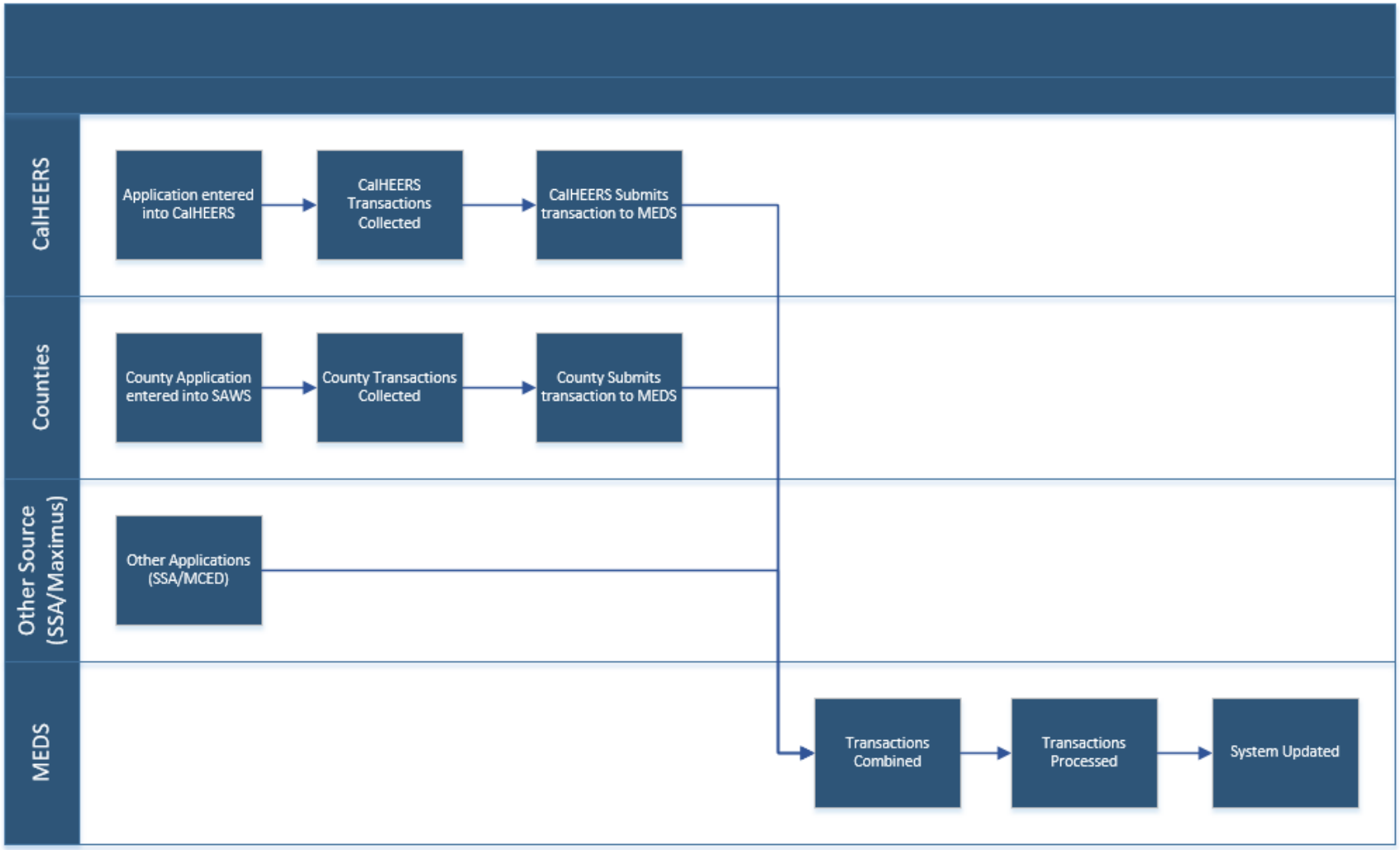
- Individuals can provide or update their contact and demographic information:
  - In Person: At the local county social services office
  - By Phone: Calling the local county social services office
  - Online: Make changes online at www.CoveredCA.com or on the county SAWS portals.

Contact and Demographic Information

Below are the contact and demographic information maintained in the Medi-Cal Eligibility Data System (MEDS):

- Case Name
- Name (Including Alias)
- County ID
- MEDS ID
- CIN
- Birthdate
- Gender
- Ethnicity - optional
- Language (Spoken and Written) - optional
- Phone Number - optional
- Email Address - optional
- Driver License Number- optional
- County of Origin
- Immigration Status
- Authorized Representative (if applicable)
- Address (Physical and Mailing)
- Death Date
- Family Size
- Relationship to Applicant

Process Flow



Discussion

- Are there existing concerns with how contact or demographic information is updated today?
- What considerations should DHCS take under advisement for updating contact or demographic information?
- Is there demographic information that is not captured today? If so, what are they?

County-to-County Transfers

Intercounty Transfer (ICT)

Requesting the Transfer

- Beneficiaries (or Authorized Representative) must report the new address within 10 days of the move.
- Beneficiaries may:
  - notify either the prior or new county to request a transfer to the new county, in person, in writing, by phone, or online using their county portal accounts.
  - tell their managed care plan (MCP), which provides updated information to county office; or
  - update address information online at their Covered California account at www.CoveredCa.com

Intercounty Transfer (ICT) Policies and Processes

- The notified county must initiate the ICT within 7 business days of notification.
- An electronic process known as an e-ICT will send the case information to the new county.
- The ICT must be completed by the new county no later than the 1st day of the next available benefit month following 30 days after the beneficiary notifies either county.

ICT Policies and Processes (Cont'd)

- During the month of transfer, counties assist beneficiaries with urgent requests for MCP disenrollment in order to access non-emergency care in the new county.
- The beneficiary must remain eligible during the ICT process.
- The beneficiary is not required to reapply in the new county.

Discussion

- What beneficiary eligibility issues are you aware of during ICTs?
- Are there certain types of cases that are more problematic when transferring to a new county?
- Are ICT concerns identified throughout the state or are they only in certain counties?
- Are beneficiaries and authorized representatives able to get needed assistance from the county offices?

High Need Jail Re-Entry

High Need Jail Re-Entry

Issue: Ensuring continuity of care for inmates who are reentering the community upon release.

Existing Policy Mitigations: The following are existing policies and procedures to ensure continuity of care for inmates transitioning from incarceration to the community upon release.

- Individuals may submit Pre-Release Applications – 60 to 90 days prior to release
  - All County Welfare Director's Letters (ACWDL)14-24 and 14-24(E)

High Need Jail Re-Entry

Pre-Release Applications

- Pros
  - If a new Medi-Cal application is required to establish eligibility, the California Department of Corrections and Rehabilitation (CDCR), County Sheriff's Office or its designee may assist the inmate with completing a pre-release Medi-Cal application.
  - If eligible, Medi-Cal eligibility would be established upon release and access to FFS Medi-Cal services will be available.

High Need Jail Re-Entry

Pre-Release Applications

- **Pros (Cont.)**
  - Pre-Release Applicants can complete the Medi-Cal Managed Care Enrollment Packet to access Medi-Cal Managed Care Provider services as soon as possible.
  - Though not mandated, counties may assist soon-to-be-released county jail inmates with Medi-Cal applications 60 to 90 days prior to their release to ensure coverage is active at the time of release. (ACWDL 14-24 and 14-24 (E))

High Need Jail Re-Entry

Pre-Release Applications

- **Cons**
  - Processing pre-release applications is a very manual process.
  - Tracking pre-release applications is handled manually outside county systems.
  - Process relies heavily on coordination and communication between counties and CDCR/Sheriff's Office.
  - If county is not made aware of any changes to the inmate's parole date, release date, residence address, or etc., in a timely manner, pre-release applications may be delayed.

High Need Jail Re-Entry

Pre-Release Applications

- **County Jail Pre-Release programs**
  - Some counties have established tailored, county-specific programs
    - Not a DHCS requirement
  - Examples of County Jail Pre-Release processes and programs that work
  - Challenges with County Jail Pre-Release programs

Discussion

- Should DHCS require pre-release applicants to submit completed Health Care Options Managed Care Plan choice packets along with the Pre-Release Application 60-90 days prior to release?
- To help ensure a more seamless transition and proactive care coordination, can CDCR/County Sheriff's Offices share electronic health records data on the care inmates have received while in prison to the county/plan?
- Establishing Pre-Release programs for county jail inmates has not been an requirement of DHCS for county human services agencies to date. Should DHCS make this a requirement?

Managed Care Continuous Enrollment

Managed Care Enrollment

Managed Care enrollment is dependent upon model type:

- Managed Care enrollment in a County Organized Health System (COHS) MCP is currently continuous.
  - Continuous enrollment means the members may only switch MCPs at a specific enrollment period.
- Managed Care enrollment in a Non-COHS MCP is not continuous, as the member can switch plans on a month-to-month basis.

Managed Care Enrollment in COHS Plans

- Once eligibility is determined in a COHS county, the enrollment process for the Medi-Cal member begins and the member will be mandatorily enrolled in that MCP starting the following month.
  - Medi-Cal members may receive services temporarily through FFS during the enrollment process.
- When enrolled, members may request out-of-network (OON) access through the plan.

Managed Care
Enrollment in Non-COHS Plans

- Medi-Cal beneficiaries select a plan through the choice packet within 30 days of being found eligible. If they do not choose, they are auto-assigned.
- Members may change health plans at any time by calling Health Care Options.
- Members can request a Medical Exemption Request to complete a course of treatment for up to 12-months through the FFS delivery system. Members may re-request annually.

Importance of Continuous Enrollment

- Care coordination
- Monitoring
- Data collection and analysis

Managed Care Continuous Enrollment Considerations

Pros	Cons/Challenges
• Greater possibility that members will meet criteria for EAS measurement standards • Allows for improved care coordination efforts • Affords ongoing coverage of services such as prescriptions, etc. • Reduces potential for fraud, waste and abuse • Eases member frustrations with multiple requests for required assessments • Provides the opportunity to build a comprehensive member medical record • Easier to project enrollment and trends	• New practice/process • Limits flexibility • Could restrict the ability to utilize specific PCPs and Specialists • Limits member choice • Limits member access • Transition period for members and stakeholders

Discussion

- Should DHCS consider implementing continuous enrollment?
- If DHCS was to enact a continuous enrollment how should it be implemented?
  - How long would the enrollment period last?
  - Are there certain populations that should be excluded? Or certain populations that should start implementation first?
  - Should there be exceptions and if so for what? (change in diagnoses, invalid mailing address)
  - What would be an appropriate timeline for implementation?
- If DHCS was to enact a continuous enrollment, how would this affect the homeless/transient populations?

Review FFS Only and Voluntary FFS Aid Codes or Geographical Areas

FFS Only and Voluntary FFS Aid Codes or Geographical Areas

- Decisions regarding the enrollment of certain categories of individuals have evolved over the last several decades.
- Specific circumstances and thinking led to historical decisions regarding the inclusion, exclusion or voluntary nature of certain types of individuals or those residing in certain geographies from Managed Care enrollment.
- Additionally, the inclusion/exclusion and voluntary/mandatory requirements differ across counties.
- It may be worth revisiting these decisions to determine if perhaps another direction may be most appropriate and beneficial for the Medi-Cal population.

Discussion Questions

- Are there particular excluded populations that could benefit from managed care enrollment (either voluntary or mandatory)?
- Are there particular included populations that may best we served outside of managed care?
- Should requirements/allowances regarding enrollment be standardized statewide?
- Should DHCS consider including all zip codes in the Medi-Cal Managed Care program across California?

Committee Discussion

Next Meeting

Funding Flexibility

- Shared Savings Models
- Value Based Payments
- In-Lieu of Services
- Regional Model Approach
- FQHC Payment in Managed Care