Benefits and their Delivery System

Care Coordination Advisory Committee

October 29, 2018

Meeting Objective

The committee will discuss key components of DHCS' population health management strategy. It 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:

- Pros, Cons and Considerations of Services Carved out of Medi-Cal Managed Care Plans
- Recap of Committee Discussion
- Next Steps

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.

CBHDA Presentation

Specialty Mental Health Services

Specialty Mental Health Services Background

- The Medi-Cal Specialty Mental Health Services (SMHS) program operates under the authority of a 1915(b) waiver.
- DHCS is responsible for administering the Medi-Cal SMHS Waiver Program, which provides SMHS to Medi-Cal beneficiaries through County Mental Health Plans (MHPs).
- MHPs are required to provide or arrange for the provision of SMHS to beneficiaries in their counties who meet SMHS medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals as documented in the beneficiaries' client plans.

Specialty Mental Health Services

Pros	Cons/Challenges
• Potential for improved beneficiary care coordination and cost effectiveness of services. • Leveraging the “in lieu of” provisions of the Medicaid Managed Care Final Rule. • Mitigating existing coordination of care issues among MCPs and MHPs. • Eliminating confusion related to which service delivery system should provide a beneficiary’s mental health services. • Eliminating duplication of covered services (currently MCPs and MHPs both cover psychotherapy and medication support services). • Streamlining claiming by transitioning to a capitated payment. • Reducing or eliminating complex claiming and systems issues. • Ease of working with MCPs for implementing changes.	• County mental health departments would be left with non-Medi-Cal programs, resulting in partial and fragmented mental health systems of care. • Increased difficulty for individuals with complex needs to access additional supports and services that MCPs do not provide. • Increased difficulty with coordinating care with other county systems for children and youth. • The majority of foster children and youth are not enrolled in MCPs. It is unclear how this vulnerable population would access SMHS if they were carved-into MCPs. • Some MHP providers would not meet existing MCP provider requirements. • Potential loss of SMHS structure and flexibility. SMHS are provided under a rehabilitation model whereas services provided through an MCP are provided under a clinical model.

Specialty Mental Health Services

Considerations

Role of MHPs

- Will MHPs continue to exist in some form in a carved-in system?
- Will MHPs become contractors of MCPs?
- Will non-Medi-Cal mental health services and programs remain with county mental health departments?

Service Delivery Model

- Will SMHS continue to be provided under a rehabilitation model, or will they be provided under a medical model?
- What are the ultimate goals and desired outcomes of carving-in SMHS?

Committee Discussion

Substance Use Disorder Services

Substance Use Disorder Services Background

- Drug Medi-Cal (DMC) operates under the authority of the Medi-Cal (Medicaid) State Plan and the Drug Medi-Cal Organized Delivery System (DMC-ODS) and is authorized under the larger Medi-Cal 2020 1115 Demonstration Waiver.
- Both programs are carved-out from Medi-Cal Managed Care.
- DMC-ODS services are offered by the county through an intergovernmental agreement that regulates the county as a pre-paid inpatient health plan (PIHP), which holds them accountable to the managed care regulation final rule (42 CFR 438).

Substance Use Disorder Services

Pros	Cons/Challenges
• **Improved care coordination –** current barriers to information sharing and referral would be resolved if the services were available as part of managed care. • **Expanded provider network** – carving in these services would allow primary care physicians to use their plan's existing infrastructure to ensure patients have access to treatment. • **Streamlined contracting processes –** carving SUD services into managed care would reduce the volume of contracting that is currently required to deliver DMC and DMC-ODS services. • **Uniform reimbursement structure–** using the managed care capitation rates would resolve discrepancies between the reimbursement methodologies for DMC and DMC-ODS.	• **Counties receive Behavioral Health Subaccount (BHS) funding to provide Drug Medi-Cal –** unclear how 2011 realignment would be integrated into the carved-in benefit. • **State would remain responsible for Substance Abuse, Prevention, and Treatment (SAPT) Block Grant –** if the counties continue to contract with the state for block grant funding, it will be challenging to operate SUD Medi-Cal in managed care without strong collaboration. • **SUD is a specialty service –** unsure how prepared the managed care plans are to begin delivering SUD Medi-Cal services within federal and state regulatory standards. • **Relationships with stakeholders –** Managed care plans may not be prepared to engage with the range of provider and beneficiary advocates that are actively engaged in DMC and DMC-ODS systems.

Substance Use Disorder Services

Considerations

- The authority for DMC rate setting is in statute. For DMC-ODS interim rates, the authority is set in the waiver terms and conditions. There would be considerable effort required to incorporate both into the managed care capitated rates.
- How will OTP/NTP methadone services fit into the managed care plan?
- If all SUD Medi-Cal services moved into managed care, what would the impact be to county budgets considering 2011 Realignment and SABG block grant funding?
- Will the managed care plans continue the program integrity processes for SUD that have been mandated through state audits?
- How will the county's role as administrator of the SABG block grant integrate with the managed care plans role as administrator of SUD Medi-Cal?

Committee Discussion

Dental

Dental Background

- The dental benefit is offered by the Medi-Cal program through three delivery systems:
  - Fee-for-Service (FFS) delivery system is statewide, wherein a provider is paid for each covered benefit rendered
  - Dental Managed Care (DMC) is only in Sacramento and Los Angeles counties, through contracted dental plans, wherein a provider is paid a set rate by the plan s/he is contracted with per member per month
    - Sacramento County – 72% DMC/28% FFS
    - Los Angeles County – 12% DMC/88% FFS
  - Safety Net Clinics – approximately 493 clinics statewide, wherein safety net clinics such as Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Services Clinics are paid on an encounter basis; meaning all services rendered at one visit are billed one set rate.

Dental Transformation Initiative (DTI) Background

- DTI aims to:
  - Improve beneficiary experience to consistently and easily access high quality dental services supportive of achieving and maintaining good oral health.
  - Implement effective, efficient, and sustainable health care delivery systems.
  - Maintain effective, open communication and engagement with stakeholders.
  - Hold providers, plans, and partners accountable for performance and health outcomes.
- Domain 1: Increase Preventive Services Utilization for children
- Domain 2: Caries Risk Assessment and Disease Management
- Domain 3: Increase Continuity of Care
- Domain 4: Local Dental Pilot Programs (LDPPs)

Dental Services

Pros	Cons/Challenges
• Single delivery system to coordinate all medical and dental benefits. • Increased awareness of dental benefits through a single plan's combined outreach/marketing efforts. • Coordination between medical and dental providers. • MCPs' flexibility to help treat members with complex oral dental needs. • PCPs and MCPs can readily direct members to in-network dental providers and coordinate care for out-of-network providers. • Streamlined system for the intake of member complaints and inquiries. • Streamlined oversight and audit processes. • Under proposed MCP system, oversight of DTI Domains 1-3 would transfer over, leaving Domain 4 with the state. Lessen administrative burden.	• Addition of dental carved in could present a massive challenge to MCPs' existing infrastructure. • Significant change in payment structure and claims processing. • Providers may be unwilling to contract with MCPs (payment agreement). • Training of call center staff or hiring staff with dental background/knowledge (minimum 2-year dental office experience). • Merging dental system of record with medical. • Maintenance of historical claims, payments, referrals, complaints, and other provider or beneficiary records. • DTI is based on the dental FFS model through check write and cannot pay via a capitated rate. • Reevaluate DTI program. STCs are written to include FFS, and funding based on both delivery systems. • New baseline and benchmarks, and methodology for DTI.

Dental Services

Considerations

- Historically, there are lower utilization rates in dental managed care vs fee-for-service. How will MCPs boost utilization rates? Can MCPs increase quality of care while at the same time reduce costs by increasing coordination of care?

- Incentive payments are separate from capitated payments. How will DHCS incorporate DTI payments into a capitated rate?

Committee Discussion

Long Term Services and Supports

1915(c) Home and Community-Based Services (HCBS) Waivers Background

- 1915(c) HCBS Waivers operate under the authority of Section 1915(c) of the Social Security Act.
- Waiver participants must meet eligibility requirements for Medicaid and have care needs equal to institutional level of care.
- Allow states to waive up to three provisions of the Social Security Act:
  - Comparability
  - Statewideness
  - Income and Resources for the Medically Needy

1915(c) HCBS Waivers

Pros	Cons/Challenges
• Carving in waiver services would allow for better alignment of plan benefits and waiver services, and enable the plan to better manage connectivity and communication between the assigned primary care physician, hospital/facility discharge planners, and HCBS service providers. • Centralized care coordination would avoid unnecessary duplication of services (including care coordination) authorized through plan. • Will build MCP awareness of the scope of HCBS services available and how those services can interconnect with other services available at the local community level.	• Would require transition from 1915(c) waiver authority to a different waiver authority allowing for delivery of non-state plan (i.e.. HCBS) through a managed care delivery system (i.e.. 1915(b) or 1115). • Potential for significant impact to 1915(c) HCBS Waivers operating under an Organized Health Care Delivery System (OHCDS) model where the provision of care management and waiver administration functions is a key component of "Waiver Agency" responsibilities. • Some 1915(c) HCBS Waivers are county-specific and do not operate statewide and if carved into Managed Care could require expansion of waiver benefits statewide. • Plans do not yet have a large role in coordinating care for beneficiaries who may need this level of care or the breadth of HCBS available through the waiver.

1915(c) HCBS Waivers

Considerations

- The majority of 1915(c) HCBS Waivers operate through the OHCDS model, which utilizes delegated entities to perform care management and specified waiver administration functions. Care Management services could be purchased from the OHCDS entities by the plan, allowing plans to utilize the expertise of Waiver Agency Care Management Teams in care coordination and field-based care planning for the HCBS the MCP would be responsible for providing.
- Plans would need to build specific understanding of population-specific programs at the local and federal levels that intersect with services currently available through the waiver to ensure appropriate communication across programs and continued access to services.

Committee Discussion

In Home Supportive Services (IHSS) Background

- State Plan benefit authorized under Sections 1915(j) and 1915(k) of the Social Security Act.
- State Statutory authority through Welfare and Institutions Code (WIC) Section 12300 et seq. and WIC 14132.95 et seq.
- Administered by the California Department of Social Services (CDSS).
- Self Directed
  - 283 Maximum Hours Authorized per Month
- No cap on enrollment and IHSS is available throughout the State.
- IHSS currently serves over 550,000 beneficiaries throughout the State.

In Home Supportive Services

Pros	Cons/Challenges
• Integrates responsibility for IHSS services into managed care, ensuring better consistency in identifying and aligning personal care service needs with MCP benefits. • Ensures oversight and input from the MCP if/when delivery of personal care services is not in alignment with the care plan developed by the MCP. • Can provide the MCP better access to monitor actual delivery of IHSS services against what was identified in the care plan.	• IHSS is a social-model program not a medical model; integration of the IHSS program into the Medi-Cal managed care delivery system would be viewed as shift in model construct. • It would be difficult to untangle specific components out of the current IHSS construct when determining how the program would be carved into Medi-Cal managed care. • Under the self-directed model utilized by the majority of IHSS participants, the MCP would have no authority over IHSS providers, impacting plan ability to monitor service delivery outcomes from a provider oversight perspective.

In Home Supportive Services

Considerations

- How could this opportunity be used to build on the foundation established through the Coordinated Care Initiative (CCI), taking into account the required communication between CCI plan care coordinator and the County IHSS team?
- In order to shift IHSS program functions to include service authorization, will MCPs need to be set up with CMIPS II access?
- If carved-in, who would be responsible for conducting the initial/change/annual assessments?
  - Counties (currently)
  - MCP

Committee Discussion

Long-Term Care (LTC) Background

- Long-Term Care (LTC) means care provided in a skilled nursing facility and sub-acute care services. (Contract definition)
- LTC is currently carved into County Organized Health System (COHS) plan model and Coordinated Care Initiative (CCI) program.
- Currently Non COHS and/or CCI MCPs are required to submit policies and procedures for the provision of services at non-contracted LTC facilities.

Long-Term Care

Pros	Cons/Challenges
• Improves ease of care coordination and continuity of care with the same team communicating services from beginning to end. • Reduces confusion to members by eliminating two different delivery systems for one service. • Standardizes the provision of LTC within all managed care models. • Improved oversight of LTC benefit. • May intensify impetus for placing in community as care coordination might move more members towards independence. • Allows for MCPs to forge relationships with LTC facilities and providers to enhance discharge planning.	• Accounting for Share of Cost might be difficult in capitated environment. • Limitations due to county borders which could impact access to care. • MCPs would need provider contracts in place for LTC services; contracting might be more expensive than FFS. • DHCS would need to oversee pre-implementation of services including plan deliverables and network review. • DHCS must ensure that the MCPs have the capacity to provide LTC services.

Long-Term Care

Considerations

- Should DHCS carve in LTC into Non-COHS/Non-CCI counties beyond the second month of admission?
- What lessons learned exist from COHS counties?
- Do MCPs anticipate any issues contracting with LTC providers?

Committee Discussion

Other Carve Outs

Pharmacy Background

- Certain categories of traditionally high cost drugs (Psychiatric (Antipsychotics), Substance Use Disorder, Blood Factor, and Antiviral Medications (HIV/AIDS)) are carved-out of the managed care delivery system and paid for through the Fee-for-Service delivery system.
- Managed care plans (MCPs) are required to coordinate/arrange for the provision of carved-out drugs to their beneficiaries.
- DHCS provides MCPs a monthly data file reflecting beneficiary utilization of carved-out medications.

Universal Pharmacy

Pros	Cons/Challenges
• Real time managed care plan level access to formerly carved-out medication classes and associated utilization data. • All services related to coordination of care for the condition(s) would fall under the direct management of the managed care plan.	• Diminished oversight of authorization criteria and review process to ensure appropriate access to vital medications. • Diminished scope of medications readily available on managed care plan Formularies. • Loss of revenue from grants dependent on direct state oversight of projects. • Loss of revenue from collection of state supplemental drug rebates. • Developing mechanisms to guarantee no catastrophic gaps in care during transition to, and between managed care plans. • Potential confusion at the community pharmacy level for changes in claims processing and formulary criteria. • Inconsistent application of care and utilization controls across plans. • Continued procurement of grant funding for each individual managed care plan. • Amending statute to allow for the collection of state supplemental rebates on managed care utilization.

Category Specific Issues- Pharmacy

Blood Factor Medications

- Decrease in overall quality of care provided to the patient due to lack of network specialists and lack of managed care plan history and expertise in managing hemophilia patients.
- Uneven distribution of hemophilia beneficiaries among managed care plans.

Antiviral Medications

- Negative impact on the “California HIV Affinity Initiative” - decreased ability to obtain updated claims data quickly for all HIV beneficiaries.
- Current collaboration between advocates and stakeholders of SUD acquired (IV drug use) and sexually acquired disease may not transfer well to the individual managed care plans.

Category Specific Issues- Pharmacy

Substance Use Disorder Medications

- More formulary restrictions on SUD medications could dissuade already reluctant prescribers from treating addiction.
- Delayed and/or limited DHCS access to pharmacy claims for monitoring core initiatives on access to SUD treatment medications.

Psychiatric Medications

- Newer therapeutic agents and costly long-acting injections may not be made easily available at the plan level.
- DHCS monitoring of psychotropic utilization in targeted populations (i.e. foster care) would no longer be available using existing FFS data sources.

Pharmacy

Considerations

- Do the “pros” of carving these classes of drugs into managed care outweigh the “cons”?

- Would managed care plans accept DHCS established utilization controls for some/all of these classes of drugs if they were to be carved-in?

Committee Discussion

Transplants Background

- Major organ transplants, except for kidney and cornea, are Medi-Cal FFS benefits (“carved out”) except for COHS.
  - If a member is in an MCP they will be disenrolled to FFS for the transplant and then will reenroll into the MCP after the transplant and safely assessed to be in managed care
- Leads to continuity of care issues and potential for clinically disruptive transitions for members in Two Plan and GMC counties
- Transplants can only occur at Centers of Excellence (COE) identified by DHCS.

Should DHCS carve in the coverage of major organ transplants in Non-COHS counties?

Pros	Cons/Challenges

• Improve care coordination:
  • Member would not have to disenroll, then re-enroll after the transplant.
  • Prevents members from having to receive care from a different network of providers leading up to and following the transplant.
  • Facilitates coordination for pre-surgical tests and evaluations and actual transplant surgery because all services would be provided by MCP.
• Enhances continuity of care:
  • The medical team performing the transplant can continue to perform all necessary follow up.
• Reduces confusion and delays in care caused when members file medical exemption requests (MERs) when instead they actually need to be disenrolled.
	• DHCS will need to consider if MCPs will continue to use COE transplant facilities that are approved by DHCS to perform transplants.
	• MCPs will need to establish contracts with transplant COE.
	• Variation in MCPs' policies on transplant referrals; some may have a fairly permissive referral process, while others may have a lengthier list of criteria/medical record documentation requirements.
	• Unknown and unpredictable annual costs to MCP could lead to challenges calculating the capitated rate.

Transplants

Considerations

- Does the current Medi-Cal requirement that transplants only be performed by Medi-Cal designated Centers of Excellence (COE) present issues for carving in transplants?
- To what extent will the COE continue to care for beneficiaries when in a managed care delivery system?
  - Can it be a timeframe?
  - What is the clinical criteria?
- Do the MCPs foresee any issues with contracting with transplant providers?
- Should DHCS carve in the coverage of major organ transplants in non-COHS counties? Or should DHCS require continuous managed care plan enrollment and only carve out transplant services in non-COHS counties?
- Do MCPs have the clinical expertise to evaluate members for transplants?

Committee Discussion

Other County and CPE Based Programs

- California Children's Services (CCS)
- Child Health & Disability Prevention Program (CHDP)
- Health Care Program for Children in Foster Care (HCPCFC)
- Targeted Case Management (TCM)
- Local Educational Agency (LEA) Medi-Cal Billing Options Program

Committee Discussion

Recap of Committee Discussion and Next Steps

Recap Committee Discussion

Identifying and Managing Member Risk and Need through Population Health Management Strategy

- Risk Stratification and Assess Members for Risk and Need
- Wellness and Prevention
- Transitions in Care
- Point of Care and Community Based Care Management
- Addressing Social Determinants of Health

Data Driven Solutions that Improve Quality Outcomes and Support Value Based Payment Arrangements

- Funding Flexibility
- Shared Savings Models
- Roles of 2020 1115 Waiver and MH 1915b Waiver

Reduce Variation and Complexity across the System

- Plan Accreditation
- Review FFS Only/Voluntary FFS Aid Codes or Geographical Areas
- Eligibility Concerns Impacting Care Coordination
- Pros/Cons/Challenges/Considerations for Carving-in Benefits to Managed Care

Next Steps

- Draft a concept paper with roadmap
- Re-engage workgroup to vet concept paper/roadmap
- 30-day Public Comment Period