DHCS Care Coordination Project: Coordination at the Point of Care and In the Community

Background on Medi-Cal Managed Care

Care coordination programs for complex populations increasingly emphasize coordination at the point of care (at a provider location) or in the community, as opposed to by telephone. In this discussion we will explore when, and how, it is appropriate to provide this type of coordination, and for what populations.

The DHCS managed care plan (MCP) contracts include requirements for care coordination, outside of the Health Home Program (HHP) language, there is significant flexibility for plans to determine location or method of services. HHP contract language states that care coordination should be provided at the point of care, such as at a Federally Qualified Health Center (FQHC) where the member is assigned for primary care. However, HHP services can be provided directly by MCP staff (and by telephone), for specific situations, areas, or populations within the MCP's coverage area, where the MCP can demonstrate that the point of care model is not viable because of remote geography, lack of viable providers, etc. This allows the MCP to use the best method available to maximize the HHP outcome goals for any given area or population. The HHP model also encourages coordination in the community, outside of the provider's office, when appropriate, such as for homeless members who present engagement and coordination challenges, members who do not regularly visit their PCP, and when it is helpful to attend medical or social service appointments with the members.

Framing the Issue

In the past, MCPs mostly provided coordination through MCP staff, by telephone, for Disease Management and Complex Case Management programs. Stakeholders stated that for specific populations and situations, care coordination works best when provided either at the point of care in a provider's office or otherwise in the community. During our site visits, many MCPs and counties noted that they are now operating programs based in the community. They said these programs are more appropriate for members with chronic health, mental health, and substance use disorder conditions, and those with "social determinant of health" factors, such as unstable housing, lack of social support, and food insecurity. Often these members do not regularly visit their primary care physician (PCP), preferring instead the emergency department (ED) and other

community providers, such as providers serving homeless members. Some members only trust the community provider that they see regularly and the MCP staff may not be able to engage these members by telephone. Stakeholders also noted that a care coordinator who operates in the local area will establish better connections with community resources and providers. And coordinators in the community who have behavioral health or justice-involved "lived experience" develop trust faster with members who have similar experience. Furthermore, that the department should allow the assigned care managers to be contracted or employed by the plan, PCP, specialist, mental health professional, SUD provider, home and community services agency, or a community based organization.

Additional Information

- **HHP Program Guide (APL 18-012):** The HHP Program Guide is available at the link below. Within the Program Guide, the following sections address HHP requirements for point of care coordination and coordination provided in the community:
    - Organizational Model (Page 4);
    - Managed Care Plan Responsibilities and Duties (Pages 5-6);
    - Community Based Care Management Responsibilities (Pages 6-8;
    - Community Based Care Management Models (Pages 8-9);
    - Multi-Disciplinary Care Team (Pages 9-11); and
    - HHP Network (Pages 20-23).

  HHP Program Guide:
  http://www.dhcs.ca.gov/services/Documents/MCQMD/HHP_Program_Guide-Final_6-28-18_Clean.pdf

- **Inland Empire Health Plan (IEHP) Presentation**: A presentation on IEHP's experience with NCQA's Population Health Management strategy, Complex Case Management, and innovative Point of Care and Community Based Care Management programs IEHP has designed and funded.

- **Los Angeles County Presentation**: A presentation on Los Angeles County's Whole Person Care (WPC) Pilot community-based care coordination.

Discussion Questions

1. You received information and presentations on several programs that provide care coordination in the community. What elements of these programs are appropriate to build into a statewide population health management strategy, and what are issues and considerations for doing this? Are there elements that seem easily scalable or others that seem problematic from the following examples?
    a. DHCS Health Home Program;
    b. IEHP Programs; and
    c. Los Angeles County Program.

2. What are the key issues that drive where the care coordination actives should primarily occur? Does it vary by population?

3. What coordination activities should be done by the MCP? Complex Case Management is usually provided by the MCP. Is this appropriate generally, or in all cases?

4. What coordination activities should be done by other organized delivery systems, such as mental health plan (MHPs), Drug-Medi-Cal Organized Delivery System (DMC-ODS), or even case management provided through local delivery systems under Targeted Case Management?

5. What coordination activities should be done at the provider's office? The HHP will primarily provide care coordination with staff located at the member's PCP office. But in many cases the PCP will not have the capacity or desire to provide HHP intensive care coordination.

6. What coordination activities should be done in the community at locations other than the provider's office? Are there specific populations that need this type of approach? And how can it be braided with the broader population health management strategy?

7. When coordination is done in the community, is there still some role for the MCP, MHP, or DMC-ODS. For the HHP, the MCP may provide certain types of Health Home services to assist a lower-volume community-based care management entities (CBCME), such as clinical consultants who assist with Health Action Plan development. Or this can be done as a transitional strategy until the CBCME builds enough volume or develops the capacity. The MCP may also assist the primary CBCMEs by contracting with other entities to perform specific activities, such as outreach and engagement or housing services for members experiencing homelessness.

8. Are community providers ready to take on additional care coordination activities? Are there gaps in capacity? Can community providers develop additional capacity to take on a greater role in community care coordination for Medi-Cal?

9. Community providers, such as those working with the Los Angeles County WPC pilot, have developed specific capacities and expertise for community care coordination. How can this resource continue to be utilized in a state-wide Medi-Cal population health management strategy?

10. If different types of coordination happen at different locations (the plan, PCP, specialist, mental health professional, SUD provider, home and community services agency, or a community based organization), how can we ensure non-duplication of care coordinators and services, and avoid member confusion? How can we avoid MCP, clinic, and community organizations each assigning a care coordinator and no one overall owning that process? Should this be the

responsibility of the MCP? And how should MCPs and other Medi-Cal providers ensure coordination with other agencies that have a role in coordination for specific services. If the MCP assigns a care coordinator outside the plan, can roles be documented through written agreements to define the responsibility of each party in meeting the requirements to ensure compliance and avoid duplication of services?

11. Should the MCP be required to document the assigned Care Coordinator for each member in an electronic format, including care coordinators assigned from outside of the MCP staff, such as a Patient-Centered Medical Home, or Health Homes Community-Based Care Management Entity?