Medi-Cal Managed Care Advisory Committee
GMC Model / Stakeholder Feedback
April 23, 2018

GMC ISSUES AND POSSIBLE SOLUTIONS

Recap:

- **January 2018** – Committee members engaged in a structured brainstorm process to address three questions: What is working? What is not working? What changes are needed?
- **February 2018** – Committee members began to discuss issues that are not working in the GMC Model.
- **March 2018** – Continued to discuss the structured brainstorm data.
- **April 2018** – Review feedback from Jan – Mar 2018 Meetings. Some of the potential solutions noted below were from the initial brainstorm.

COMPLEX SYSTEM

1. Problem: Sacramento has 6 health plans, 5 IPAs and 4 hospital systems which add to complexity. Safety net specialty practices have been purchased by medical foundations and closed to Medi-Cal. Many specialty providers in Sacramento are linked to a hospital system. Multiple payers add to the complexity of multiple plans and hospital systems.

   Potential Solutions:
   - Realign specialty services so there is shared access. This would require greater collaboration among hospital systems.
   - We have stability in 4 large hospital systems that are not-for-profit that have sophisticated delivery systems. We could figure out a way to work together to serve the population by dividing it up based on needs, but multiple payers complicate it.

2. Problem: Providers must deal with multiple IPAs, health plans with direct contracts, fee-for-service Medi-Cal, MCOs, etc., each with different authorization procedures, different service providers, etc. Must refer to a grid. It is cumbersome for providers and patients.

   Potential Solutions:
   - Develop a uniform authorization process.
   - Plans and hospital systems could work together to simplify referral paths, internal processes, etc. There is opportunity around process simplification.
   - Reduce duplication of effort. Need to figure out best practices, consolidate resources/expertise, and manage the population together. Coordinate better.
   - Have one location to go to for solving consumer issues, rather than multiple plans/IPAs.

3. Problem: Except for Kaiser, Medi-Cal patients lack integrated care. Medi-Cal patients have unequal treatment vs. commercial patients and must travel out of the area for specialty care.

   Potential Solution:
   - Medi-Cal reimbursement rates need to be higher so that more physicians will participate.

4. Problem: The State sets parameters for payments.

CONFUSING

1. Problem: Huge increase in number of beneficiaries since ACA. Patients don't know where to go. Typical member who has trouble getting care will turn to the ED.

   Potential Solutions:
   - Educate beneficiaries about accessing primary care.
   - Need more standardization and consistency.
   - Ensure plans, CBOs, etc. work on consistent messaging.
   - Public information campaign.

2. Problem: Most Sacramento FQHCs entered the market in the last ten years. The infrastructure was lacking. The growth has been rapid, but has the investment kept pace? Perhaps higher quality scores in other markets were due to larger financial investment.

   Potential Solution:
   - Clinics are continuing to build infrastructure. Development is ongoing.

3. Problem: Choice is not real. Lots of places to go, but they will not take you, and you cannot figure out where to go that will take you.

   Potential Solution:
   - Individual can change plans. However there is large network overlap.

4. Problem: The system is confusing for providers. Example: Pregnant woman will need 6 ultrasounds. There can be 6 or 7 different ways to handle based on differing IPA procedures, fee-for-service Medi-Cal, etc. Additionally, FQHCs also add complication to the process by determining the range of CPT codes, what lab to use, etc.

5. Problem: Time spent on claims payment, navigation (including calls escalated to management to resolve problems), etc. has a cost and takes away from care.

ACCESS ISSUES

1. Problem: Specialists unwilling to contract. Many physicians stopped taking Medi-Cal when SPDs became mandatory managed care. Access issues may be due to lack of providers, low rates of participation in Medi-Cal, or the unit price structure compared to other counties. Private practices (non-FQHC) in Sacramento are becoming system foundation models and do not increase access. The foundation models accept Medi-Cal when commercial volumes are low, but may not accept Medi-Cal at other times.

   Potential Solutions:
   - Focus funding on providers we have been unable to get, but who care for those who are the most sick and needy.
   - Block purchasing opportunities.
   - Increase reimbursement rates.

2. Problem: State pays each plan differently (not a single rate).

   Potential Solutions:
   - If every provider participated equally, there would be no access problem.
   - May need change at the State level (contracting, procurement, etc.)

3. Problem: Specialty access is a local issue.

   Potential Solutions:
   - Work together to develop innovations.
   - Address locally first, then go to DHCS if necessary.

4. Problem: Members are unable to get care where they live.

   Potential Solution:
   - Plans now provide transportation.

5. Problem: Access has shifted. Primary care is being provided in the ED. High cost primary care.

6. Problem: Committee members may be willing to implement change, but the layers above us within each organization must give approval.

LACK OF STANDARDARDIZATION

1. Problem: Multiple ways of doing things based on 6 plans plus 5 IPAs.

   Potential Solutions:
   - Identify key elements plans could work together on to look the same – referral protocols, authorization requests, formularies, etc.
   - Use evidence-based guidelines for care and develop a standardized order set.
   - 80/20 Rule – Select a few items to work on that can have the largest impact.

2. Problem: Difficult for consumers and providers due to multiple access points, services, etc. Unclear how to access services, how to coordinate, and what are the criteria for approval.

   Potential Solutions:
   - Centralize what can be centralized.
   - Doctors (including hospital/plan/IPA doctors) come together to develop protocols.
   - Simplify how the consumer is served through standardized care coordination. Consumer should be able to make one phone call that will support connections to all services.

3. Problem: Labs do not always verify who the patient is enrolled with. If patient is enrolled with a plan or IPA that does not contract with the lab, the provider gets billed. Difficult to get labs to change. Some plans/IPAs contract with only one lab. Especially problematic during transitions.

   Potential Solutions:
   - Develop protocols for transitions.
   - If the lab accepts the sample, the service should be covered and paid for by the plan.
   - Plans/IPAs contract with multiple labs.
   - Using HIE, establish a data warehouse for information such as lab, radiology, etc.
   - See how San Diego does it. (Later two members said San Diego is not comparable and gave reasons.)
   - Put information such as contracted IPA, lab, etc. on member identification card.

4. Problem: Doctors do not want to participate in GMC.

   Potential Solution:
   - Simplify/standardize the items that prevent doctors from participating.

5. Problem: May not be able to get the necessary approvals from GMC plans and the State for suggested changes.

   Potential Solutions:
   - Some items may not be subject to approval.
   - Start with low hanging fruit – items that are easy to standardize.

6. Problem: Lack of data sharing.

   Potential Solutions:
   - Increase / improve data sharing.
   - Need all physicians to have an accessible, compliant EMR. Need EMR standards.

PERFORMANCE CONCERNS

1. Problem: Sacramento has relatively low quality / HEDIS scores.

   Potential Solutions:
   - Try to make apple-to-apples comparisons. Most COHS/Local Initiative plans are more mature with the populations they serve. From county to county, populations can be different, networks differ, and human behavior differs with regard to preventive care.
   - Have consultation with a high performing plan (e.g. Kaiser).
   - Look at how HEDIS data is collected and try to figure out the disconnect between HEDIS and other data. For example, other data (WIC, schools, etc.) shows school children are getting immunized, but HEDIS immunization scores are very low.
   - Analyze HEDIS data by separating members who changed plans/clinics or relocated vs. those who had continuity. For example, immunizations and diagnostics may be current, but data gets lost when a member makes a change. Lost data results in low HEDIS scores. (HEDIS requires continuous enrollment for plans, but not for clinics, so additional analysis would be required.)
   - Learn from San Diego (HEDIS scores are higher). San Diego has HIE, all clinics are on the same data system, and the FQHCs are mature.
   - Look at newer HEDIS data. Data we reviewed previously was based on Measurement Years 2015 and 2016. Will report on Measurement Year 2017 data in the fall.
   - Pick a few measures and analyze the negatives for root causes. For example, service not received vs. service received outside the required timeframe.
   - Consider whether Social Determinants of Health play out differently in Sacramento vs. other counties.
   - Accountability at every level. Focus on top issues and have direct accountability for the result.
   - Conduct a Community Needs Assessment to understand needs of Sacramento residents, develop a shared mission, and identify and overcome the gaps.

2. Problem: Reimbursement rates in specialty care are too low.

   Potential Solution:
   - Increase reimbursement rates and quality will improve.

KEY THEMES

- Complex
- Confusing
- Access Issues
- Lack of standardization
- Performance concerns

POTENTIAL SOLUTIONS

- Standardize processes used by providers – authorization requests, referral protocols, formularies, labs, standardized order sets, transition protocols, etc.

- Centralize and/or simplify how the consumer is served –
  - One location or method for accessing services and solving issues.
  - Standardize care coordination.
  - Provide patient education. Ensure consistent messaging.

- Specialty services – Hospital systems could collaborate to share access to specialty providers.

- Analyze data and take action –
  - Start small. Pick a few measures, analyze data, and develop actions. Analyze for differences between members who changed plans/clinics/residence vs. those who had continuity.
  - Develop standardized treatment protocol.
  - Analyze the disconnect between HEDIS and other data sources.
  - Conduct a community needs assessment, develop a shared mission, and identify and overcome the gaps.

- Data sharing –
  - Increase data sharing. Improve how clinical data is shared.
  - Develop EMR standards and ensure all physicians have an accessible compliant EMR.
  - Need a HIE. Develop a data warehouse for information such as lab, radiology, etc.

- State involvement –
  - Need local management or some type of change in model.
  - May need change at the state level (revenue, contracting, procurement, etc.)
  - Need an active, engaged, and informed DHCS.

- Funding –
  - State needs to increase Medi-Cal reimbursement rates.
  - Focus funding on providers who are not participating but who care for the most sick and needy. Block purchasing opportunities.