ITUP
Insure the Uninsured Project

Notes from the Field

FEBRUARY 2020

ITUP 2019 REGIONAL WORKGROUPS TELL THE STORY
Coordinating Health Care Services in California

"If we are providing care coordination services to individuals because of a dysfunctional health care system, we have a lot more work to do." **2019 ITUP Regional Workgroup Participant**

Purpose of this Report

This report highlights key findings from the 2019 ITUP regional workgroup discussions on care coordination in Medi-Cal, California's Medicaid program. The discussions were timely and informative and reflect the complexity of the care coordination challenges in California.

About ITUP Regional Workgroups

Each year, ITUP convenes 11 regional workgroups throughout California. ITUP regional workgroups bring together local health care leaders for a half-day session of constructive dialogue, problem-solving, and identification of creative policy solutions.

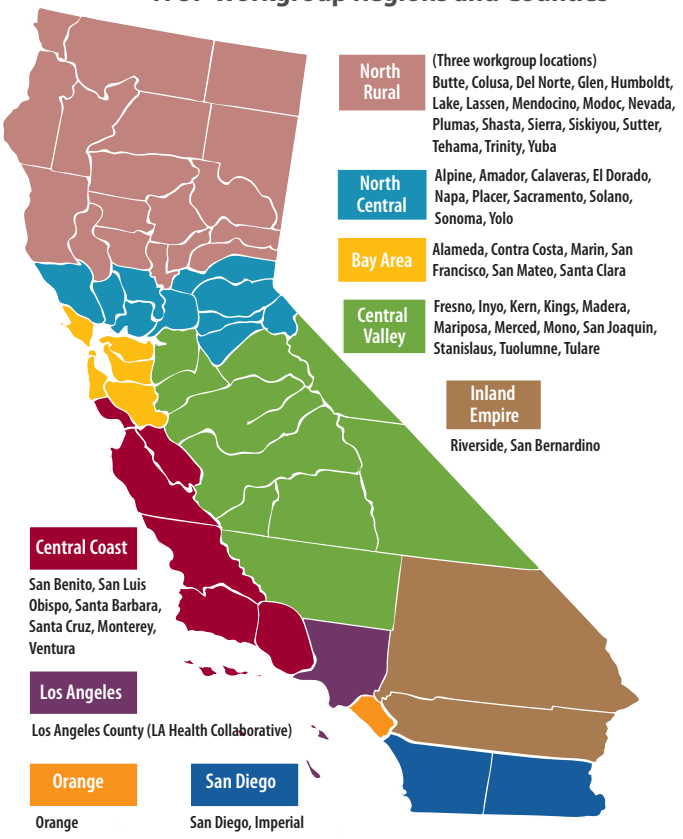
Typical participants include safety-net providers, state and local government agencies, legal assistance providers, health care foundations, health plans, legislative district offices, community organizations, and health care advocates.

Participants in 2019 reported that they came to the meetings for multiple reasons including that care coordination is their profession or role, they see care coordination happening locally but not systemically, and they were interested in talking about integrating strategies to address the social determinants of health into all systems of care.

Workgroup findings also provide ITUP with timely updates from the field to inform ITUP research and communications. Discussion topics are responsive to the changing health care environment.

Notably, in the Fall of 2019, the Department of Health Care Services (DHCS) rolled out the Medi-Cal Healthier California for All (MHCA) initiative (formerly known as CalAIM). The MHCA proposes major system changes in Medi-Cal — from how health plans manage care to funding for nontraditional services — that are intended to support the overall health and well-being of Medi-Cal recipients.

ITUP Workgroup Regions and Counties



FAST FACTS

13 million Californians are enrolled in Medi-Cal[1]

Enrolled in managed care

Defining Care Coordination

The federal Agency for Healthcare Quality and Research defines care coordination as

> *"deliberately organizing patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and this information is used to provide safe, appropriate, and effective care to the patient."*[2]

Care coordinating efforts can include medication management, assessing patient needs and goals, linking to community resources, supporting transitions of care, and establishing clear roles and responsibilities among providers and agencies involved in a client's care.

For more background on care coordination, See the ITUP Care Coordination Discussion Guide.

THE CALIFORNIA STORY

California began its care coordination efforts in the mid-1970s by expanding managed care in Medi-Cal to promote the stated goals of cost efficiency, improved access, higher quality, and better-coordinated care. Currently, Medi-Cal managed care is statewide and covers more than 80 percent of beneficiaries.

However, as of this writing, the Medi-Cal program remains fragmented by numerous carve-outs from participating health plan contracts and multiple systems and programs providing services to recipients. The current structure means that Medi-Cal recipients can have very different experiences depending on the county where they live or the health plan that provides for their care.

Although the Department of Health Care Services requires managed care plans to coordinate care and services for enrollees, certain services and populations are excluded, or "carved out," from managed care. For instance, specialty mental health services, substance use disorder (SUD) services, In-Home Supportive Services (IHSS), and California Children's Services (CCS), among others, are carved out and administered by counties or directly through the Medi-Cal Fee-for-Service (FFS) program with DHCS directly reimbursing providers. The benefits provided can vary by health plan type or county and some populations are not required to enroll in managed care, such as individuals dually eligible for Medicare and Medi-Cal.

The specialty programs and carve-outs typically focus on specific, high-need, vulnerable populations with the goal of ensuring that such programs can be refined to meet the specialty care needs of Medi-Cal beneficiaries. To meet these needs managed care plans, providers, and many beneficiaries must coordinate with multiple Medi-Cal delivery systems and programs, while navigating conflicting requirements and other barriers to fully integrated, whole person care.

Despite efforts to improve the coordination of care for recipients via managed care delivery systems, and specific specialty and pilot programs, significant challenges persist. Figure 1 identifies the domains affecting care coordination and lists some of the barriers to success within each domain.

Figure 1. Challenges to Coordinated and Integrated Care

POLICY

- Lack of clear policy goal setting at the state level. What problem(s) are we trying to solve?
- Different legal frameworks (federal and state) by discipline, service, or program
- Medi-Cal Managed Care as the preferred delivery system but different models and health plan structures by region and county
- Primary responsibility for health and social services at the individual county level
- Competing and conflicting statutory and regulatory standards across programs

FINANCING

- Federal funding silos
  - Restrictions and limitations on available funding
  - Limited or no funding for key elements
  - Program and waiver requirements, special terms and conditions, restrictions
- State funding silos
  - Restrictions and limitations of available funding
  - Limited or no funding for key elements
  - Misaligned financial incentives
- Complex, legacy financing and payment arrangements

STRUCTURAL

- Multiple delivery systems and program silos within health care, and within related services clients may need, including social supports, housing, etc.
- Multiple state and local agencies responsible for different services and programs
- Service and program "carve outs"
- Variation across counties and regions
- Communication and data/information sharing challenges
- Insufficient numbers, training, and categories of staff and professionals

INDIVIDUAL/POPULATION CHARACTERISTICS

- Complex, chronic health, and behavioral health conditions
- Lack of social supports and available caregivers
- Episodic health care seeking habits
- Language, cultural, or literacy barriers (including health literacy) intensify navigation challenges
- Unmet social and environmental needs (social determinants)– e.g., poverty, housing, transportation
- Distrust and trauma because of negative prior experience with health care or related services and programs

Source: Insure the Uninsured Project

Updated February 2020

This section summarizes the findings from the ITUP 2019 regional workgroup discussions, including specific examples from among the many stories and insights shared at the meetings.

Finding: Existing Barriers

Workgroup participants in all regions repeatedly identified inflexible barriers that create challenges for effective care coordination, including:

- ***Physical and behavioral health care silos.*** Workgroups in every region identified the separation of physical and behavioral health care services, and treatment for mental health conditions and substance use disorders, as major barriers to care coordination. Multiple county program administrators and providers acknowledged that different funding streams are a key barrier in keeping physical and behavioral health services from fully integrating at the point of care. A North Central attendee highlighted the need to improve the physical health treatment system in a way that can also help the behavioral health system.

- ***Reimbursement restrictions.*** Workgroup attendees also cited instances where reimbursement policies complicate care coordination if services provided are not reimbursed or funding is not aligned with client needs. A participant from a North Rural health center noted that clients using alcohol or methamphetamines can sometimes be treated with services other than medication-assisted treatment (MAT), but those services are not always reimbursed. The reimbursement limitations restrict the ability of providers to offer necessary treatments and organizations often end up bearing the financial risk and cost. For example, health centers reported that they recruit and hire Marriage and Family Therapists (MFTs) at most of their sites because it is important to have those providers available, even though there is a delay at the state level in reimbursement for MFTs.

  Participants in regions from Humboldt to San Diego also expressed concern about the inability of Federally Qualified Health Centers (FQHCs) to bill for multiple services on the same day. Health centers noted that this restriction prevents clients from accessing needed services, such as physical and mental health services, and challenges providers trying to coordinate care. In San Diego, a participant from an FQHC reported that clients are referred from county health facilities to FQHCs, but if the FQHC has not been assigned to that client then rendered services are not likely to be reimbursed.

- ***Data-sharing barriers.*** Throughout California, workgroup participants highlighted barriers to information and data-sharing that, if eliminated, could facilitate better care coordination. Legal constraints on sharing client data and information continue to be a major barrier to working across programs, services, and agencies.

  A county administrator from the Central Valley highlighted how problematic it is for care coordination when a provider learns two months later that a client accessed a service. The participant stressed that with real-time data-sharing, providers would be able to coordinate a client's care right as they enter a health care facility or access a needed social services program. Participants from the Central Coast workgroup described the challenges of data sharing between different electronic health record (EHR) systems or instances where data is simply not provided in a useful manner. Even when a local health plan receives the correct data and inputs, the data "puzzle pieces" still need to be pulled together in a sensible fashion to know which services clients need. A participant from a County Organized Health System (COHS) responded that the best-case scenario is for a coordinator to have access to all data and contact points a client has with programs and providers.

- ***Cross-county delays.*** Participants around the state identified significant challenges when clients need to access services across county lines. Many attendees reported huge delays when a Medi-Cal client moves to another county because a new case file cannot be opened until the client's case is closed in their previous county. In addition, clients in severely underserved areas must sometimes travel outside their home county to access services, but providers in other counties cannot accept the client's county-specific Medi-Cal managed care plan. For example, disabled children enrolled in CCS often must receive care and services in another county due to the limited availability of sub-specialists. The same issue arises when a client travels from a Whole Child Model (WCM) county to receive services in an adjacent non-WCM county.

- ***Inflexible services for the homeless.*** Most regions highlighted the challenges in coordinating and providing services for homeless clients who are marginalized and ill-served by various systems. Participants in San Diego and Orange County discussed how health care services for homeless clients are typically separate and, from the homeless individuals' perspective, seem specifically designed to keep them out. In Orange County, participants observed that the necessary services are not always available, providers are ill-equipped to care for and coordinate services for complex homeless clients, and eligibility criteria limit access to critical services. A hospital-based participant also pointed out that the Assisted Living Waiver, which transitions eligible individuals from nursing facility care to residential facilities with Medi-Cal coverage for services above the cost of room and board, is not extended to homeless clients. One county administrator pointed out that more Whole Person Care (WPC) clients could be eligible for the Health Homes Program (HHP) when HHP determines how to define chronic homelessness.

- ***Diffuse provider networks.*** Another issue that surfaced in multiple regions was the challenges providers, care coordinators, and families face when health plans contract with multiple delegated medical groups. For example, CalOPTIMA contracts with 13 different provider networks but beneficiaries may not understand the limitation on available providers depending on the primary care provider/medical group they choose. This issue has been especially problematic for care coordination of children eligible in the CCS program and for WCM families trying to access providers who are affiliated with different provider groups.

- ***Limited awareness of available community services.*** A health plan participant from the North Central workgroup said that health care providers may not always be aware of the community services available to clients. Others noted that if it is difficult to access services because of a lack of knowledge or information, providers either end up taking on the care coordination role or the client does not get the care they need.

- ***Lack of medical respite and other needed services.*** Across the state, a persistent theme was the low supply or complete absence of many services that are needed to effectively manage and coordinate care. This is especially true for individuals with complex health conditions and co-occurring disorders, such as physical and mental health conditions or mental health conditions and substance use disorders. In rural and remote regions, these challenges are severe as providers try to coordinate care, particularly for homeless individuals and families, children, and seniors that need services which do not exist locally.

A common refrain was that there is a growing need for "medical respite," also known as recuperative care, which is not a Medi-Cal benefit or included in the HHP. Medical respite is an option for individuals being released from the hospital who may still be recovering or are medically compromised and too sick to return to the streets or to an unstable home environment. One administrator of a WPC pilot stated that the program spent its medical respite budget within the first six months of the year. A health plan participant expressed concern that some long-term care facilities have Medi-Cal bed limits and it can be hard to find openings for Medi-Cal clients.

Participants also discussed challenges with medical respite and care coordination when services have an uneven geographic distribution. In San Diego, the northern part of the county has 32 medical respite beds available for homeless clients needing intensive case management and care coordination, while there are no beds in the rest of the county.

- ***Public charge and the complex immigration climate.*** In every region, ITUP provided an update on the Department of Homeland Security's public charge rule (proposed at the time but now final). Attendees consistently reported that the rule and public debate about it have caused fear and uncertainty for immigrant communities and created a chilling effect in individuals accessing public benefit programs, including Medi-Cal. A participant in Mendocino from a social services organization said that a client concerned about the complex public charge rule could be difficult to advise and assist with care coordination. In the Bay Area, a community health center representative discussed the challenges of following-up with mixed-status families where some family members are currently ineligible for health care programs or potentially subject to the public charge rule.

  For more information on the potential impacts of the rule for California, see the ITUP fact sheet Final Federal Rule on Immigrants and Public Charge.

Finding: Inadequate Workforce to Provide and Coordinate Care

Workforce shortages that limit both health care services capacity and the ability to effectively coordinate care were a common theme throughout the workgroup discussions.

- ***Shortage of providers in the region***. Care Coordination is made even more difficult when there are inadequate numbers of appropriately trained providers within a client's county or region. Workforce shortages are a persistent challenge reported in every region of the state, with attendees identifying acute shortages in rural and remote communities. There were many poignant and sometimes alarming stories of the impacts and unmet needs of clients directly related to inadequate staffing and lack of appropriate services. Only a few are highlighted here.

  In the Central Valley, a health plan participant noted the serious shortage of psychiatrists as a key barrier. In the same region, a county administrator expressed concern that they often must refer clients outside their resident county because there is only one Medi-Cal dental provider in the county that serves children, or only one OB/GYN that takes Medi-Cal. The scarcity of providers can also be a personal challenge for patients if they are not comfortable with the only provider locally available.

  A participant from an Orange County community organization reported that uneven provider distribution leads to transportation barriers in the northern and southern regions because most accessible providers are in central Orange County. In the Bay Area, a hospital representative mentioned issues coordinating care when the infrastructure for the WCM program to conduct hand-off referrals is insufficient. Inland Empire participants reported challenges hiring nurses and Licensed Vocational Nurses and cited the need for a larger, more culturally diverse workforce ranging from allied health professions to physicians.

Many attendees highlighted observations of significant provider burnout because clients have so many complex barriers that are difficult to prioritize and address, exacerbated when there are shortages of professionals and services to meet their needs.

- ***Long commutes to services.*** In addition to the transportation barriers mentioned above, participants in other regions of the state expressed concern over the long distances clients must travel to receive services. Some Northern California residents travel hours to Sacramento (UC Davis Medical Center) for pediatric specialists. Health plans in the Central Valley often assist clients in coordinating transportation, however many must take day-long trips to access services. Shasta county participants shared a region-specific concern that, since California does not contract with services located in bordering states, clients living close to the California-Oregon border must sometimes travel long distances to access services, despite services and providers in Oregon being available closer to home.

Finding: Desired Flexibilities

The regional workgroups focused not just on the challenges and barriers to effective care coordination but also on specific strategies and desired flexibilities that could advance more effective coordination of client services. This section highlights some of those "wish list" items.

- ***Common electronic systems and data sharing.*** Participants from multiple workgroups expressed the need for better data sharing systems and standardized electronic record keeping. Participants specifically want to see systems that can allow health plans, providers, and community organizations to identify local availability of health and social services, as well as the ability to determine all of the services one client is receiving. All regions expressed major frustrations with data challenges, and many called for implementation of a universal consent form across services and programs to help everyone better communicate and organize services for clients. Attendees suggested that electronic record systems should be structured to allow service providers to "follow the person."

- ***No wrong door approaches.*** Although there have been many efforts to develop and implement the "no wrong door" approach to service delivery, according to attendees, there is still a lot to do to achieve that desired outcome. A no wrong door philosophy, with the systems to back up the strategy, would give providers and community organizations the ability and the information to connect clients with the appropriate services and referrals in a streamlined fashion, even if a specific provider does not offer the services a client needs. A health plan participant from the Inland Empire workgroup stated that successful care coordination involving the no wrong door approach would ensure care that is continuous, integrated, and provided where the client is located.

- ***Coordinating the care coordinators.*** Attendees also regularly described the need for a "lead" care coordinator, provider, or program that assumes ultimate responsibility and accountability for patient management and successful outcomes. One Central Coast participant stated that, from a client's perspective, a coordinator outside of the health plans who understands and can help a client navigate all the services they need, not just health care, would be immensely helpful. A county administrator offered that instead of being concerned about which program or agency employs the coordinators, the rules should provide all care managers and coordinators with enough authority and opportunity to insightfully help clients navigate the system.

- ***State reimbursement changes.*** Participants at multiple workgroups also emphasized the need for system changes affecting state reimbursement that incentivize, better coordinate, and improve the client experience. For example, a health plan representative from the Central Valley suggested statewide reimbursement for community health workers, rather than only through Medi-Cal waiver and pilot programs such as WPC. A county administrator from Orange County expressed concern regarding access to skilled nursing facilities for individuals who are homeless, especially for Medi-Cal enrollees. Facilities often mention that low Medi-Cal reimbursement rates relative to Medicare are one of the reasons facilities limit the number of Medi-Cal beneficiaries they will accept. One suggestion is to allow the use of WPC resources to incentivize facilities to take Medi-Cal clients because under current WPC rules the programs cannot offer incentive payments for services already covered by Medi-Cal.

- ***Homeless service improvements.*** The workgroups included a lot of discussion about the challenges in addressing the needs of homeless individuals given the existing funding and program silos. In San Diego, a hospital representative suggested that state and local policies should more directly support the continued engagement of homeless individuals beyond a first encounter to ensure that they can successfully access the services they need. One provider acknowledged that the care systems and program requirements fail to recognize the unique characteristics of homeless clients who may be unable or unwilling to wait hours for care or services. One strategy mentioned was "open scheduling" where health care providers leave some appointments open for walk-ins and same-day visits to ensure that individuals can be seen timely.

Finding: Promising Strategies

Despite the many barriers to successful care coordination, workgroup participants across California shared innovative and emerging strategies being developed and implemented in local communities and regions. This section highlights just some of those promising strategies.

- ***Data sharing solutions.*** Participants from multiple regional workgroups highlighted areas of progress on data sharing between providers and programs, such as universal release forms and health information exchanges.

  - In the Central Coast workgroup, participants talked about the San Luis Obispo County Universal Release Form that enables referring agencies and clients to secure one common release from a client to allow sharing of protected information with multiple entities, thereby facilitating more timely and effective care coordination. In addition, Central Coast also discussed the local health information exchange that shares data among agencies in San Luis Obispo and Santa Barbara Counties, helping to identify gaps in services and tracking when referrals are completed.
  - In San Diego, participants talked about the community information exchange, which is trying to reduce data duplication and avoid multiple agencies having to enter the same information.
  - In the Bay Area, a participant from a social services organization offered information about their organization's social health information exchange, which includes multiple levels of program licenses so that different providers can access the appropriate information about a client to coordinate and provide care or services.

- ***Provider-based solutions.*** Participants shared promising provider-based solutions that facilitate care coordination and client access to services.
  - In the North Rural region, a participant from a community health center talked about their organization's growing case management program, which includes two case managers serving transgender clients that fill an important need in the community. The case management program also includes pediatric case managers to provide wraparound services for clients and their families.
  - In San Diego, a provider organization discussed how a lower caseload ratio allows providers from People Assisting the Homeless (PATH) to offer a high level of care coordination for homeless individuals. This lower caseload ratio enables frequent engagement with homeless individuals to meet them where they are located.
  - A county administrator from the North Central region noted that their WPC program also uses a low caseload ratio to provide intensive services to homeless individuals. In addition, the program uses housing coordinators who successfully navigate the more flexible funding of WPC to provide housing and related support services for clients.
- ***Health Care Delivery.*** Health care agencies and health plans have also engaged in efforts to increase and improve care coordination.
  - In the Bay Area, a county administrator shared that their organization is piloting real-time discharge notifications of client Electronic Health Records (EHRs) to help case managers coordinate care more quickly.
  - A participant from Inland Empire Health Plan (IEHP) discussed their pilot project to coordinate more closely with regional centers and school-based services.
- ***Program Enrollment.*** Workgroup participants shared how increased program enrollment and better administration improved care coordination efforts.
  - Clients are unable to enroll in both the WPC and HHP programs. In the Bay Area, a participant from a community provider discussed efforts to reduce client confusion by conducting a simultaneous eligibility assessment for WPC and HHP to understand which program is most suitable for the client.

Conclusion

In 2019, over a five-month period, ITUP held 11 regional convenings around the state and invited participants to focus on care coordination efforts in California. Participants described barriers and challenges to effective care coordination, identified desired flexibilities, and highlighted promising strategies around the state. The discussions revealed major efforts by counties, health plans, providers and community organizations to meet the complex and diverse needs of Medi-Cal clients, despite the numerous barriers identified in Figure 1.

This report highlights key findings to offer a representation of the robust, informed, and energizing workgroup discussions ITUP facilitated around the state. Based on the conversations at the ITUP workgroups, the state is well-positioned to have the discussion and debate about the best strategies to more successfully meet client needs through coordination, collaboration, and system change.

Notes:

1. Department of Finance, 2020-21 Health and Human Services Proposed Budget Summary, January 2020.
2. Agency for Healthcare Research and Quality (AHRQ), Care Coordination, online resources.

Resources:

Insure the Uninsured Project (ITUP), Medi-Cal Waivers Discussion Guide, October 2019.

Insure the Uninsured Project (ITUP), Discussion Guide for the 2019 Regional Workgroups: Care Coordination, June 2019.

Department of Health Care Services (DHCS), Medi-Cal Healthier California for All Proposal, October 2019.

Department of Health Care Services (DHCS), Whole Person Care, online resources.

Department of Health Care Services (DHCS), Health Homes Program, online resources.

Department of Health Care Services (DHCS), Whole Child Model, online resources.

About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

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