September 26, 2019

Medi-Cal Managed Care Health Plans – San Diego
George Scolari, Chair
Healthy San Diego Behavioral Health Subcommittee
2420 Fenton St, Suite 100
Chula Vista, CA 91914

To whom it may concern at San Diego-based Medi-Cal Managed Care Health Plans:

As Community Based-Care Management Entities (CB-CMEs) we are committed to making the Health Homes Program a success.

Throughout the implementation, Healthy San Diego Medi-Cal Plans have expressed a commitment to work together to standardize and streamline documents, process, and workflow to reduce and minimize administrative burden to allow CB-CMEs to be efficient in the care of patients. Unfortunately, with number of Medi-Cal Plans and the State allowing a certain amount of latitude in the implementation of general program guidelines, there is significant inconsistencies in how the Health Homes Program is being implemented among the Health Plans. We are concerned that without improvement to Health Homes, the program may not be sustainable long-term.

Towards that end, we would like to highlight some of the issues and challenges that have surfaced now that we are three months into the program. In each instance below, we have highlighted the concern, suggested a remedy, and provided supporting examples or commentary.

- **<u>Inconsistent reporting & documentation requirements</u> – all Health Plans should agree to use a single documentation submission expectation and process. This standardization should include a single documentation tool, whether CCA or another reporting format.**
    - At least one Health Plan wants reporting through their portal (in addition to CB-CME EHR documentation); others want reporting via Excel spreadsheets and the Excel sheets change monthly so CB-CMEs cannot predict how to build reports; 27 data variables are now 52.
    - HRA's are due within 72 hours to 90 days depending on the Health Plan.
    - One Health Plan has asked that paper claims be submitted in addition to other reporting.

- **<u>Lack of identification of Whole Person Wellness (WPW)</u> - prior to July 1, 2019, all Health Plans agreed to identify patients enrolled in WPW. We need a firm commitment that all Health Plans are to pre-identify WPW clients on the TEL lists the Health Plans submit to the CB-CMEs. Health Plans should commit to meet with CB-CMEs and other stakeholders to develop a Whole Person Wellness (WPW) / Health Homes crosswalk and referrals pathway process.**
    - 6 of 7 Health Plans have declined to identify WPW patients on the TEL lists.
    - There is continued lack of clarity about how to work with WPW.

  - CB-CMEs (with WPW) have been independently developing a crosswalk and referral pathway due to lack of Health Plan involvement.
  - Since patients can be in both WPW and Health Homes at the same time but are not to receive duplicate services, we will need Health Plan assistance in identifying these patients for appropriate referrals and developing a future transition plan.

- **<u>Unnecessary data requests</u> – CB-CMEs need to know specifically the data reporting requirements of DHCS for the Health Homes Programs. There seems to be significant variation in what the Plans are asking CB-CMEs and the frequency the data reports are being requested.**
  - CB-CMEs are being required to report back patient data (e.g. demographics, diagnosis data, and utilization date) that the Health Plans already have in their possession. It is an unnecessary time consuming and manual process to complete and submit this information in Excel and via other methods.
  - Data requests from the Plans have varied from weekly, monthly and quarterly.

- **<u>IT / System challenges</u> – all Health Plans and CB-CMEs should begin formal discussions now about a single information exchange platform to share data going forward, as these will take some time to implement.**
  - One Health Plan has established a special FTP site for Health Homes even though there is an existing FTP site in use for that Health Plan.
  - Some Health Plans are requesting complex privacy and security surveys be completed even though there are existing primary care contracts and BAAs with these Health Plans. (One CB-CME estimates it will take 40 hours to complete the survey with additional costs incurred to secure special certifications).
  - CB-CMEs need 1-2 dedicated staff per Health Plan just to manage systems and portals. It took one CB-CME two working days to compile a report for a single month.
  - CB-CME clinical staff are used to documenting in their own EHR but did not foresee having to learn and navigate multiple Health Plan systems and portals. This issue is exponentially magnified by the number of Health Plan contracts a CB-CME holds.
  - One Health Plan uses Clinical Care Advance (CCA) case management software platform. CB-CMEs are beginning to hear that other Health Plans may move to this platform in 2020.

- **<u>Inconsistent terminology</u> – all Health Plans should commit to using the same terminology to describe the same documents and processes for the Health Homes Program.**
  - Plans use different terminology for the same documents. CB-CMEs are having to create crosswalks for staff just to talk with each other and Health Plans.

- **<u>Inconsistent consenting processes</u> – all Health Plans should commit to the same process and requirements for consenting into the Health Homes Program.**

  - One Health Plan requires patient consent via electronic signature within the Health Plan's system, which causes delays. To obtain consent, CB-CMEs must go to a patient's home or to the hospital where the patient is admitted. Hospital's will not allow electronic tablets for SMI inpatients. This is not reasonable and goes against previous Health Plan commitments.
  - Other Health Plans are fine with verbal consent.

- **<u>Inconsistent payment for outreach</u> – Health Plan arrangements where outreach efforts are not reimbursed inhibits the full potential of the Health Homes Program.**
  - CB-CMEs are increasingly financially exposed because some Health Plans are not paying for outreach.
  - CB-CMEs have taken it upon themselves to meet with each other to discuss best practices and how to overcome challenges with outreach.
    - In the first month there were Health Plan system challenges, confusing navigation, unclear direction, technical difficulties, and delayed training. Some patients lost interest in enrolling during the gap.
    - CB-CMEs try to enroll patients immediately with initial engagement. It can take one person one hour to complete the process (without travel).
    - External community health workers can only see / reach 2-4 patients per day.
    - CB-CMEs are trying to repurpose staff and provide necessary support, but some managers foresee burnout and are having to hire more staff to cover that and gaps/vacations and/or offer overtime to willing staff on a fixed budget.
    - Most CB-CMEs are targeting their own patients first because they have the medical record, the patient has the connection as the PCP, and it's easier to do team-based care. This will be more difficult for health centers that act as a hub and try to reach another provider's patients.

- **<u>Inconsistent care management approach / protocols</u> – Health Plans can delegate care management to the CB-CME (and let the CB-CME do the work) or retain it in-house. Co-management is counterproductive and should be discouraged.**
  - One Health Plan wants to co-manage highest tier (high risk /catastrophic) patients with CB-CMEs which is causing confusion with patients and staff as to who is on point for what. Patients get multiple calls for same thing, causing unnecessary duplication of efforts and disrupting ability to achieve outcomes. CB-CME and Health Plan staff schedules also do not align.
  - Frequent and time intensive conference calls impact patient care and administrative work.

- **<u>Segregated CB-CME trainings and meetings</u> – given the number of Health Plans in San Diego, the CB-CMEs support a consolidated training with all their contacted CB-CMEs going forward for operational efficiency, clarity of communication, ease of administration, and best practice discussion Additionally, for components of Health Homes that affect all CB-CMEs, we encourage continued efforts to**

consolidate trainings across all payors; this reduces administrative overhead for all parties.

- CB-CMEs didn't need the same content training by 5-6 different Health Plan plus DHCS. That time could have been better spent.
- CB-CMEs have had to form their own best practice workgroups to address challenges and issues. They must reach out to Health Plans individually to get similar concerns addressed which is not an efficient or productive process.

Healthy San Diego provides a good model and framework for our seven Medi-Cal Health Plans to meet and collaborate on a projects and implementations, as they have in the past, but we feel that individual Health Plan implementations on Health Homes has produced a fragmented and inconsistent process that is taking away from our ability to affect and improve patient care – which is especially critical for this complex and hard to reach population. This is also producing unexpected administrative costs and burden, causing some to re-think contracting or the number of Health Plan contracts that they have.

We have submitted two previous joint provider statement letters, which were turned into FAQs. We would be remiss if we didn't point out that most of those responses offered us no real solutions, were non-answers, or offered only possible consideration of issues at some point in the future without any real commitment. We hope that by outlining the concerns above, that we can come together for a meaningful discussion and solutions starting at the September 27, 2019 Healthy San Diego Health Homes meeting.

Thank you,

Jeffrey Norris, MD, on behalf of the following Health Homes CB-CMEs and consortia:

- Borrego Health
- Community Health Systems, Inc.
- Family Health Centers of San Diego
- Father Joe's Villages
- Health Center Partners
- Imperial Beach Health Center
- Integrated Health Partners
- La Maestra Community Health Centers
- Mountain Health
- Neighborhood Healthcare
- North County Health Services
- People Assisting the Homeless (PATH)
- Samahan Health
- San Diego Family Care
- San Ysidro Health
- Vista Community Clinic