Medi-Cal Managed Care Advisory Committee
GMC Model Stakeholder Feedback
January 22, 2018

GMC MODEL: STRUCTURED BRAINSTORM EXERCISE

Brainstorm Process:

- The first part will be a round robin exercise. We will go around the table, one question at a time. Members should say "skip" if they have no response. Repeat answers are OK.
- The process guidelines include actively participate, one speaker at a time, be respectful and open, provide input from the stakeholder's perspective while maintaining a systems perspective, and members with a potential direct financial interest should refrain when indicated.
- Three questions will be addressed, one at a time:
  - ✓ What is working?
  - ✓ What is not working?
  - ✓ What changes are needed?
- Plan responses will be marked with asterisk (*).

COMMITTEE RESPONSES

Plan responses are marked with asterisk (*).

What is working?

- Options for consumers. Choice.
- Plans engaged in Medi-Cal Managed Care (MCMC) meeting – venue for discussing concerns.
- Community engaged in having healthcare work in Sacramento.*
- MCMC member relationships – transparency, willingness to take on challenges.
- Potential for population health management.
- Pockets of excellence in service delivery.
- Collaboration within a competitive market.*
- Building coalitions with MCMC members to solve problems outside of meetings.
- Social media is good at getting the word out.
- Multiple plans / choice
- MCMC meeting – great venue for information sharing.
- Providers committed to quality and service.
- Maturation of IPAs. Better working relationships with providers. IPAs have learned how to deal with the managed care model.
- Collaboration among MCMC members leads to innovative solutions.*
- Shared responsibility. Previously beneficiaries were eligible but had no access. Now fewer beneficiary complaints.
- Collaboration / relationships.
- Leadership at MCMC meetings provides important input.*
- Commitment from members and audience at MCMC meetings.*
- Plans' effort to make the system work.

- Quality of care.
- MCMC group: Committed leaders share ideas – a great cross-functional team.*
- Benefits of choice: 1) Each plan has different things they do well. Different member needs determine best fit. 2) Consumer may need a fresh start.
- Competition breeds quality.
- Lowest default rate.*

What is not working?

- Communication between Plan / IPA / consumer is an issue. Consumer is confused.
- Consumers get lost with different plans.
- Lack of uniformity. 4 – 6 different answers or ways of doing things.
- The way we share clinical information.*
- Access. Most providers are not contracted with all IPAs. Example: Newborn may not have access to the provider because they are not contracted.
- Confusing – patients do not know where they can go.
- Access – Providers are overlapping, so capacity has not been created.
- Multiple plans = variation, but is not positive. Patients and providers do not know where to go for answers and find it confusing.
- Delegated model not working. Result of delegation to IPAs is consumers and providers have 8 or 9 plans to deal with. What gets delegated and what does not is difficult to track. Makes it difficult to get access to primary care and the whole array of services.
- Lack of standardization.
- Processes, especially escalation around care needs – difficult to access.
- Complicated system.*
- Complicated – different ways of doing it.
- Inequality. Some get better care than others.
- Complicated.
- Access.*
- Accountability is too far from direct service. Contracts are with the State, service is local. We cannot fix problems, but have to try to get the State involved.
- Barriers to getting care where they live.
- Quality of specialty care from PCP clinics with a high preponderance of mid-level practitioners is mediocre. Need more physicians to participate in Medi-Cal.
- Provider participation as opposed to lack of providers.*
- Complexity of the overall system (not unique to Sacramento). Patients must seek services across multiple systems – Plan, County MHP, DMC, Care Coordination, etc.*
- Access to specialty care close to where they live.
- Complex system. Difficult for providers and consumers.
- Fragmented system within a region that is geographically fragmented. Difficult to understand, access issues, easier to go to ED.
- State oversight as opposed to local.
- Complex for all, especially consumers.*
- Physicians dislike GMC because of the contracting process, paperwork, etc.
- Patients without computers cannot access online records.
- Relatively low HEDIS scores.

What changes are needed?

- Standardize authorization forms / processes.
- Local management of the GMC model.
- Ensure Plans, CBOs, etc. get common information for consistent messaging.*
- Public information campaign.*
- Accountability at every level. Physicians need to adhere to the model, patients need to understand the model, etc.
- Reduce duplication of effort. 6 Plans means 6 Complex Case Management programs. Need to figure out best practices, consolidate resources/expertise, and manage the population together.
- Better data sharing.*
- Standardization. Find areas in common to standardize collectively.
- Increase data sharing.
- Conduct Community Needs Assessment to understand needs of Sacramento residents, develop shared mission, and identify and overcome the gaps.
- More social media.
- Standardization.*
- Declare the GMC pilot over.
- Ensure proposed solutions address the main issue.
- Streamline / reduce duplication of effort. Coordinate better.*
- Standardization.
- Have one location to go to for solving consumer issues, rather than multiple plans/IPAs.
- From various pilots, find something sustainable moving forward.
- Accountability. Focus on top issues (access) and have direct accountability for the result.*
- Eliminate duplication. Consolidate resources.
- What are the options (models)?
- From consumer perspective, more standardization is better. What incentive do plans have for standardizing? They each do things differently based on internal structure.
- Need all physicians to have an accessible, compliant EMR. Need EMR standards.
- Need an active engaged DHCS Representative on the MCMC Committee.
- Single payer model is better.

PUBLIC COMMENT

The brainstorm exercise included a Public Comment period. Members of the public were also invited to respond to the three questions. 6 out of the 32 members of the public in attendance offered comments. All responding have experience working in managed care.

See meeting minutes for Public Comment (two sections).