Medi-Cal Managed Care Advisory Committee
GMC Model Stakeholder Feedback
February 26, 2018

GMC MODEL: STRUCTURED BRAINSTORM SUMMARY

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 are marked by a (P).

Summary:

Medi-Cal Managed Care Committee members engaged in a round robin brainstorm activity for 20 minutes on three questions. 19 Committee members participated in the exercise. All member seats were represented with the exception of the FQHC seats. Both FQHC representatives were absent. Sandy Damiano facilitated.

Staff organized the responses into categories within each section. Plan responses are marked by a (P) and are listed at the end of each category.

Question 1: What is working?

Medi-Cal Managed Care (MCMC) Committee:

- Plans are engaged in MCMC meeting. It is a venue for discussing concerns.
- MCMC member relationships, committee transparency, willingness to take on challenges.
- Building coalitions with MCMC members to solve problems outside of meetings.
- MCMC meeting is a great venue for information sharing.
- Community engaged in having healthcare work in Sacramento. (P)
- Collaboration among MCMC members leads to innovative solutions. (P)
- Leadership at MCMC meetings provides important input. (P)
- Commitment from members and audience at MCMC meetings. (P)
- Committed leaders in the MCMC group share ideas. It is a great cross-functional team. (P)

Collaboration:

- Maturation of IPAs and better working relationships with providers. IPAs have learned how to deal with the managed care model.
- Collaboration / relationships.
- Plans' effort to make the system work.
- Collaboration within a competitive market. (P)

Quality:

- Pockets of excellence in service delivery.
- Providers committed to quality and service.
- Quality of care.
- Competition breeds quality.

Choice:

- Options for consumers; choice.
- Multiple plans / choice.
- Benefits of choice: 1) Each plan has different things they do well. Individual member needs determine best fit. 2) Consumer may need a fresh start.

Miscellaneous:

- Potential for population health management.
- Social media is good at getting the word out.
- Shared responsibility. Before GMC, beneficiaries were eligible but had no access. Now fewer beneficiary complaints.
- Lowest default rate. (P)

Question 2: What is not working?

Complex System:

- Complicated – different ways of doing it.
- Complicated.
- Complex system. Difficult for providers and consumers.
- Fragmented system within a region that is geographically fragmented. Difficult to understand.
- Complicated system. (P)
- Complexity of the overall system (not unique to Sacramento). Patients must seek services across multiple systems – Plan, County MHP, DMC, Care Coordination, etc. (P)
- Complex for all, especially consumers. (P)

Confusing:

- Communication between Plan / IPA / consumer is an issue. Consumer is confused.
- Consumers get lost with different plans.
- Confusing – patients do not know where they can go.
- Multiple plans = variation, but is not positive. Patients and providers do not know where to go for answers and find it confusing.

Access:

- Access. Most providers are not contracted with all IPAs. Example: Newborn may not have access to the provider because they are not contracted.
- Access – Providers are overlapping, so capacity has not been created.
- Processes, especially escalation around care needs – difficult to access.
- Barriers to getting care where they live.
- Access to specialty care close to where they live.
- Access issues. It is easier to go to the ED.
- Access. (P)
- Provider participation as opposed to lack of providers. (P)

Lack of Standardization:

- Lack of uniformity. 4 – 6 different answers or ways of doing things.
- 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.

Quality:

- Inequality. Some get better care than others.
- 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.
- Relatively low HEDIS scores.

Contract Issues:

- 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.
- State oversight as opposed to local.
- Physicians dislike GMC because of the contracting process, paperwork, etc.

Miscellaneous:

- Patients without computers cannot access online records.
- The way we share clinical information. (P)

Question 3: What changes are needed?

Standardization:

- Standardize authorization forms / processes.
- Standardization. Find areas in common to standardize collectively.
- Standardization.
- From consumer perspective, more standardization is better. What incentive do plans have for standardizing? They each do things differently based on internal structure.
- Standardization. (P)

Reduce Duplication:

- 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.
- Eliminate duplication. Consolidate resources.
- Have one location to go to for solving consumer issues, rather than multiple plans/IPAs.
- From various pilots, find something sustainable moving forward.
- Streamline / reduce duplication of effort. Coordinate better. (P)

Communication:

- More social media.
- Ensure Plans, CBOs, etc. get common information for consistent messaging. (P)
- Public information campaign. (P)

Model:

- Local management of the GMC model.
- Declare the GMC pilot over.
- Single payer model is better.
- What are the options (models)?

Data Sharing:

- Increase data sharing.
- Need all physicians to have an accessible, compliant EMR. Need EMR standards.
- Better data sharing. (P)

Accountability:

- Accountability at every level. Physicians need to adhere to model, patients need to understand the model, etc.
- Accountability. Focus on top issues (e.g. access) and have direct accountability for the result. (P)

Miscellaneous:

- Conduct Community Needs Assessment to understand needs of Sacramento residents, develop shared mission, and identify and overcome the gaps.
- Ensure proposed solutions address the main issue.
- Need an active, engaged, and informed DHCS Representative on the MCMC Committee.

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).