December 16, 2019

Via Email: Brian.Hansen@dhcs.ca.gov
Michelle.Retke@dhcs.ca.gov

Attention:
Brian Hansen, Health Program Specialist II,
Michelle Retke,
Chief, Managed Care Operations Division
California Department of Health Care Services
1501 Capitol Avenue,
MS 4000 Sacramento, CA 95899-7413

**Subject: Population Health Management Program – Comments for CalAIM Workgroup Process**

Dear Mr. Hansen and Ms. Retke:

Thank you for the opportunity to comment on the CalAIM proposals for the Population Health Management Program. We offer the following comments on behalf of county behavioral health directors.

- **Population health management strategies, interventions, and outcomes measurement must be coordinated across Medi-Cal delivery systems.**
  County behavioral health directors strongly support DHCS' focus in its CalAIM proposals on driving measurable improvements in beneficiary health outcomes with population health management strategies. Improving health outcomes for Medi-Cal managed care beneficiaries with substance use disorders (SUDs) and serious mental health conditions is a shared responsibility of Medi-Cal Managed Care Plans (MCPs) and county behavioral health (BH) plans. However, the CalAIM proposals for population health management implicitly or explicitly seek to improve outcomes for county behavioral health clients through strategies and interventions managed exclusively by MCPs. County behavioral health directors believe this is a flawed approach that will inadvertently miss the opportunity suggested through CalAIM's goals to better coordinate care for high risk beneficiaries across multiple Medi-Cal delivery systems.

  In addition, under the current proposal, population health management programs will identify subpopulations in need of case management and enhanced care management (ECM). Population health management programs will also identify "in-lieu of services" (ILOS) or substitute services used to avoid utilization of other high-cost services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. Since 2004 with the implementation of the Mental Health Services Act (MHSA), county BH plans have collectively expanded their expertise in coordinating and providing a wide range of services related to the social determinants of health for our clients, including services closely resembling ILOS, i.e., alternative and innovative services used to improve outcomes for individuals with behavioral health conditions. Counties also implement a more elaborate version of ECM with the "whatever it takes" approach used in MHSA-funded Full

Service Partnerships. Without a clearly articulated role for county BH plans in developing ECM and ILOS interventions, county BH plan expertise gained through MHSA and other county innovations related to our social determinants of health work will be underutilized, or potentially duplicated unwittingly, undermining the effectiveness of these interventions for beneficiaries with behavioral health conditions.

Ideally, population health goals, interventions, and outcome measures for these beneficiaries would be established in a coordinated manner across both the BH plans and MCPs in order to promote joint accountability across both health and behavioral health delivery systems.

**CBHDA Recommendation:** The Department of Health Care Services (DHCS) should require MCPs to consult with their county BH plan in the development of the population health management program as it relates to beneficiaries with co-occurring SMI and SUD needs.

- **Data on behavioral health utilization must inform population health management strategies in addition to MCP claims and other data sources.**
  Assessing risk and stratifying beneficiaries by risk cannot be successfully accomplished unless behavioral health utilization data is included in the risk assessment and risk stratification process. Understanding the behavioral health status of beneficiaries at the individual and aggregate level is central to any effective risk assessment and stratification model because the risk of poor outcomes for beneficiaries with physical health issues increases when these individuals have co-occurring behavioral health conditions. The Substance Abuse and Mental Health Services Administration (SAMHSA) found that "people with mental and substance use disorders may die decades earlier than the average person – mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease."

  Without integrating behavioral health utilization data in risk assessment and risk stratification processes, an assessment/stratification model that predicts risk of poor outcomes will inaccurately calculate risk for any beneficiaries with behavioral health conditions. Population health management strategies and interventions designed without the benefit of behavioral health data are likely to perpetuate the conditions reported by SAMHSA that limit interventions for people with mental illness and substance use disorders.

  In addition, while county BH plans and MCPs are already required to have Memoranda of Understanding (MOUs) in place to coordinate care for beneficiaries, plans across the state have yet to develop adequate beneficiary data sharing arrangements to achieve even basic goals, such as identifying shared beneficiaries. With the development of population health management programs, CalAIM provides the state with an opportunity to facilitate the kind of basic enrollee data sharing, in addition to clinical data sharing, which is necessary to achieve its population health management goals across both systems.

  **CBHDA Recommendation:** DHCS should facilitate the ability for MCPs and their county BH plans to share enrollee data, as well as clinical utilization data, for the population health management program. DHCS should require MCPs to include behavioral health utilization data in risk assessment and risk stratification processes.

- **Beyond behavioral health, county public health departments also offer opportunities to harness relevant population health data sets to improve health outcomes.**
  In addition to our desire to see MCPs coordinate more closely with county behavioral health for beneficiaries with SMI and SUD needs, county behavioral health suggests similar requirements for MCPs to coordinate with local public health departments to assess which available data sets and

public health indicators may be critical to the development of broader population health management strategies.

- **California should adopt strategies for developing joint accountability for shared outcomes across Medi-Cal delivery systems.**
  County behavioral health systems would like to advise DHCS on the development of outcomes measures that can be used to better assess behavioral health plan performance and quality of care for Medi-Cal clients with behavioral health conditions. Historically, performance measures for county behavioral health systems have focused on utilization, cost, and to a limited extent, access to care (e.g., the use of timely access measures as part of the EQRO process). Counties seek to adopt meaningful outcomes measures that can help assess the quality of the behavioral health services offered within our systems, as well as "whole-person" health outcomes for behavioral health clients who also access physical health benefits managed by MCPs.

  Ideally, these measures would help assess care coordination and specific outcomes for clients with complex physical and behavioral health conditions who are impacted by multiple social determinants of health. Outcomes measures and performance goals for both BH plans and MCPs should be developed in a manner that considers the shared role of the behavioral health and physical health delivery systems in supporting health and addressing the holistic needs of Medi-Cal clients. We believe CalAIM presents a unique opportunity for the state to look across the behavioral health and physical health delivery systems and begin to develop performance measures and corresponding, cross-system strategies that will hold BH plans jointly accountable with MCPs for specific outcomes. We do not believe overall outcomes for the Medi-Cal population can be improved unless we end the practice of approaching performance measurement and quality goals for BH plans and MCPs in complete isolation, and would emphasize the need to upfront discussions with both plans about the accountability intended with chosen metrics.

  **CBHDA Recommendation:** DHCS should consult representatives from the MCP and BH delivery systems, and potentially public health representatives as well, to begin developing common, statewide multi-system performance goals and outcomes measures for Californians with behavioral health conditions. These measures or goals can inform and guide the strategies that are adopted within population health management programs, which as noted above should be developed collaboratively at the local/service area level.

Thank you for your consideration of these comments.

Sincerely,

Elia Gallardo

Elia V. Gallardo, Esq.
Director of Government Affairs, CBHDA

cc: Mari Cantwell, Department of Health Care Services
Sarah Brooks, Department of Health Care Services
Brenda Grealish, Department of Health Care Services
Dr. Kelly Pfeifer, Department of Health Care Services
Jacey Cooper, Department of Health Care Services
Lindy Harrington, Department of Health Care Services
John Connolly, Health and Human Services Agency
Michelle Baass, Health and Human Services Agency