

Integration of Behavioral & Physical Health: Proposals Discussion Document

Discussion Items	<u>Straw Proposal #2: Shared Savings for Medi-Cal Managed Care & County Behavioral Health Entities</u>	<u>Straw Proposal #6: Shared Savings for Physical & Behavioral Health Providers for Team-Based Care</u>
Summary of Work Group Feedback	<ul style="list-style-type: none"> • Include measures to encourage coordination with social services and related data collection <ul style="list-style-type: none"> ○ Potential savings from identifying intersection between health care, county services, and the corrections/ criminal justice system • Link to/align with Cal MediConnect efforts • Focus on structure, then process, then outcome. Phase in to accommodate range of capabilities • Improved, seamless access to physical health would likely yield greatest impact on individuals with SMI • Integration activities at the plan/county level should be embedded at the practice/delivery site level 	<ul style="list-style-type: none"> • Maintain a bi-directional approach (e.g., 4-quadrant model) • Co-location goal: ensure full range of needs are met across the diagnostic spectrum • Determine clearly what outcomes we want to achieve, and account for current plan performance objectives to avoid duplication and burden. Where can plans improve on HEDIS metrics currently collected? • Requires plan level infrastructure to incentivize care coordination • Low rates for mental health services are a barrier • Align with Health Homes • Incorporate quality metrics and practice requirements from IMPACT model for depression care
Proposed Quality Measurement Principles	<ul style="list-style-type: none"> • Keep it simple: Avoid overly burdensome requirements <ul style="list-style-type: none"> ○ Decide upfront on total numbers of measures to collect ○ Identify meaningful and “collectable” metrics ○ Identify target population • Basic policies and procedures for the requirements laid out in MOUs between the MCPs and county MHPs should be actively in place; could form basis of first set of structural requirements • Process measures on care coordination and information sharing • Outcomes measures that are: <ul style="list-style-type: none"> ○ Jointly impacted by both systems, e.g., reduced emergency department visits ○ Key physical health metrics from current HEDIS or quality strategy that affect individuals with SMI ○ Social determinants, e.g., employment, housing, etc. 	<ul style="list-style-type: none"> • Align with HEDIS, Health Homes, DSRIP, and other measures currently collected in related programs to measure improvements • Include emphasis on screenings and follow-up, drawing upon IMPACT program measures plan • Opportunity to measure member satisfaction, quality of life, experience with care system at the delivery system level
Discussion Questions	<ul style="list-style-type: none"> • What other principles or related activities should drive measurement selection? • How would incentive payments actually flow from DHCS to MCPs and MHPs (e.g., PA example)? How would DHCS create the initial fund and would the state continue to sustain the funding? • What must happen operationally within MCPs/county MHPs and at DHCS to improve alignment? What are opportunities to catalyze these activities? • Should the target population be narrowed? An example could be individuals with SMI or substance abuse disorders who have chronic, co-morbid conditions. • Where do substance use disorder services fit? Should this proposal be examined in the context of the pending Drug Medi-Cal waiver amendment? 	<ul style="list-style-type: none"> • What are necessary investments that plans would make? • What are the biggest gaps on the ground at the delivery level to fill to make this work? • How can plans work with county behavioral providers to encourage physical health co-location at their clinics?