



4365 Executive Drive
Suite 500
San Diego, CA 92121

March 24, 2015

Diana Dooley, Secretary California Health and Human Services
1600 Ninth Street, Room 460
Sacramento, CA 95814

Dear Secretary Dooley:

We appreciate the opportunity to provide comment on the Medi-Cal 2020 1115 Waiver Renewal Concept Paper that was released March 16, 2015.

First and foremost, we share the State's excitement regarding the potential for Medi-Cal 2020 to be at the forefront of Medicaid reform and usher in the next phase of innovation for California's Medicaid system. California's rapid journey to establish the first DSRIP, expand Medicaid, and increase the number of individuals in managed care has been remarkable. By expanding Medicaid nearly 50% and providing coverage to an additional 3.8 million individuals, Medi-Cal's opportunity to transform the overall healthcare system has never been greater. UnitedHealthcare is excited about the opportunity to partner with the State to continue to transform Medi-Cal and the overall healthcare system.

Second, we share the State's recognition of the importance of whole-person care. The integration of behavioral and physical health is a foundational piece to any approach that seeks to achieve whole person care. For this reason, we are glad to see the attention the State has directed toward this building block of integration. While we believe that ideal integration is most effectively achieved when a single entity is at-risk for all benefits, we appreciate that that approach is not reflective of the State's current system. As such, the proposals outlined in the Concept Paper provide strong incentives to build collaborations between the medical health plans (MHP) and the behavioral health systems (BHS) and overcome the coordination issues inherent in the current structure. We, however, encourage the State to continue to consider full integration at some point in the future.

We encourage the State to provide flexibility for MHPs and BHSs to identify working relationships that best leverage each entity's unique capabilities, but structure the system to

support collaboration, consistency across regions, and equity for individuals throughout the State. We suggest the State:

1. Develop a common definition for the demarcation between mild to moderate and specialty care for behavioral health. Currently, MHPs and BHSs must negotiate a burdensome process that may lead to potential inequality in care as each county and MHP define these thresholds differently. This is especially challenging for MHPs serving members in multiple counties and navigating potentially different applications of the definition for specialty behavioral health.
2. Develop a path to capitation if not through an integrated all-in benefit structure than through county behavioral health as a prepaid inpatient health plan (PIHP) - similar to structure in other states like WA, MI, OH. Concepts such as shared savings and alignment to initiatives work best when entities participating are similarly structured with a common financial design.
3. Support similar behavioral health benefits across counties. In California's Drug Medi-Cal Organized Delivery System waiver amendment counties will be given the option to participate in the expanded benefits. This opt-in design is likely to create situations where benefits are very different in counties adjacent to each other, further fragmenting the system and challenging alignment for regional initiatives, MHPs, and county systems.
4. Consider shared incentives and performance measures that align with HEDIS quality measures that encourage alignment between MHPs and counties on measures, care coordination and data sharing. HEDIS offers the following:
 - 4 long standing behavioral health measures
 - 4 schizophrenia and bipolar measures introduced in 2013
 - 3 child antipsychotics measures introduced in 2015
 - 3 new depression measures under development
5. Support the Provider Integration model to encourage alignment between the MHP and BHS by increasing integration through team-based care. However, as it is proposed, it appears that the MHP would be solely responsible for funding the incentive program. While it is anticipated that cost-savings due to improvements in coordination are likely to occur on the medical side and BHS are not at risk for the BH services, we encourage the State to consider avenues for the BHSs to participate financially in the tiered incentives for integration.

In regards to the **Managed Care System Transformations and Improvement Programs** (Section 4.1), we appreciate the State's movement toward value-based contracting through all levels of the delivery system. At UnitedHealthcare, we are partnering with our providers to pay for value through outcome-based payment models. Currently, UnitedHealthcare has over \$21 billion dollars of our network health care spend (across Commercial, Medicare and Medicaid

lines of business) tied to value-based contracts with 600 hospitals, 1,150 medical groups & 80,000 physicians.

Based on our experience and appreciation of the power of value-based contracting, we respectfully encourage the State to consider the following during the development of the strategies listed in Section 4.1:

- Be transparent in the State's calculation of the total cost of care. This transparency will allow MHPs and BHSs insights into the expectations, trends, and risks associated with the shared savings arrangements. It is important that capitated payments are appropriately funded to support value based models; administrative requirements needed to establish the coordination between entities at the onset; and support the needs of the population served. We also encourage the State to consider the potential for pent-up demand that may be seen as integration of behavioral and physical health improves.
- Identify quality measures that are appropriate for the populations served and are reflective of the current state of the program in the particular region. We appreciate the inclusion of a base level of attainment and the recognition of improvement in quality scores. We encourage the State to continue to work with health plans and other stakeholders to further define the measures and the methods for determining the base and improvement calculations.
- Recognize that provider pay for performance (P4P) programs are a component to successful business operations in today's market and represent a business advantage if developed, delivered, and executed effectively. If standardization limits health plans' opportunity to innovate and leverage their experience developing high performing networks, the State will ultimately be stymieing its efforts to achieve payment reform throughout the system. UnitedHealthcare has found that providers vary widely in their interest and preparedness to take on risk. Having a variety of P4P strategies that meet providers where they are on the continuum has proven to be an effective way to encourage continuous improvement in provider transformations.

Regarding the **Public Safety Net Transformation** (Section 4.3), we appreciate the State's forward looking approach and its efforts to meet our health systems where they are in their journey to reform. As health systems and the State embark on the design and implementation of the initiatives under each domain, we encourage our partners to consider how MHPs could support or augment the efforts being done within the health system. This is especially true of initiatives under the second domain – Care Coordination for High Risk, High Utilizing Populations. For those who are enrolled in Medi-Cal, health plans should be engaged and responsible for the care coordination. There is significant opportunity for collaboration between MHPs and health systems; however, initiatives under this domain should be designed with special attention to avoiding duplication or layering of care coordination. UnitedHealthcare has had success in several markets developing partnerships with providers

and health systems that leverage our capabilities to support practice transformation and improvements that could be examples for the State or health systems to consider.

Within the **Workforce Development** section (Section 4.4), UnitedHealthcare is excited to see the State's recognition of the importance of Community Health Workers (CHW) and Peer Support Specialists (PSS). As an organization we are dedicated to expanding the number of CHW and PSS serving our members. We encourage the State to carefully review rules and regulations regarding credentials, experience, or backgrounds of individuals serving in these roles. While there is a need for training, oversight, and discretion in finding individuals who are effective CHW and PSS, the protections should not limit opportunities for individuals with varied life experiences to fill the roles of CHW and PSS. In fact, it is these experiences that make many CHW and PSS effective in engaging individuals and providing culturally competent services.

We appreciate the State's efforts to address access issues by incentivizing providers for increasing the number of Medicaid beneficiaries served within their practice. We are excited to see the impacts of this approach and encourage the State to make every effort to measure the program's outcomes. We do note that rates must be sufficient to continue to attract and retain providers and health plans to serve Medi-Cal.

The **Housing and Whole Person** (Sections 4.5 and 4.6) strategies are of particular interest to UnitedHealthcare. We recognize the importance of stable housing and overall wellbeing in supporting health. UnitedHealthcare's extensive experience with managed long term supports and services (MLTSS) programs provides a unique view on the opportunities and complexities of supporting individuals transitioning from institutions – hospitals, nursing homes, and other State facilities. This work reinforces the need to address not only the medical, behavioral, and pharmacy, but the expanded social supports.

As the State knows all too well, a greater portion of the Medicaid population could benefit from broader attention to these social determinants of health; however, budget limitations and waiver structures have limited Medicaid's ability to pay for social supports such as affordable housing, room and board, and rent assistance. While we are eager to see CMS's response to the housing interventions proposed, we do encourage the State to appropriately fund tenancy supports either through an administrative expense or through encounters. Additionally, in the case of individuals who are eligible for LTSS, we encourage the State to incentivize community placement through the use of blended rate cells.

As with previous sections, we want to highlight the need for quality measures to be appropriate for the populations targeted by the pilots. Measures focused on the percentage or number of individuals housed will be greatly impacted by the stock of affordable housing options available

in the region. We ask that the State select appropriate measures that mitigate the potential for regions with the greatest housing access issues to avoid participation due to limited ability to achieve quality targets and realize incentives.

We encourage the State to think broadly when considering cost-savings to also consider (especially within the Regional Housing Partnerships and the Whole Person Pilots) the savings the county receives if individuals are not cycling through the county jail system, emergency shelters and not utilizing other services like EMS. If the State is seeking to shift its thinking to a system-wide total cost of services approach, shared savings should not only acknowledge the cost of healthcare utilization. While there are limitations for the purposes of calculation of waiver neutrality and the flow of Medicaid dollars, we encourage the State and its county partners to think innovatively about how, if done effectively, such pilots could shift how State and county dollars are spent across budgets.

Furthermore, we encourage the State and entities participating in the Whole Person Pilots to take a broader look at policy and procedural reforms that can be addressed to improve system wide collaboration as part of a broader system reform. For example, looking at those that are justice involved, counties may want to consider their stabilization and treatment services offered while in jail, consider timing for enrollment in Medicaid while in jail, and review processes and procedures for releasing individuals from jail including engagement in case management prior to release. UnitedHealthcare is working with several States and counties to examine the system dynamics that, if addressed, could improve outcomes for justice involved individuals.

Additional clarity is needed regarding the shared savings funding pool described in section 4.6, how the pool is utilized, who operates the pool, and how the savings from a particular pilot would be distinguished from savings achieved through other strategies. As it stands now, the requirement that all savings be reallocated to the funding pool limits incentives for plans and regions to participate in the pilots.

When taken as a whole, the **Delivery System Transformation Strategies** funded through the **State – Federal Shared Savings and Reinvestment**, present multiple thought-provoking and innovative strategies. We appreciate the State's efforts to use reinvestment funding to support managed care, FFS, provider, and safety net reforms. We believe that the inclusion of various components to the healthcare system will help the State achieve its desired goals. We would also encourage the State to consider:

- Opportunities to support upfront investment, similar to the structure utilized in the Whole Person Pilots, funding at the beginning will infuse capital needed to make the initial administrative burden inherent in these initiatives possible.

- Staggered implementation of initiatives to better incent participation that may otherwise be curbed by concerns over programmatic uncertainty.
- Potential consolidation of strategies to more narrowly focus efforts and result in greater cost savings. As is, there is the potential that funding and resources will be stretched too thin to provide the impact necessary to achieve the cost-savings envisioned by the State.
- Rates must be actuarially sound and account for the multiple layers of cost-savings and incentives presented in the proposal. Additionally, any incentive payments that health plans are to pay out should be done within the context of total cost of care to ensure operational viability for the plans.
- While the State must account for differences within regions, whenever possible the State should seek equity for members and plans throughout the State. This not only means benefits are consistent, but that plans should be held to common standards and requirements. This consistency ensures an even playing field, encourages competition and drives innovation within the system. Furthermore, this consistency will position counties, should they choose, to form regional collaborations. We encourage the State to support competition among MHPs that have the capabilities and demonstrated experience to serve these regional collaborations.

UnitedHealthcare sincerely appreciates your consideration of the above listed comments and we welcome the chance to provide additional insights through the on-going stakeholder engagement process. We look forward to partnering with the State to continue to transform Medi-Cal and the healthcare system.

Sincerely,

A handwritten signature in blue ink, appearing to read "K. P. K. I. / H".

Kevin Kandalajt, CEO
UnitedHealthcare Community Plan of California, Inc.