April 27, 2018

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FROM: Linnea Koopmans, Senior Policy Analyst
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SUBJECT: **CBHDA Comments on Draft Medi-Cal Managed Care Quality Strategy Report**

Thank you for the opportunity to review the draft Medi-Cal Managed Care Quality Strategy Report. The below table outlines the comments that we provided directly on the draft document. We have also noted some overarching recommendations directly below. Please don't hesitate to contact Linnea Koopmans at lkoopmans@cbhda.org or Paula Wilhelm at pwilhelm@cbhda.org with any questions.

General feedback and recommendations:

1) County Behavioral Health programs would appreciate the opportunity to further discuss how the quality strategy will be operationalized and used to guide county quality improvement activities for MHPs and DMC-ODS participants.
2) Certain sections (specified in comments) refer to quality measures or processes that are not yet in place; we recommend clarifying timelines and processes for implementation.
3) For the development of future QSRs, we recommend DHCS consider how quality metrics connect across Medi-Cal delivery systems in furtherance of the Department's statewide goals and priorities.

Page #	Section/Topic	Comment
10	2.3 – Drug Medi-Cal Organized Delivery System (DMC-ODS)	Suggest additions/revisions to list of DMC-ODS services, as shown in track changes on the accompanying document.
10	2.3 – Drug Medi-Cal Organized Delivery System	For adolescents, eligibility criteria for ODS services includes those who are "at risk" of developing an SUD.
13	4.3 – Evidence-based Clinical Practice Guidelines for the DMC-ODS	This section could include mention of the 5 Evidence Based Practices that meet requirements under the ODS, and outline how counties need to select at least two for use by providers.

13	4.3 – Evidence-based Clinical Practice Guidelines for the DMC-ODS	Statement on additional MAT in second paragraph of this section is confusing and seems to imply that MAT needs to be offered via OTP's. However, counties can elect to offer MAT via FFS Medi-Cal, as opposed to DMC, and thus MAT can be offered in other settings than OTP. Suggest making the edit included in track changes to recognize this flexibility in MAT implementation.
14	5 – Continuous Quality Improvement	By only mentioning "physical and mental health," particularly given that Medi-Cal is carved out into 3 separate funding streams for physical health, mental health, and SUD, it overlooks SUD as a health condition. As such, recommend simply referring to "health". SUD should not be construed as one and the same as mental health in a payer system that treats them distinctly, as this leads to confusion. See suggestion in track changes.
14	5 – Continuous Quality Improvement	"Physical and mental health . . ." appears again at bottom of page. Where is SUD? Defining "behavioral health" is another way to explicitly acknowledge SUD.
23	5.2 – Continuous Quality Improvement for MHPs	To the extent DHCS increases reporting measures for MHPs, request that counties be involved in their development.
23	5.2 – Continuous Quality Improvement for MHPs, Children and Youth	Request county involvement in development a methodology for tracking. DHCS may also consider the proportion of youth referred to MCPs for care after an initial assessment.
23	5.2 – Continuous Quality Improvement for MHPs, Health Disparities	Will input for these new requirements for demographic reporting be developed by the AB 470 stakeholder workgroup? Request involvement with county subject matter experts in addition to the workgroup.
25	5.2 – Continuous Quality Improvement for MHPs, Performance Outcome Systems	Don't the adult performance dashboards exactly mirror the EPSDT POS reports? If so, would recommend removing this clause.
27	5.2 – Continuous Quality Improvement for MHPs, Performance Improvement Activities	What will this more robust process look like and when can counties anticipate receiving TA?
27	5.2 – Continuous Quality Improvement for MHPs, Care Coordination	CBHDA looks forward to continued engagement regarding the development of these tracking and monitoring mechanisms.
28	5.3 – Continuous Quality Improvement for the DMC-ODS	Providing counties with ODS claims data could support the process of identifying, tracking, and utilizing ODS quality/dashboard measures. In general, it may be helpful to include more specifics on what data might be included in ODS performance dashboards, the timeline for dashboard development, and how dashboards will be used when they are up and running.

28	5.3 – Continuous Quality Improvement for the DMC-ODS – "Program Goals and Objectives" (Table)	Suggest elaborating why CalOMS augmentation is specific to DMC-ODS, rather than behavioral health in general, to avoid implying that the SUD system is behind, when in fact, in some ways it is well prepared given CalOMS/TEDS data. Suggest adding language about continuing efforts to streamline CalOMS, which may mean removing or modifying questions, to ensure only the most useful data is collected. This may be an opportunity to also eliminate duplicative reporting (e.g., DATAR). Suggest explicitly including County and/or Provider leadership in the Dashboard development process to obtain buy-in early.
29	5.3 – Continuous Quality Improvement for the DMC-ODS –"Quality Metrics and Performance Targets"	Suggest clarifying how "initial diagnosis" (within HEDIS measure of Beneficiary Initiation and Engagement) is defined, as this may be challenging to determine based on current CalOMS data which only has admission date, and DMC claims are not that specific.
29	5.3 – Continuous Quality Improvement for the DMC-ODS – "Performance Improvement Activities"	Currently network adequacy standards only apply to outpatient and OTP LOCs. Given the infancy of the DMC-ODS waiver, this needs to remain as the official standard while the goals should certainly be to improve access to all levels of care. It would also be helpful for this document to use terms consistent with ASAM for clarity – level of care vs. type of service or OTP vs. NTP.
31	5.3 – Continuous Quality Improvement for the DMC-ODS –"Data Collection System Improvement"	Consider including additional information on how the CalOMS system update will be built to support counties in accessing data to measure quality and compliance with ODS measures at both the county and provider levels. For consistency, suggest explicitly mentioning the CalOMS Rewrite stakeholder process here. Recommend that in addition to creating new reporting/dashboard capabilities with CalOMS, there also be a mechanism allowing subcontracted providers to generate their own reports.
35	6.3 – External Independent Review for the DMC-ODS	This section is very high-level. Consider including the EQRO metrics developed for Year 1, and the proposed metrics for Year 2.
36	7.2 – Transition of Care Policy for MHPs	Will this policy guidance be published before the end of the FY? Counties have not yet seen the guidance on transition of care.
36	7.3 – Transition of Care Policy for the DMC-ODS	UCLA is evaluating how clients move through the continuum of care using the UCLA ASAM reporting tracking sheet submitted via ITWS. More info about this could be included here, including how it will be used, and how data will be shared back to counties.

		In practice, case management services may be coordinated/performed by subcontracted network providers rather than being done specifically by County staff. Could be helpful to make a distinction/clarify the difference between the care coordination requirement and the case management benefit.
37	8 – Reducing Health Disparities	*" . . . DHCS provides beneficiary demographic data to county MHPs and DMC-ODS programs".* Is this in fact being done for ODS counties? If so, in what form and how often? Recommend including an explanation of the process by which counties can obtain this data, or otherwise discussing how this will be operationalized with DMC-ODS participants.
40	8 – Reducing Health Disparities for the DMC-ODS	Last paragraph, "FY 2017-18 is a baseline data collection year . . ." As mentioned above: how will this data be shared with counties, and how might they be expected to use it to reduce disparities? Via their PIPs?