October 1, 2020

Will Lightbourne, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Re: Medi-Cal Managed Care Plan RFI 20-001

Dear Director Lightbourne:

On behalf of the California Pan-Ethnic Health Network (CPEHN), we thank you for the opportunity to provide comments on the Department of Health Care Services' (DHCS) Medi-Cal Managed Care Plan Request for Information, 20-001. The current procurement process is a critical opportunity for California to revamp its oversight and accountability mechanisms to strengthen the quality of care and reduce disparities for the 10.8 million Medi-Cal beneficiaries in a Managed Care Plan (MCP). As a co-sponsor of SB 936 (Pan) CPEHN strongly supports a standard procurement timeline and a transparent, robust stakeholder procurement process as other states have implemented, as a way of ensuring greater health plan accountability.

DHCS has requested stakeholder responses to four key questions regarding the specific contract changes or actions we recommend to:

- Question 1: To address health disparities and inequities, as well as, identify and address social determinants of health
- Question 2: To increase MCP's community engagement
- Question 3: For emergency preparedness and response for disasters
- Question 4: To achieve the other MCP goals listed

CPEHN's comments on questions 1-4 were submitted as part of a broader set of Appendix 1 comments by consumer stakeholders submitted by Linda Nguy with Western Center on Law & Poverty. CPEHN's comments on the topics above are provided in greater detail below:

Comments on DHCS' Medi-Cal Managed Care Plan RFI 20-001

Health Disparities (Question 1)
In California, well-document and persistent disparities exist by ethnicity, language, disability status, sexual orientation, and gender identity amongst other socioeconomic factors. Because their persistence, overall improvement or access cannot be assumed to also result in narrowing disparities. Failure to make health disparities reduction a central component of quality improvement efforts in physical,

oral, and behavioral health will leave disparities in place and may even exacerbate them. California's health care system often perpetuates or even deepens inequities, particularly for communities of color. To improve health care quality and reduce disparities, California must require health plans to:

Embrace and invest in community-based care, which produces better health outcomes for communities of color:

- **Authorize MCPs to bill for community-defined evidence practices including doulas and midwives, mental health professionals and traditional healers for the evidence-based care they provide in their communities.** These services should be seen as core to health and wellness, and must recognize the value of community-based healing traditions. Minnesota's Medicaid program reimburses for mental health patient education and care coordination provided by community health workers. In addition, New Mexico's Medicaid program reimburses traditional healers for providing traditional healing practices to Native American Medicaid members. Currently, 10 states all provide for licensure of dental therapists including Alaska, Arizona, Idaho, Maine, Michigan, Minnesota, Oregon, Vermont, Washington and New Mexico.

Prioritize tracking, reporting and reducing disparities:

- **Require plans to report on how it is gathering self-reported patient data by race, ethnicity, language and other sociodemographic factors;** percentage of successful collection; and annual progress of this data collection. Require plans to report on what internal training, consumer education and engagement activities they are engaged in to faciliate self-reporting and utilization of demographic data.
- **Updated contracts should set and align year-over-year targets for self-reported demographic data collection for all quality measures, reporting and utilization**, and institute pay-for-reporting and pay-for-improvement incentives (in reporting and utilization/stratification) through withholds. Data should be disaggregated beyond federal Office of Management and Budget standards in order to properly identify and target disparities experienced by smaller populations including Asian, Native Hawaiian and Pacific Islander, and American Indian/Alaska Native communities. DHCS should adopt a uniform standard for the collection and reporting of demographic data to ensure it is consistent and comparable between programs.
- **Require MCPs to publicly report their PNA results, incorporate this data into plan-specific dashboards, and tie measurable results to payment incentives:** The Population Needs Assessment requirements APL 19-011, CAHPS and Supplemental Survey questions, results and PNA Action Plans should be made publically available and tied to MCP payment. Other states are already reporting this type of data publically and are even starting to establish new measures for equity. For example, the state of Oregon, through its Coordinated Care Organizations, has developed a health equity measure designed for people with LEP, Meaningful Language Access to Culturally Responsive Health Care Services, and incentive payments are based on measuring their performance in providing quality interpreter services.

- **Require and incentivize plans/providers to implement the 2015 federal Office of National Coordinator (ONC) for Health Information Technology standards.** Adoption of the 2015 federal ONC HIT standards (finalized in 2019) will help to facilitate collection of patient race, ethnicity, language, sexual orientation, gender identity, and social and behavioral risk data in electronic health records (EHRs); these standards facilitate both self-reporting and collection of disaggregated data; granular patient information regarding disabilities and accommodation needs should also be consistently collected, reported, and utilized. The federal Quality Payment Program already incentivizes the use of these ONC standards for Medicare providers and California public and private purchasers could add aligned requirements and incentives.
- **Require plans and providers to collect and report on patient demographic and social and behavioral risk data** to California's electronic health information exchanges, and any all-payer databases used throughout California. Implementation of CMS' new Interoperability Final Rule will help to ensure data flows more freely between payers, providers and patients.

Implement equity as a strategic organizational priority:

- **Require MCPs to provide information regarding the steps they are taking to implement equity as a strategic organizational priority** for example, with regards to staffing and operations as well as their business practices.
- **Require health plans to report on steps they are taking to simplify contracting processes** to make it easier for community-based organizations who provide assistance with health navigation or social services, and are often trusted messengers in their communities, to assist in providing team-based care and efforts to address the social determinants of health. LA Care, for example, is exploring different contracting strategies such as paying smaller providers up-front for their services, to make it easier for people of color and women- owned businesses to provide services to their members. DHCS should require MCPs to provide training and tecnical assistance to CBOs and small businesses to desmystify the contracting process.
- **Amend Cultural Competency training requirements to require all MCP providers and staff to undergo annual, ongoing and continuing training on cultural competency, cultural humility and trauma-informed care** that is updated annually to reflect California's changing demographics, revised learnings and best practices for caring for racially and ethnically diverse consumers, including LGBTQ+, persons with disabilities, and people who hold multiple, marginalized identities; DHCS should work with MCPs to align training requirements and opportunities across MCPs to maximize participation and reduce duplicative requirements.

Social Determinants of Health (Question 1):

Social determinants of health are "conditions in which people are born, grow, live, work, play, and age that shape health."[i] In a state as diverse as California, systemic racism; persistent poverty and income inequality; lack of affordable housing; under-investment in education; over-investment in policing, criminalization, and mass incarceration; rural needs, and federal

immigration policies also impact the health of Californians. Other external factors such as climate change also have impacts on health. While health care payers should not be expected to pay for all the housing, food, transportation, employment, and other needs of their members and patients, issues such as housing instability and food insecurity are health-related social needs that require increased attention. These unmet social needs have been highlighted and aggravated by COVID-19 and the economic downturn. Focusing on population health management provides an opportunity for health care, social services and other systems, agencies, and organizations to work together to improve the health outcomes of the communities they serve. At the state government level, California already has committed to a "health in all policies" approach, engaging the Department of Health Care Services (DHCS), Department of Public Health, Department of Social Services, and other state departments and agencies in looking at the health impacts of all policies and funding priorities. In the CalAIM proposal, DHCS acknowledged the importance of addressing these upstream social determinants of health by including population health management strategies. Since much of this work is still developmental, there should be robust evaluation and support for replication of emerging best practices. DHCS' revised contracts should:

- **Require MCPs to Implement Population Health Management (PHM) contract requirements that include basic case management for all enrollees:** PHM contracts should require MCPs to develop population health management strategies for all levels of health risk and clearly state that MCPs must establish a model of care for addressing enrollee health needs at all points along the continuum of care including interventions for enrollees informed by risk stratification or segmentation that provides case management services, health care services, and other interventions that improve beneficiary health outcomes and reduce disparities.
- **Require MCPs to work with DHCS to Eliminate Bias in Risk-Stratification and Segmentation:** MCPs should be required to make the methodology or algorithm they use to conduct stratification and segmentation public and mitigated for racial and other biases.
- **Require MCPs to Conduct Screening, Referrals and Linkages for Health-Related Social Needs:** MCP contractors should be required to conduct patient and family-centered screening, referrals, individualized care plans and linkages for health-related social needs. California's Comprehensive Perinatal Services Program (CPSP) and the state's Early Periodic Screening Diagnostic and Treatment (EPSDT) program are two models already in statute that are geared towards providing screening and referrals for a broad array of health care services including health-related social needs, individualized care plans, a determination of whether the referral happened and what the outcome was. However DHCS has not readily enforced the provision of these services.
- **Require MCPs to contract with community-based organizations (CBOs) for appropriate social services, and for outreach, engagement, education, assessment, and follow-up services**. The Whole Person Care pilots are examples of successful partnerships between health plans and CBOs. The experience of Medi-Cal plans that have contracted with Long Term Services & Supports, especially Home and Community-Based Services, is another example of the need for strong linkages and contracts with community- based providers. The COVID-19 pandemic has highlighted how important it is to improve integration and coordination of health care services with existing community-based social

and human services. DHCS and other purchasers should support technical assistance for both health plans and CBOs in setting up data, coding, reporting, technology and other systems to share information and facilitate these linkages; intermediaries such as local health departments and county health systems can also support these linkages. For example, Massachusetts requires ACO contractors in its large Medicaid ACO program to screen for "health-related social needs" and to have referral relationships with CBOs for services related to those needs, as well as requirements for network contracts with CBOs that focus on Behavioral Health (BH) and Long-Term Services and Supports (LTSS) to provide care management. Advocates have identified significant progress (as well as challenges) in Medicaid--CBO relationships under this new ACO program.

- **DHCS in partnership with plan and providers should support comprehensive electronic health information exchange among all health care systems and providers, and with other public assistance programs (SNAP, WIC, housing assistance, etc.) to streamline eligibility decisions and share appropriate information to support comprehensive patient-and family-centered services.** Electronic health information exchange in California is still a patchwork of incomplete linkages; there needs to be more state-level leadership to create more comprehensive access to and utilization of health information exchange technologies. Linkages to other state and county systems for streamlined eligibility (e.g. the successful use of CalHEERS to support enrollment in both Medi-Cal and Covered California), and more "no wrong door" policies should be implemented and expanded beyond enrollment to support the health and other needs of individuals and families Technical assistance and adoption of technological advances needs to be ongoing and built into these initiatives.
- **DHCS should authorize and incentivize plans to pay for health-related social needs**: California should follow the lead of other states that are leveraging federal funds to improve housing, access to healthy food, employment, and other life conditions through value-added, in-lieu of, and flexible services, and other payments. For example, the Oregon Health Authority has provided detailed guidance to its Medicaid coordinated care organizations on how to bill for health-related housing and other social needs. Other states and payers have used "Z codes" to bill for these services. These services should leverage existing and potential new funding sources rather than "medicalizing" all social needs. Community benefit requirements on hospitals and health plans can also be leveraged for prioritized investments in health-related social needs. A new hospital rating index from the Lown Institute shows California hospitals lagging in community investments and other equity indicators.ii COVID-19, the economic downturn, and increased awareness of structural racism and over-policing also have created opportunities for re-evaluation and re-prioritization of economic and social needs in state and local governmental budgets.
- **DHCS should require plans to make Community Health Investments:** MCPs should also be required to make investments in community health to improve quality and reduce disparities. Other states and California counties have already set up such community investment requirements. Arizona requires its Complete Care plans to contribute six percent of their annual profits to community reinvestment and submit an annual Community Reinvestment Report (CHCS). Oregon's Community Care Organization 2.0 application requires a portion of revenue be spent on addressing SDOH (CCO 2.0) In Imperial County,

California Health and Wellness agreed to a per-member per month community health investment as part of their rural expansion contracting (GHPC).

Behavioral Health (Question 4): Despite federal and state laws that require parity for access to behavioral health care, behavioral health care continues to be extremely challenging for consumers to access in Medi-Cal. Consumers face obstacles such as lack of education about how to access behavioral health care, health plan denials, long wait times, shortages of culturally and linguistically appropriate providers, and poor quality of care. ***Consumers have a greater awareness of the county mental health system, despite the fact that most people with a mental health need should be obtaining services from their health plan***. Recent data shows disparities in access to behavioral health services for adults in Medi-Cal managed care plans, with consumers of color and limited-English proficient beneficiaries having much lower access to behavioral health services than their White and English-speaking counterparts.[iii] Particularly since COVID-19 appears to be disproportionately exacerbating the behavioral health needs of low-income communities of color, it is critical that consumers are able to access behavioral health services through their Medi-Cal managed care plan, and that these services are culturally and linguistically responsive.[1] DHCS' revised contracts should:

- **Ensure MCPs are complying with federal and state mental health parity laws.** California proactively investigates the consumer experience with access to mental health services in Medi-Cal managed care health plans. The Department of Managed Health Care is planning a long-term investigation into consumer issues accessing behavioral health to understand their experiences and plan to seek corrective action/enforcement against plans that are engaging in bad practices. DHCS should require plans to submit a report including the data and analysis that proves it is complying with the Parity Act *before* it is permitted to contract with DHCS. Additionally, the plans themselves must do more to inform consumers of their parity rights and make it easier for them to fully access mental health and substance abuse care under their insurance contracts. No one should die or lose a loved one because they cannot get through the red tape and receive treatment.
- **Hold MCPs accountable for reducing behavioral health disparities and improving utilization rates.** Six years after its implementation, the behavioral health benefit in MCPs should be considered mature and health plans should be held accountable for poor performance. DHCS should use its regulatory authority to strengthen contract language to improve health plan performance specifically with regard to access to behavioral health care. This may include rate adjustments, penalties, or corrective action plans. For example, Arizona's Medicaid program utilizes a quality structure that includes Medicaid and the Children's Health Insurance Program and encompasses their acute and long-term care contractors, the Arizona Department of Health Services, the Division of Behavioral Services, and Children's Rehabilitative Services. Arizona Medicaid establishes minimum performance standards, goals and benchmarks based on national standards for which each contractor is held accountable across each state agency. Failure to meet minimum performance standards results in contractors receiving a Correction Action Plan. Arizona

[1] Data is not stratified by Sexual Orientation and Gender Identity (SOGI).

Medicaid requires contractors to evaluate each corrective action on an annual basis to determine if improvements have been made. The Arizona Medicaid agency also evaluates the effectiveness of the CAP during annual site visits.

- **Authorize and incentivize MCPs to pay for community-defined evidence practices (CDEPs):** Rather than lay blame on individuals for reluctance to seek behavioral health care or on individual behaviors for low utilization, we must acknowledge the history of racism in health care and how that affects the quality of behavioral health care that people of color, individuals with disabilities, and LGBTQ+ people both experience and perceive today. Most currently reimbursable "evidence-based" practices were primarily tested on White patients. Developed specifically to address the unmet needs and strengths of a cultural group, community-defined evidence practices (CDEPs) can be an important component of a behavioral health system that assists diverse communities.[iv] Examples of these types of practices include traditional healing activities for Native Americans[v], peer-led community gardens for refugees[vi], gender-affirming support groups for lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals[vii], and advocacy training for Latinos and African Americans.[viii] ***These practices could be reimbursed by Medi-Cal through a State Plan Amendment as an additional service under the Medi-Cal preventive services benefit or alternatively as part of the in-lieu of services (ILOS) that Medi-Cal managed care plans can offer under the proposed Cal-AIM framework.*** Medicaid programs in other states have increased access to the use of mental health services based on community-defined evidence under the preventive services benefit. Arizona has pursued this approach for reimbursement of Tribal Traditional Healing Practices through its Section 1115 waiver. Some states invite or encourage MCPs to provide what are known as "value-added" services beyond the standard benefits to adults in order to improve the overall health of plan enrollees. New Mexico has used this value-added approach to pay for traditional healing.
- **Require MCPs to increase culturally and linguistically appropriate outreach to consumers about the availability of behavioral health services**: Both the utilization data and our focus groups findings demonstrate that the majority of Medi-Cal consumers are not aware that they are entitled to behavioral health services for mild to moderate concerns through their health plan. DHCS should require health plans to:
  - Publicly post on their websites: the contact information of every MCP behavioral health administrator; the contact information of every MCP staff member (i.e. mental health navigators, care coordinators, etc.) who assist with accessing behavioral health services, as county MHPs already do: http://file.lacounty.gov/SDSInter/dmh/1071321_SANavigatorContactList_Revised3-4-2020.pdf ; and the outpatient behavioral health referral forms of all MCPs. DHCS should also aggregate and post this information on its own website (similar to what is already done for County MHPs: https://www.dhcs.ca.gov/services/MH/MHSUD/Pages/CountyProgAdmins.aspx).
  - Undertake significant outreach efforts through a culturally and linguistically competent statewide awareness campaign.
  - Partner with trusted community messengers and should ensure that their providers are equipped to respond to an increased demand for care. Health plans should also conduct outreach to primary care providers to ensure that they have the tools to

make effective referrals to behavioral health care. People of color often first report behavioral health challenges in primary care so it is essential that providers are equipped to assist their patients in navigating the system.

- **Enforce quality measurement in behavioral health.** Despite consistently low performance six years into implementation, California has been slow to set performance targets. In 2018, California required MCPs to report quality measures on depression screening and follow up for the first time. These measures could help pinpoint the major barriers consumers face when trying to access mental health services in their health plan, in particular whether consumers are not being consistently screened for depression or if consumers are not receiving necessary follow-up care after a positive screen. However, MCPs struggled to identify the necessary data sources and codes to identify the use of depression screening as required to report this data accurately, and no measures were published in 2018. MCPs should be required through their contract with DHCS to engage in more robust data collection and reporting so DHCS and the public can better understand the challenges MCPs are facing when providing behavioral health care to their consumers in order to devise appropriate solutions.

- **Require MCPs to publicly report their timely access results, incorporate this data into plan-specific dashboards on mental health utilization, and tie measurable results to payment incentives:** California's MCPs are required to provide access to mild-to-moderate behavioral health care services yet they are falling short necessitating the need. Unfortunately DMHC only publically reports plan performance for Medi-Cal managed care by the behavioral health-only plan it contracts with. Most consumers have never heard of the behavioral health-only plan their health plan contracts with. Managed Health Network, HAI-CA, Value Options of California, Inc., Holman Professional Counseling Centers, Cigna Behavioral Health of California, Inc. or Optum Behavioral Solutions of California are not household names. The ability for consumers to compare the performance of full service plans on the provision of behavioral health is critical to ensure they those plans are fulfilling their responsibility to provide an adequate behavioral health network for their members.

- **Invest in broad array of behavioral health integration models***:* Under the CalAIM proposal, California has suggested one form of integration where one entity – Medi-Cal managed care plans - would be responsible for the physical, behavioral, and oral health needs of their members. ***We question an approach that would place health plans at the center of this model, driven primarily by payment efficiencies rather than system and provider integration, and instead recommend exploring alternatives***. Currently, health plans are responsible for the physical health care for consumers living with serious mental health conditions but have consistently failed to deliver appropriate care. As a result, people living with serious mental illness continue to die, on average, 10-20 years younger than their counterparts, primarily due to chronic physical health conditions that are undertreated. DHCS' revised contracts should instead:

- **Preserve and strengthen the role of the community behavioral health safety net.** California's counties provide a broad range of behavioral health services, in addition to services that support the social determinants of health. Counties, public hospitals, and community health centers have decades of specialized case management and care coordination experience for complex populations. California's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a good example of integrated care for children including those with special health care needs. There is an opportunity for increased coordination between these entities, as well as others like rural and district hospitals and the University of California academic health centers, in order to provide better access to care. In addition, the Department of Health Care Services should require health plans to invest in and leverage this existing infrastructure, as well as provide resources and assistance to ensure physical and programmatic accessibility, language access, and cultural competence across population groups.
- **Integrate medical services into the county behavioral health safety net** so at risk or high-risk populations receiving behavioral health services within the county behavioral health safety net can access physical health care in a trusted setting. People living with serious mental illness often report discriminatory or stigmatizing treatment in health care settings, and therefore may shy away from seeking out care. Offering care within the specialty mental health system could ensure that services are coordinated and consumers are treated with a greater degree of respect and knowledge about their mental health condition. Additionally, patients should always have the option to receive care where they choose, and access to care should not be conditioned on receipt of other county services (e.g. housing).
- **Continue to support the centrality of community health centers and other models of integrated physical, oral, and behavioral health:** Community health centers, which include federally qualified health centers as well as free and community clinics, can serve as examples of services that are fully integrated. Many community health centers also staff school-based health services, bringing integrated care into school settings. DHCS should require health plans to leverage and support these existing models of integration through contracting and financial incentives, including alternate payment models (APMs). DHCS can help to facilitate and encourage greater adoption of APMs by striving to shorten the current 3-year delay in payments – and penalties – for quality performance as a result of the lag time in accessing comprehensive data. Additionally the state must work with CMS to make sure the dollars from any savings get re-invested and stay in the health care delivery system.

Oral Health (Question 4):

- **Adhere to the recommendations and targets presented in the Little Hoover Commission's 2016 report *Fixing Denti-Cal* to improve utilization.** According to the most recent Medi-Cal Dental data on children ages 0-20, utilization under Dental Managed Care sits at 43.86% for annual dental visits, 38.57% for preventive services, 24.04% for treatment services, and 46.89% in overall utilization for one year. For adults the rates are

much worse with 21.44% of adult members completing an annual dental visit, 9.6% accessing preventive services, 14.49% accessing treatment, and overall utilization for one year at 21.42%.[2] In *Fixing Dent-Cal,* the Commission explicitly details what the Medi-Cal Dental program should do in order to significantly improve the program, with recommendations that are equally applicable to Dental Managed Care plans. For example, they recommend a target of 66% utilization for annual dental visits among children. Yet, the level of utilization growth in children's annual dental visits from 2018 to 2019 was only 1.2% in Dental Managed Care (in 2018 the utilization percentage for annual dental visits was 42.65% and in 2019 it was 43.86%). Even with Proposition 56 supplemental funding and an outreach campaign (Smile CA), the numbers hardly show any effort to significantly improve utilization. The Department of Health Care Services should take the re-procurement opportunity to bolster its Dental Managed Care requirements to assure quality care for all its members.

Strengthen Oversight and Accountability (Question 4):

- **Explicitly condition and limit the use of public dollars to contract with health plans that can demonstrate an ability to meet the needs of diverse consumers:** Absent more radical reforms, DHCS should at a minimum, ensure that contracted Medi-Cal health plans provide consumers with access to care that is culturally and linguistically responsive. Health plans that are unable to meet the access standards in law today should not be eligible to continue contracting with the Medi-Cal program. Furthermore, health plans that fail to meet benchmarks for quality of care across multiple measures and populations should no longer be eligible to contract with Medi- Cal. In order to effectuate these changes:
    - **Increase transparency and timely public reporting of quality measures including the experiences of diverse patients, and progress towards identification and year-over-year reduction of disparities**. Health plans are now required by federal, state, and industry purchasers and regulators to report on dozens of health care quality measures, but consumers and community advocates have limited access to the data, especially in a timely and actionable manner. The Integrated Healthcare Association partners with the Department of Managed Health Care to report quality performance data from health plans and medical groups and publishes the California Regional Health Care Cost & Quality Atlas that reports cost and quality data across Medicare, Medi-Cal, and commercial plans. California state purchasers should make more comprehensive de-identified claims data, encounter data, prescription drug data, social service data, oral and behavioral health data and cost data on out- of-pocket costs, reinsurance and negotiated rates more transparent and timely, and should hold health plans accountable through withholds, penalties or sanctions for quality improvements, including the identification and reduction of disparities.

[2] Medi-Cal Dental Services Division Statewide Fact Sheet (August 2020) https://www.dhcs.ca.gov/services/Documents/MDSD/Stakeholder-Meeting-Materials/Statewide-Fact-Sheet-Aug-2020.pdf

Stratification of data by race, ethnicity and language is a critical underpinning to this recommendation.

- **Establish a standard procurement schedule**, approximately 5 years, for eligible managed care plans as other major purchasers like Covered California and CalPERs have done, using contracts to more effectively implement policy changes tied to quality improvement, disparities reduction and population health management.
- **Ensure health plans subject to procurement are meeting minimum quality performance standards** and requirements such as network adequacy, timely access, after-hours availability of services, language access and physical accessibility standards, and explicit reduction of disparities, amongst others. DHCS should work more proactively with other state purchasers and regulatory agencies tasked with monitoring to ensure plans are meeting these basic requirements.
- **Institute a robust stakeholder process:** to receive and act on public comment on model contracts, procurement qualifications, and evaluation criteria.

Conclusion:

Thank you again for this opportunity to provide our comments on ways to leverage DHCS' contracting authority to improve health care quality, reduce disparities and address the social determinants of health. Procurement is a critical lever to improving health care quality and reducing disparities. However for contract requirements to be most successful they must also be paired with financial incentives and payment reform.[ix] This step - financially incentivizing plans for their performance - has been a consistent recommendation of national and state experts looking at the Medi-Cal managed care program for several years and is particularly important given the fact that most Medi-Cal plans are county-affiliated plans which do not face competitive re-procurement.

Sincerely,

Caroline Sanders, MPP
Senior Policy Director
California Pan-Ethnic Health Network

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[i] Healthy People 2020. https://www.cdc.gov/nchs/healthy_people/hp2020.htm

[ii] Lown Institute Hospitals Index: https://lownhospitalsindex.org/why-this-matters/

[iii] Med-Cal Managed Care Performance Dashboard https://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx

[iv] Pacific Southwest Mental Health Technology Transfer Center Network. Resource Compendium: Evaluating Community-Defined Evidence Practices. Retrieved from: https://mhttcnetwork.org/centers/pacific-southwest-mhttc/home

[v] For a comprehensive list of Native American and Alaskan Native Community-Defined Evidence Practices, See Appendix: Catalogue of Effective Behavioral Health Practices for Native American Communities (pg. 36) in Native Vision: A Focus on

Improving Behavioral Health Wellness for California Native Americans. Retrieved from https://cpehn.org/sites/default/files/native_population_report.pdf

[vi] For a comprehensive list of Asian Pacific Islander Community-Defined Evidence Practices, See Table 5: Summary of Promising Program and Strategy Submissions (pg. 67) in Asian Pacific Islander (API) Population Report: In Our Words. Retrieved from: https://cpehn.org/sites/default/files/api_population_report.pdf.

[vii] For a comprehensive list of LGBTQ Community-Defined Practices, see "Community Defined & Promising Practices" (pg. 181) in First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual Transgender, Queer and Questioning Populations in California. Retrieved from: https://cpehn.org/sites/default/files/ lgbtq_population_report.pdf

[viii] For a comprehensive list of Latino Community-Defined Evidence Practices, see "Latino SPW Matrix of Organizations with Community-Defined Evidence Programs" in Community-Defined Solutions for Latino Mental Health Care Disparities. Retrieved from: https://cpehn.org/sites/default/files/latino_population_report.pdf

For a comprehensive list of "D4. Models: Community-Defined PEI Practices for Blacks" (pg. 188) in We Ain't Crazy! Just Coping with a Crazy System: Pathways into the Black Population for Eliminating Mental Health Disparities. Retrieved from: https://cpehn.org/sites/default/files/african_american_population_report.pdf

[ix] "Oversight and Accountability of Medi-Cal Managed Care Plans," CPEHN, February 2020: https://cpehn.org/sites/default/files/cpehn_data_oversight_and_accountability-_final_.pdf