

**Children Now comments on the Medi-Cal Managed Care Request for Information (RFI)  
Submitted to the Department of Health Care Services via email  
October 1, 2020**

**General**

It is past time for the Medi-Cal managed care program to truly ensure that every enrolled child receives appropriate physical, behavioral, and oral health care at the right time. An acceptable Medi-Cal contract for children's health would establish accountability and payment mechanisms across the range of children's health care services that are: centered on equity; rooted in youth and parent voice; and firmly held to high standards that drive quality improvement in child health services and outcomes. DHCS must take this procurement opportunity to connect contract performance to payment for children's health care. This should apply for both performance on compliance measures (e.g., Bright Futures utilization, encounter data reporting) and performance on quality measures (e.g., MCAS). DHCS actions and contract changes can:

- Require health plans to spend a minimum portion (e.g., 30%) of the child capitation rate from the state on children's preventive care to ensure that essential services are being delivered, especially for very young kids.
- Withhold a portion of the plan's monthly capitation payments for children until complete encounter data is submitted.
- Include a new quality incentive program in recognition that many MCPs largely fail to provide adequate access or quality care to low-income consumers today. We support the primary use of *an effective accountability mechanism* written into the contracts and recommend that the consequences be significant enough and in a timely enough way to drive behavior change.
- Incentivize and encourage health plans and providers to establish integrated pediatric medical homes which target proven approaches to support families furthest from opportunity, as well as evidence-based home visiting and group-based prenatal care.
- Regularly publicly report county-level summaries of utilization by plan on children's "Bright Futures" preventive care services, and there should be penalties for plans that fall below certain minimum utilization thresholds on an annual basis. Make it clear that responsibilities extend to subdelegated entities. The contract should also require plans to publicly report on quality measures at the sub-plan / delegated entity level to ensure that beneficiaries can choose the plan and network that will meet their needs and provide high quality care. We echo concerns that the existing contract language allows plans to "accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations" and we believe oversight should not be further delegated, especially since California law is stronger than federal requirements in numerous instances, including for language access and network adequacy standards.

**EPSDT benefits (Q4)**

The contracts need to clearly articulate plan responsibility and accountability for the unique EPSDT benefit guarantee for children. Specifically, contracts should:

- Clearly articulate the expectations for delivery of preventive care and the Bright Futures periodicity schedule, unless a stricter standard, such as for blood lead screening, applies.

- Specify the health plan responsibility for trauma screenings to be adopted more broadly. restate the federal definitions of the EPSDT benefit and medical necessity for clarity and consistency.
- Make clear that specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services in the same day, or location of service) in clinical coverage policies, utilization management policies, service definitions, or billing codes do not apply to children (ages less than 21 years). The quantities, frequencies, and locations of visits must be determined by what is medically necessary per federal EPSDT criteria rather than based on arbitrary policy limit. If a service is requested to correct or ameliorate a defect, physical or mental illness, and found to be medically necessary it shall be provided. This includes visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.
- Authorize MCPs to pay for other types of providers, like community health workers, community dental care coordinators, community-based mental health professionals, traditional healers, and navigators, for the evidence-based care they provide in their communities. Community-based healing traditions and services should be properly recognized and valued as core to health and wellness
- Establish the creation of plan-specific dashboards on children’s health that include data such as PNA results and Action Plans, quality data (for MCAS, CAHPS, etc.), summary-level encounter and coordination data, compliance with timeliness in referrals, grievance and appeals data etc. and are published publicly by DHCS.
- Include a Utilization Management section that requires plans to proactively identify and connect with enrollees who have not used EPSDT services to facilitate outreach and assist in scheduling an appointment, and in providing interpretative services and non-medical transportation as needed. The UM systems should also capture components to screenings and addressing social determinants of health. Considering the issues with previous contractors and to ensure services and notices are not delayed, utilization management program should not allow for editing date of request, approval, or denial.
- Add clarifying language that: Contractor shall maintain a Case Review or other mechanism to identify when, where and how children who should be eligible for EIS, LEA, or the CCS programs, or who have Developmental Disabilities or Special Health Care Needs are identified or if are not identified, when, where and how their identification is missed and how to improve on case identification.
- Require written descriptions of referral and follow up procedures, systems, processes, and partnerships in place to monitor the provision for timely referral and follow-up.
- Require plans to enter memorandums of agreement or subcontracts – that include agreed upon screening and referral protocols - with community partnerships, including but not limited to, family resource centers, child care centers, schools/LEAs,, cultural organizations, churches, faith-based organizations, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.
- Articulate how plans are expected to address social determinants of health. For example, DHCS should require all plans to use the "Hunger Vital Signs" screening for beneficiaries and explain how they provide case management support to link beneficiaries who are experiencing hunger to local food resources. 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 for kids and families.

### **Quality (Q4)**

DHCS' Quality goal, as written, does not emphasize *improvement* in quality, but rather simply meeting the minimum levels. A quality incentive program should look for year-over-year improvement in metrics, not simply achieving the minimum. To that end, a quality incentive program should:

- Penalize deterioration in plans performance rates over time, so that significant declines in rates do not go unaddressed as they do today – for example by specifying that plans are required to complete an improvement project for any quality measure each year with a statistically significant decline (regardless if MPL is met) in order to actively address deterioration. Any and all slips in performance should be actively addressed if maintenance and improvement are quality goals.
- Make clear that minimum benchmarks will be set at least the 50<sup>th</sup> percentile, or some higher floor, and that there will be real consequences for under-performance. That is, while benchmarks could be set higher than this depending on the measure, the 50<sup>th</sup> percentile should be a floor.
- Require a minimum performance change that is required beyond what is statistically significant. For example, DHCS could reward improvement only if it is significant enough that the plan, if it continues to improve at the same rate, will reach the benchmark within 3 years.
- Be family friendly. For example, if there is an auto-assignment policy, it should be made family-friendly by considering health plan enrollment of other family members.
- Consider metrics of quality beyond the Medi-Cal Accountability Set.
- Include and operationalize metrics of care coordination in order to track health plan ability to ensure seamless coordination of all medically necessary care a child needs, including Medi-Cal dental services, behavioral health services, and developmental services.
- Consider consumer satisfaction as a component of quality and, like other performance measures, establish accountability mechanisms. DHCS should require each health plan to annually report CAHPS data and establish a grading system with identified consequences for changes in CAHPS scores across populations over time. That way, as an important factor of quality, health plans would have to address low consumer satisfaction scores and be responsible for the consumer experience of their members.
- Utilize the array of performance improvement tools and penalties that have not been considered such as shared savings, prohibiting plans from expanding to new regions or from bidding on future contracts, and dis-enrolling certain populations from poorly performing plans.
- Be centered on health equity and focus on eliminating health disparities, as well as improving quality across the lifespan. In other words, a quality incentive program needs to be designed to focus on health equity throughout. Because the DHCS Comprehensive Quality Strategy calls for a central focus on health equity, it is not clear how a quality improvement design that does not focus on disparities is consistent with that DHCS goal. We cannot assume that overall quality improvement will reduce disparities, regardless of the measures chosen; in fact, the opposite may be true. Plans must be required to produce sufficient demographic data such that quality benchmarks and incentives can be tied to the reduction of health disparities. Disparities reduction should be a driving objective of a quality incentive program from top to bottom, not a catchall afterthought for undefined delivery system reform.

### **Disparities and Social Determinants of Health (Q1)**

To address child health disparities, inequities, and social determinants of health, contracts should:

- Build on the lessons of the Asthma Mitigation Project that DHCS is currently supporting and ensure that asthma home visiting services are available to all Medi-Cal beneficiaries on an ongoing basis once the Project ends. Black children and other children of color are by far the most likely Californian children with asthma to need emergency room or urgent care visits for asthma compared to white children. We recommend that the MCP contract make changes to reflect coverage for asthma home visiting services via two policy pathways: (1) a Medicaid state plan amendment to allow for asthma education and home environmental trigger assessments provided by qualified non-licensed professionals under the supervision of a licensed practitioner and provided for Medi-Cal beneficiaries with poorly controlled asthma as a covered benefit; and (2) Environmental asthma trigger remediation can be covered as a service offered under CalAIM's "In Lieu of Services" program. Detailed recommendations have previously been shared with DHCS and have been submitted by our partners at Regional Asthma Management and Prevention (RAMP).
- 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 facilitate self-reporting and utilization of demographic data.
- 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 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.
- Require plans to identify a set of disparity measures for children that they will establish incentive targets for and report on publicly.
- Establish new measures for equity and require public reporting like other states are already doing. 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.

### **Community Engagement (Q2)**

Contracts should require plans to collaborate with stakeholders on identifying and achieving health priorities, including the reduction of health disparities, in the service area as part of any Population Needs Assessments. Contracts should clarify a minimum percentage of the membership of required Community Advisory Committees be filled with parents of enrolled children and enrolled youth, and also

include members with Limited English Proficiency (LEP), and members from diverse cultural and ethnic backgrounds. Finally, contracts should require plans to facilitate meaningful consumer engagement in advisory committees and similar groups by providing necessary assistance for participation including, as appropriate, child care, transportation to meetings, language and sign language interpreters, and assistive devices and other accommodations needed by persons with disabilities.

#### **Behavioral Health (Q4)**

DHCS must eliminate the need for specific clinical diagnoses for children and families to access care, particularly as it relates to children's mental and substance use disorder services. The contract should clarify that the health plans are responsible for ensuring that child members are appropriately referred for treatment without delay. The new contract must ensure that children can directly access mental health and substance use disorder services without a diagnosis. It must be made clear that children are entitled to receive non-specialty mental health services that are medically necessary through Medi-Cal managed care plans or fee-for-service providers under the EPSDT entitlement. Because of EPSDT, children have been entitled to greater benefits than adults, both through the MHPs and managed care plans (MCPs), prior to the ACA's adult benefit expansion in January 2014. We believe it is crucial to ensure all plans are aware that children may qualify for SMHS regardless of impairment level, and who is responsible for providing mental health services for a particular child is not merely dictated by the severity of the child's impairment.

#### **Dental Care (Q8)**

Contracts must make explicit the responsibility of MCPs in the delivery and coordination of dental care. Specifically, add a subsection related to children's preventive dental care in Exhibit A, Attachment 10 on Scope of Services. This subsection would outline the plan requirements to work with providers in their network to ensure that children receive preventive dental services that can be conducted in the medical office, such as an initial dental health assessment as part of a well-child visit, fluoride varnish and caries risk assessment, and that the plans work to integrate their systems with state's Medi-Cal Dental fee-for-service and dental managed care systems to ensure that information regarding a member's dental health and preventive services provided in the medical office are communicated and coordinated as needed between medical and dental providers (e.g. number of times fluoride varnish is applied per a caries risk assessment). Furthermore, for the dental section (#15) of Exhibit A, Attachment 11 on Case Management and Coordination of Care, DHCS should include the specific measures by which plans are expected to fulfill provisions of AB 2207 as it relates to dental care, specifically around the requirement to ensure and track that an eligible beneficiary is referred to an appropriate Medi-Cal dental provider in a timely way; and to have an identified plan liaison available to assist families, dental managed care contractors, dental fee-for-service contractors, and county departments of public health with referrals to health plan covered services and carved out dental services, as well as track the number of times a plan liaison is contacted to assist with a dental request and whether that request was able to be fulfilled.

### **Enforcement and Compliance (Q5)**

Undergirding all of the goals DHCS has set out is the assumption of sufficient enforcement and compliance with contract provisions. MCP compliance and quality have been substandard and according to several State audits of Medi-Cal managed care, many of the issues stem from ineffective oversight, accountability, enforcement and clearer delineation of MCP responsibilities in DHCS guidance and contracts. As part of this procurement, DHCS should lay out a plan for more transparent and effective enforcement and oversight, particularly of the EPSDT provisions relating to children that have been contracted to MCPs. To that end, DHCS should install a Medi-Cal children's EPSDT officer to focus DHCS oversight and enforcement of MCPs' EPSDT responsibilities and require each plan to have an EPSDT compliance officer to flag for MCP leadership EPSDT under-utilization and violations of MCP's EPSDT responsibilities. New contracts should also:

- Strengthen provisions on sanctions, allowing DHCS to impose sanctions more quickly when MCPs fail to comply with contract provisions and performance measures.
- clearly articulate how and when plans must report encounter data documenting the provision of EPSDT services that plans must submit and make explicit in contract language that false EPSDT encounter data submission is a violation of the Federal and California False Claims Act. The contract should articulate the significant penalties for non-compliance with timely encounter data reporting.
- Aim to reduce and eventually eliminate alternative access standards for network adequacy and ensure compliance with existing pediatric network adequacy standards. not find ways to allow plans to skirt the standards.

### **Selection Criteria (Other)**

DHCS should establish procurement selection criteria that prioritizes children. DHCS should carefully scrutinize and consider the track record of health plans in delivering health care for children in California's insurance markets *and* in other states when deciding which bidding health plans to contract with. DHCS should also require MCPs to provide information regarding the steps they are taking internally with regards to staffing and operations as well as their business practices to advance equity as an organizational priority.