



Interested Party Requested Information Feedback Instructions

1. Insert organization's name and mailing address, and contact information for primary point-of-contact (POC) below:

Organization Name:	California Pan Ethnic Health Network, Health Access, Maternal and Child Health Access, National Health Law Program, The Children's Partnership, and Western Center on Law and Poverty
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2. In Appendix 1, there is a "Feedback" Tab to provide feedback on the information provided in the RFI. You may provide multiple comments for any category. On the "Feedback" tab, provide your feedback by providing the following information:

Category:	Choose the category from the drop down menu. Options are: "Q1 - Response to Question 1" "Q2 - Response to Question 2" "Q3 - Response to Question 3" "Q4 - Response to Question 4" "Q5 - Response to Question 5" "Q6 - Response to Question 6" "Q7 - Response to Question 7" "Q8 - Response to Question 8" "General" - Procurement-related items not specific to the Health Plan Contract. "Other" - Other categories not identified.
Feedback:	Type your feedback

3. Do not change the formatting of this document.

4. Submit this document according to the instructions located in the RFI Cover Letter.



Appendix 1 Feedback

OID	Category	Feedback
1	Q1 - Response to Question 1	Health Disparities. Require the Population (Group) Needs Assessment to add other demographic questions to the survey including but not limited to age, race, ethnicity, gender, disability status, sexual orientation and gender identity.
2	Q1 - Response to Question 1	Health 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 facilitate self-reporting and utilization of demographic data.
3	Q1 - Response to Question 1	Health Disparities. 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.
4	Q1 - Response to Question 1	Health Disparities. 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.
5	Q1 - Response to Question 1	Health Disparities. 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.
6	Q1 - Response to Question 1	Health Disparities. 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.
7	Q1 - Response to Question 1	Health Disparities. Authorize MCPs to bill for community-based 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.
8	Q1 - Response to Question 1	Health Disparities. 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.
9	Q1 - Response to Question 1	Health Disparities. 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 technical assistance to CBOs and small businesses to demystify the contracting process.
10	Q1 - Response to Question 1	Health Disparities. MCPs should be required to include one QIP or PIP related to health disparities based on their PNA findings.
11	Q1 - Response to Question 1	Health Disparities. Require MCPs to publicly report their PNA results, and incorporate this data into plan-specific dashboards.
12	Q1 - Response to Question 1	Health Disparities. Exhibit A, Attachment 9 , E. Cultural Competency Training should be amended 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.
13	General	(1 of 4: CPSP SDOH context) Providing access to services that address social determinants of health (SDOH) must become a high priority for Medi-Cal. A model for doing this, that could be extended to children as well as adult beneficiaries, is Medi-Cal's evidence-based Comprehensive Perinatal Services Program. (Lennie A., Klun J., Hausner T. "Low-birth-weight rate reduced by the obstetrical access project." Health Care Finance Rev. 1987 Spring; 8(3): 83–86. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192843/ . And Kinsler, Sarah."Supporting High Performance in Early Entry into Prenatal Care: Spotlight on California's Comprehensive Perinatal Services Program." National Academy for State Health Policy, August 29, 2014: https://nashp.org/wp-content/uploads/sites/default/files/files/CaliforniaFINAL-prenatal-care.pdf) CPSP is already part of California's State Plan, is included as a health plan benefit, and is supported with federal matching funds. Faithful implementation of the model is key to improving birth outcomes and decreasing racial disparities in maternal and child health, especially in the COVID-19 era. To achieve these goals, however, the Department needs to: (1) adopt and robustly implement mechanisms for both CPSP quality assurance and enforcement; 2) clarify that Medi-Cal will reimburse for covered SDOH benefits when rendered in an individual's home, neighborhood community center, or other similar non-clinical settings, including while a beneficiary is in Medi-Cal fee-for-service before plan enrollment begins; and 3) adopt a mechanism for sustainably engaging and compensating qualified community-based organizations (CBOs) for delivering SDOH services. Once faithful implementation of the CPSP model is assured, it could and should be considered for adoption for the Children's Medi-Cal program to comply with the preventive services mandate of EPSDT as well as for adults in Medi-Cal. In other words, to effectively deal with the impact of SDOH as well as to meaningfully address racial disparities in health, the Department must expand its current narrow focus on rendering SDOH services in the community primarily for the homeless

14	General	(2 of 4: CPSP SDOH context) Medi-Cal's CPSP provides an enhanced, evidence-based package of benefits, including services to SDOH during pregnancy and the postpartum period. It was enacted into law in 1987 following the state's evidence-based OB Pilot Project, which integrated SDOH services into the delivery of prenatal care for Medi-Cal beneficiaries, an approach that not only saved the state money but also improved maternal and child health outcomes. The plans are capitated for CPSP. Due to a variety of factors, however, the promise of the evidence-based CPSP model has been undermined. The model's original emphasis on incorporating technical assistance on SDOH and other non-clinical services for pregnant women from public health experts has changed with the transition to capitation. If the COVID-19 era has taught us anything about health disparities it is that we ignore public health experts at our collective peril. The state has instead largely relied on the plans to self-certify that CPSP social determinants services are being provided for individuals who need them. This lack of accountability must end. The Department finally incorporated CPSP's SDOH benefits into plan medical record review for the first time on March 4, but APL 20-006 has been postponed due to the pandemic. And even when implemented, this alone, with a three-year gap between any given established plan's prior review and little public reporting of the results, are insufficient to ensure faithful implementation of the CPSP social determinants model to meet beneficiaries' needs.
15	General	(3 of 4: CPSP SDOH context) Fortunately, however, local communities provide bright spots, showing the way back to CPSP's SDOH roots and the potential for far better birth outcomes. For example, community peer pregnancy coaches with Black Mothers United (BMU), a project of Her Health First in Sacramento (http://herhealthfirst.org/black-mothers-united/), provides SDOH services in a manner closely aligned with CPSP's evidence-based protocols, assessments, individualized care plans, tracking, and follow up documentation requirements. Women participating in the BMU program are all Medi-Cal managed care plan enrollees who are not receiving from their plans the CPSP SDOH services they need. Evaluations for the BMU project, which is funded by foundations and the Sacramento 1st 5 Commission, show significant improvement in birth outcomes for families in a county with one of California's worst track records on racial disparities in birth outcomes. In Los Angeles County, the county with California's highest poverty rate at 22.3%, Maternal and Child Health Access (MCHA) conducts home visitation for low-income families with newborns, enrolls families into Medi-Cal, assists families with navigating the health care, food, housing and other support systems, and provides or arranges for the kinds of SDOH services that CPSP requires. Pregnant women with Medi-Cal are significantly more likely to bear the burden of SDOH impacts than women with private insurance, according to the state's Maternal and Infant Health Assessment (most recently available data are from 2013-2014; update request pending). The impact of the 2020 COVID-19 pandemic is likely having additional substantial impacts on SDOH for low-income
16	General	(4 of 4: CPSP SDOH context) This also has consequences for racial disparities. California's black infant mortality at 8.4 per 1,000 is two to three times higher than for white babies 3.1 per 1000, while Black/African American women are nearly four times more likely to die as a result of pregnancy and delivery/postpartum complications than women of other races. Prematurity is the leading cause of infant mortality and morbidity, and the premature birth rate in California has steadily increased since 2014, with Los Angeles County always slightly higher. In 2018, one in 11 babies (9.1% of live births) was born preterm in Los Angeles County. The rate of preterm birth in Los Angeles County is highest for black infants (12.3%), followed by American Indian/Alaska Natives (10.0%), Hispanics (9.2%), all higher than the state average, then whites (7.9%) and Asian/Pacific Islanders (7.6%). According to the state Department of Public Health, while perinatal depression and other mental health conditions pose serious threats to health, timely screening and early interventions, such as group counseling and other social supports, can offer effective protection. https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/PAMR.aspx . Coordinating with CBOs to ensure adherence to CPSP's evidence-based model, with federal matching funds, could have a dramatic impact on the health of California's women and children. It could also serve as a model for an SDOH benefit in Children's Medi-Cal under EPSDT and for adult beneficiaries as well. We provide specific recommendations to move toward achieving these goals in our responses to several of the questions the Department has posed.
17	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 10, 7(a) Pregnant Women: At p. 79, ¶ 7, A, edit as follows: "Contractor shall cover and ensure the provision of all Medically Necessary services, mental health, and social determinants of health services for pregnant women. Contractor shall ensure that, at a minimum , the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) and those of the Comprehensive Perinatal Services Program (CPSP) are utilized to provide, at a minimum , quality perinatal services."
18	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 10, 7(b) Pregnant Women Risk Assessment: At pp. 79-80, ¶ 7, B, edit as follows: "Risk Assessment and Services for Identified Needs . Contractor shall implement a comprehensive risk assessment tool for all pregnant female Members that is at least comparable to the ACOG standard and that uses the Comprehensive Perinatal Services Program (CPSP) standards per Welfare and Institutions Code §§ 14132(u) and 14134.5 and Title 22 CCR Section 51348 and the elements of the CPSP Assessment forms that are set forth in Exhibit A, Attachment ___ . The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial (i.e., mental health and social determinants of health), and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. An Individualized Care Plan shall be prepared to address identified risks . Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record."
19	Q1 - Response to Question 1	SDOH. We also recommend the following related actions for oversight and monitoring of the CPSP benefit: 1) implementation as soon as possible of APL 20-006, which for the first time includes CPSP's SDOH requirements in the Medical Record Review (MRR) process; 2) detailed public reporting of the MRR findings; 3) clear guidance to the plans on CPSP's SDOH requirements and expectations for plan compliance; 4) creation of a broad stakeholder work group to streamline the CPSP trimester and postpartum assessment forms and integrate them into the Department's existing requirements for initial health assessments for adults; 5) clarifying that Medi-Cal will reimburse for SDOH services delivered to a pregnant individual and others in a community setting; 6) clear guidance to the plans on incorporating qualified CBOs into the screening and delivery of SDOH services, with adequate compensation; and 7) a stakeholder work group to consider requiring plans to reinvest a specified percent of profits to support referrals to CBOs for SDOH services.
20	Q1 - Response to Question 1	SDOH. Research shows that children in Medi-Cal can benefit significantly from SDOH screening and services. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2548441?alert=article For Children's Medi-Cal under EPSDT, we recommend the addition of a requirement to not only screen for SDOH but also, when social needs are identified, to prepare an Individualized Care Plan and document what services were offered and whether services were received. This should be done in coordination with ACES screening and follow up. As with CPSP, robust oversight and monitoring must be incorporated into the plan review process to ensure faithful implementation of the model.
21	Q1 - Response to Question 1	SDOH. For beneficiaries other than children and pregnant women, the plan contract should be changed to also require: 1) age-appropriate SDOH screening be integrated into the current initial health assessment process; 2) Individualized Care Plans for plan members identified as having social needs, with appropriate follow up; and 3) documentation of the SDOH services offered and how provided.
22	Q2 - Response to Question 2	SDOH. As indicated in our responses to Q 1 and the "General" tab, CBOs should be incorporated into the screening and delivery of SDOH services under the CPSP benefit. Simply referring to CBOs would be insufficient; there must also be an appropriate mechanism for adequate compensation. A stakeholder work group to consider requiring the plans to reinvest a specified percentage of profits to support SDOH services in the community should be created.

23	Q3 - Response to Question 3	SDOH. As indicated in our responses to Q 1 and the "General" tab, the involvement of qualified CBOs is key to screening and delivering services to address SDOH. Doing so is also essential to being ready to respond to public health emergencies and natural disasters. Known, trusted community workers are in the best position to reach out to plan members in linguistically and culturally appropriate ways.
24	Q5 - Response to Question 5	SDOH. As indicated in our responses to Q 1 and the "General" tab, robust and effective oversight and monitoring are essential to ensuring that the CPSP model is appropriately implemented so that women and their newborns may benefit. As the Department has never before included CPSP's SDOH benefit in the plan audit process, and has yet to launch the new procedure for CPSP under APL 20-006 and report on findings, enforcement remains as a challenge. A stakeholder process for streamlining the CPSP trimester and postpartum forms, for integration with the initial health assessment process for pregnant plan members, would go a long way to addressing the separate challenge of achieving consistency and uniformity among plans in the delivery of the CPSP SDOH benefit. Involving CBOs sustainably in SDOH screening and SDOH service delivery, along the lines of the Black Mothers United project in Sacramento, would go a long way to addressing the challenge of providing plan members with access to trusted partners for this care. A requirement that plans reinvest in such CBO services would make the successful BMU and similar models sustainable and promote quality assurance through faithful implementation of the original evidence-based CPSP model.
25	Q5 - Response to Question 5	SDOH. DHCS should require all plans to use the "Hunger Vital Signs" screening for beneficiaries and provide case management support to link beneficiaries who are experiencing hunger to local food resources.
26	Q5 - Response to Question 5	SDOH. For comment above, beneficiaries should also be linked to CalFresh.
27	Q4 - Response to Question 4	SDOH. Add a level of assistance to all "referrals", such as for WIC - Contractor, as part of its IHA of Members, or, as part of the initial evaluation of newly pregnant women, shall refer <i>and assist</i> and document the referral of <i>and assistance</i> for pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c).
28	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 4, Written Description for Quality Improvement System. At p. 18, edit ¶ 7. F. as follows: "The processes and procedures designed to ensure that all Medically Necessary Covered Services and Social Determinants of Health Covered Services are available and accessible to all Members. . . ." And at p. 19, edit ¶ H. as follows: "Description of the quality of clinical care services and non-clinical social determinants of health services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services."
29	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 4, Written Description for Quality Improvement System. At p. 19, edit ¶ H. as follows: "Description of the quality of clinical care services and non-clinical social determinants of health services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services."
30	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 4, Performance Improvement Projects (PIP). At p. 23, for the PIP Status Report contents, add new sub d. to ¶ 9, C, 3: " Interventions that address social determinants of health ".
31	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 4, Credentialing: At p. 26, in ¶ 12, G, add Licensed Midwives.
32	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 4, Items for inclusion in Member Medical Record: At p. 28, add new sub 11)) to ¶ 13, D as follows: 10) Health education behavioral assessment and referrals to health education services. 11) Comprehensive Perinatal Services Program assessments under Welfare and Institutions Code §§ 14132(u) and 14134.5 and Title 22, California Code of Regulations, §§ 51179, 51179.10, 51348, 51348.1 for nutritional, health education, and psychosocial services, including social determinants of health, at initial visit, each following trimester and the postpartum period, with an Individualized Care Plan for identified needs, and documentation in the medical record of services offered, provided or coordinated with referral entity. "
33	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 5, Utilization Management (UM) program. At p. 29, edit ¶ 1 as follows: "Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services and Social Determinants of Health Covered Services ". SDOH requirements should also be integrated throughout the rest of ¶ 1, A-I on UM.
34	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 5, Review of Utilization Data: At p. 33, edit ¶ 4 as follows: "Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services and social determinants of health services . Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request."
35	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 5, Network Composition. At p. 34, edit ¶ 2 as follows: "Within each Service Area, Contractor shall ensure and monitor an appropriate Provider Network, including adult and pediatric PCPs, perinatal and other community health workers regarding social determinants of health , OB/GYN, adult and pediatric behavioral health Providers, adult and pediatric Specialists, professional, Allied Health Personnel, supportive paramedical personnel, hospitals, pharmacies, and an adequate number of accessible inpatient facilities and service sites. In addition, Contractor shall ensure and monitor American Indian Health Service Programs, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Freestanding Birthing Centers (FBCs), where available.
36	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 5, Provider Network. At pp. 34-43, ¶¶ 1-19: Incorporate appropriate measures for perinatal health workers and other community health workers for social determinants of health throughout.
37	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 7, Network Provider Training. At p. 45, edit ¶ 5, B as follows: "Contractor shall develop and implement a process to provide information to providers and to train Network Providers on a continuing basis regarding clinical protocols, social determinants of health benefit under the Comprehensive Perinatal Services Program , other evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction for Seniors and Persons with Disabilities or chronic conditions and social determinants of health for the Medi-Cal population . This process shall include an educational program for Network Providers regarding health needs specific to this the Medi-Cal population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers. "
38	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 7, Network Provider Training. At p. 45, edit ¶ 5, C as follows: "For Out-of-Network Providers who will not receive Network Provider training, Contractor shall develop and implement a process to provide them with Contractor's clinical protocols and evidence-based practice and social determinants of health guidelines. Contractor shall arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an Out-of-Network Provider."
39	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 8, OON providers. At p. 50, ¶ 8, add Licensed Midwives to the provisions on Non-Contracting Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Reimbursement.
40	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 9, Access and Availability. At p. 56, in ¶ 1 (General Requirements), edit as follows: Contractor shall ensure Members access to Specialists for Medically Necessary Covered Services and to perinatal and other community health workers for social determinants of health services
41	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 9, Access Requirements. At p. 56, ¶ 3, B, edit as follows: "First Prenatal Visit Contractor shall ensure that the first prenatal visit and initiation of the Comprehensive Perinatal Services Program assessment for a pregnant Member will be available within two (2) weeks upon request."

42	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 9, Access Standards. At p. 57, ¶ 4, A, edit as follows: "Contractor shall ensure that Members are offered appointments for covered health care services and covered social determinants of health services within a time period appropriate for their condition."
43	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 9, Access Standards. At p. 60, ¶ 8, add Licensed Midwives to provisions on CNMs and NPs.
44	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 9, Access to Services with Special Arrangements, Minor Consent. At p. 62, ¶ 9, D, for the Minor Consent program, add out of network provisions as are provided for Family Planning services in ¶ 9, A, 2).
45	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 9, Access to Services with Special Arrangements, Minor Consent. At p. 62, ¶ 9, D, edit as follows: "Contractor shall ensure the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be . . . informed of the availability of these services. Minors do not need parental consent to access these services. Contractor shall ensure that these services be kept strictly confidential, including by not sending communications about Minor Consent services to any address the minor shares with a parent or guardian from whom confidentiality is sought. "
46	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 9, Cultural and Linguistic Program. At pp. 63-65, in ¶ 13, add Social Determinants of Health (SDOH) to the Program and throughout ¶ 13, with particular attention to the Group Needs Assessment (GNA) in sub C and adding SDOH training to the training provisions in sub E.
47	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 9, Community Advisory Committee (CAC). At p. 67, ¶ 15, add social determinants of health to the charge of the CAC.
48	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 10, Scope of Services. At p. 69, ¶ 1, A edit as follows: "Contractor shall provide or arrange for all Medically Necessary Covered Services and Social Determinants of Health Services for Members. . . "
49	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 10, Initial Health Assessment. At pp. 70, ¶ 3, edit as follows: " An Initial Health Assessment (IHA) consists of a history and physical examination, and an Individual Health Education Behavioral and Social Determinants of Health Assessment (IHEBA & SDOH) or Comprehensive Perinatal Services Program Assessment (CPSPA), as appropriate, that enables a Provider of primary care services to comprehensively assess the Member's current acute, chronic, and preventive and social determinants of health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract."
50	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 4, Initial Health Assessment. At p. 71, ¶ 3, B - D, need to add the CPSP Trimester and Postpartum Assessment forms, the CPSP Individualized Care Plan of appropriate interventions, and follow-up documentation forms to Exhibit A, Attachment 10. We also recommend that a stakeholder group of perinatal advocates and SDOH experts be created to update the current Assessment forms in collaboration with the CA Department of Public Health and in coordination with the IHEBA workgroup (see next
51	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 10, Initial Health Assessment (IHA). At p. 71, ¶ 3, B - D, need to update the age-appropriate elements of the DHCS-approved assessment tool, the IHEBA assessment form, with screening for social determinants of health. Contractors are required to use the form, which is currently "described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10)." Also need to add Individualized Care Plan and Follow-Up Documentation forms, based on the CPSP model. We recommend that a stakeholders work group be created for the updating process. A SDOH stakeholder group, including consumer advocates, should be assembled to participate in the review and update of the IHEBA for SDOH.
52	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 10, IHA for Members Under 21. At p. 71, ¶ 5, edit as follows: "Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including services listed under 42 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132(v), unless otherwise excluded under this Contract. The screening shall include screening for social determinants of health, followed by an Individualized Care Plan for identified social needs, if any, and shall be done in coordination with screening for and responses to adverse childhood experiences. "
53	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 10, Scope of Services for Adults. At p. 78, ¶ 6, A, 2, i), edit as follows: "Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to. . .IHEBA & SDOH."
54	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 10, Adult Preventive Services. At p. 78, ¶ 6, B, edit as follows: "Contractor shall cover and ensure the delivery of all preventive services, social determinants of health services, and Medically Necessary diagnostic and treatment services for adult
55	Q1 - Response to Question 1	SDOH. Exhibit A, Attachment 10, Services for All Members. At pp. 80-81, ¶ 8, add new sub C, for "Social Determinants of Health Services", and re-letter following subs accordingly.
56	Q1 - Response to Question 1	SDOH. 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.
57	Q1 - Response to Question 1	SDOH. 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.
58	Q1 - Response to Question 1	SDOH. 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.
59	Q1 - Response to Question 1	SDOH. 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. As a condition of requiring CBO contracting, DHCS 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.

60	Q1 - Response to Question 1	SDOH. Require MCPs in partnership with DHCS to 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.
61	Q1 - Response to Question 1	SDOH. DHCS should authorize and ntivize planinces 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. 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
62	Q1 - Response to Question 1	SDOH. 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).
63	Q2 - Response to Question 2	Community engagement. DHCS should monitor and report on all use of Medi-Cal Managed Care funds beyond provider payments. For example, LA Care supports community need in the area of CalFresh enrollment and training community agencies to enroll in CalFresh. The Medi-Cal Managed Care Advisory Group should be involved in a Best Practice workgroup and presentations/exchange of ideas.
64	Q2 - Response to Question 2	Community engagement. Require plans to collaborate with stakeholders on identifying and achieving health priorities, including the reduction of health disparities, in the service area.
65	Q2 - Response to Question 2	Community engagement. Require plans to provide necessary assistance for participation including, as appropriate, transportation to meetings, language and sign language interpreters, and assistive devices and other accommodations needed by persons with disabilities, to advisory committee or other similar committee or group.
66	Q2 - Response to Question 2	Community engagement. In new contract, under member representation, in addition to SPD and chronic conditions, should also include members with Limited English Proficiency (LEP), and members from diverse cultural and ethnic backgrounds.
67	Q2 - Response to Question 2	Community engagement. For the Children’s Services and Local Engagement Goals, the MCP should clarify a percentage of the membership of required Community Engagement Committees be filled with parents of Medi-Cal children and EPSDT utilization data and measures (when developed) be presented to the CAC and their input is sought in the MCPs EPDST full implementation plan.
68	Q3 - Response to Question 3	Community Engagement. Add policies and procedures for provision of member monetary incentives for attending visits, health education, etc.
69	Q2 - Response to Question 2	Community Engagement. Require MCPs to report how many patients/members are on their Boards. Federally Qualified Health Centers are required to have 51% of patient/member consumers on their boards – this should be a requirement for all safety-net providers: Medi-Cal health plans, physician groups and hospitals.
70	Q3 - Response to Question 3	Disaster preparedness. This needs fuller development with a committee. We’d recommend the Managed Care Advisory Group be a part. Language should be modified with “in an emergency” for each area, or in a separate area, to allow for alternate processes in place, such as telephonic applications and arrangements, versus when care is to be accessed virtually. Patient and provider safety and care quality should be paramount. Virtual (by visual screen) and telephonic visits can be of great use in expanding capacity, but should not be seen as a substitute for in-person visits when such a visit cannot accomplish the purpose of the visit, such as for a biopsy or for symptoms not well-seen on a screen, or when patients do not have a private space from which to have a visit, or do not have the ability to properly or correctly weigh themselves for adequate or over weight gain. We’ve seen such a “Wild West” out among providers with varying and changing protocols for services. We are sympathetic that no one has been through a disaster of this proportion. DHCS should consider how providers should submit any changes in protocols for visits, such as prenatal and well-child, and how DHCS communicates the need or
71	Q3 - Response to Question 3	Disaster preparedness. Plans should be required to have plans in place to quickly operationalize the following services during a disaster: messaging, life-safety checks, member tracking, quickly sharing critical health information, and preventing and diverting inappropriate admissions to medical facilities and institutionalization. Because health care needs arise as the first basic needs during a disaster, health plans should be on the front lines of disasters to coordinate care. Coordination of care includes proactively reaching out to members to provide information and inquire about medical needs, providing equipment, medication, and supplies that have been interrupted by loss of water and power, and working with members individually before a disaster to come up with a personal emergency plan.
72	Q3 - Response to Question 3	Disaster preparedness. Plans should work with providers to build capacity to quickly pivot to telehealth services during disasters for all health care services, including behavioral health. Telehealth services should be provided to members in ways that least disrupt utilization and should not be implemented in ways that discourage utilization. As we have seen during the COVID-19 pandemic, health plans recorded major profit increases during the first two quarters of 2020, despite declining mental health across the U.S. and ongoing chronic health needs which do not just disappear during a pandemic.
73	Q3 - Response to Question 3	Disaster preparedness. Plans should be required to operationalize their emergency response plans at a designated speed that will ensure the best outcomes for their members during a disaster.
74	Q3 - Response to Question 3	Disaster preparedness. Plans should require their contractors and vendors to also have emergency preparedness plans and to be required to enforce them. These plans should follow both state and federal emergency preparedness rules.
75	Q3 - Response to Question 3	Disaster preparedness. Please refer to: Marcie Roth, June Isaacson Kailes & Melissa Marshall. <i>Getting It Wrong: An Indictment with a Blueprint for Getting It Right</i> , The Partnership for Inclusive Disaster Strategies (2018), https://ccltss.org/cc-content-wp/uploads/2018/10/Getting-It-Wrong-Report-Excerpt-1.pdf

76	Q1 - Response to Question 1	Health Disparities/Quality. A quality incentive program must 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
77	Q4 - Response to Question 4	Quality. In recognition that many MCPs largely fail to provide adequate access or quality care to low-income consumers today, contracts should include a new quality incentive program. 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.
78	Q4 - Response to Question 4	Quality. A quality incentive program should 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.
79	Q4 - Response to Question 4	Quality. Contracts should be clear that minimum benchmarks will be set at least the 50th 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 50th percentile should be a floor.
80	Q5 - Response to Question 5	Quality. DHCS' 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. And in the event that improvement is considered, there should be 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.
81	Q4 - Response to Question 4	Quality. If there is an auto-assignment policy, it should be made family-friendly by considering health plan enrollment of other family members.
82	Q4 - Response to Question 4	Quality. DHCS should consider metrics of quality beyond the Medi-Cal Accountability Set (i.e., the Child and Adult Core Sets). For example, DHCS can ensure that quality preventive care for children is provided by regularly reporting county-level health plan utilization data on children's "Bright Futures" preventive care services. Penalties should be imposed for plans falling below minimum thresholds.
83	Q4 - Response to Question 4	Quality. Quality care includes quality care coordination. DHCS should operationalize metrics of coordination in order to track health plan ability to ensure seamless coordination of all medically necessary care, including Medi-Cal dental services, behavioral health services, and preventive services, including developmental services.
84	Q5 - Response to Question 5	Quality. The ability of a Medi-Cal managed care plan to collect and report accurate encounter data and to produce annual public summaries of encounter data must strongly be considered as a compliance issue and because of the importance of timely encounter data for quality monitoring, DHCS should levy significant liquidated damage penalties for non-compliance.
85	Q4 - Response to Question 4	Quality. The state should include 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.
86	Q8 - Response to Question 8	Quality/Coordination of Care. In the section on Comprehensive Case Management, Including Coordination of Care Services, Exhibit A, Attachment 11, DHCS should standardize with a minimum standard that plans may go above, the identification of Members who may benefit from complex case management services. Too often, community agencies carry out this role.
87	Q4 - Response to Question 4	Quality. In Exhibit A, Attachment 1 ORGANIZATION AND ADMINISTRATION OF THE PLAN, 10. Sensitivity training. The sensitivity training called for in this section should be more specific, with input from disability organizations. Who it applies to should be more specific – is this for plan personnel or providers or ?? How often would the training be required? At least yearly/every two years. Please add implicit bias training now required of providers.
88	Q4 - Response to Question 4	Quality. The QIS has explicit instructions on including providers. At least one consumer/beneficiary should be required for this committee.
89	Q4 - Response to Question 4	Quality/Oversight DE. In the new contract, DHCS should 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.
90	Q4 - Response to Question 4	Quality/Children. For the Children's Services goal, performance measures, including a newly proposed EPSDT utilization measure, and population health plans should be stratified and reported based on the developmental stages in a child's life rather than merely as one group ages 0-18. In other words, performance measures and PNAs should be collected and reported with results broken down for ages 0-5, 6-12, 13-18, and 19-21. Similarly, the MCPs' population health plans should stratify their data, analysis and plans for these age
91	Q4 - Response to Question 4	Quality. Exhibit A, Attachment 18 IMPLEMENTATION PLAN AND DELIVERABLES, 10. Scope of Services - Item C, D, E, F, G and L should be standardized among plans.
92	Q4 - Response to Question 4	Access. The section of the current contract titled "Existing Patient-Physician Relationships" should be expanded to reflect current DHCS guidance on continuity of care.
93	Q4 - Response to Question 4	Access. The sections on provider access and provider networks and OON providers should be updated to reflect current California law on geographic access, timely access, and appointment availability.
94	Q4 - Response to Question 4	Access/Coordinated care. The new contract should require plans to report annually to DHCS on utilization of NEMT and NMT services by number of unduplicated members and by service (i.e. dental, mental, medical).
95	Q4 - Response to Question 4	Access/Coordinated care. The section on prescription drugs must be revised to account for the Rx carve-out and the role of plans in facilitating access to carved out drugs.
96	Q4 - Response to Question 4	Access/Coordinated care. The new contract should clarify that plans have an obligation to provide referral assistance for non-medical treatment not covered by the plan but found to be needed because of conditions disclosed during screenings and diagnosis. The referral assistance must include giving the family or Member the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.
97	Q4 - Response to Question 4	Access/Coordinated care. The new contract should require MCPs to collect data on utilization of both MCP and carved out services and use that data to evaluate whether members are appropriately accessing care, and make referrals or provide other case management assistance where members are over- or under-utilizing services.
98	Q4 - Response to Question 4	Access/Coordinated care. The new contract should clarify plans obligations to provide case management, discharge planning, and person-centered care to dually eligible members, including the plans' obligation to coordinate with Medicare.
99	Q4 - Response to Question 4	Access/Coordinated care. The contract provisions about discharge planning should be broadened to include other members with special health care needs such as CSHCN and adults with SUDS or SMI.
100	Q4 - Response to Question 4	Access. The new contract should require plans to ensure that patients have 24/7 access to a care practioner (i.e. nights and weekends) with real-time access to the electronic health record.

101	Q4 - Response to Question 4	Access. The new contract should require plans to ensure that all new members either select or are provisionally assigned to a primary care provider within 60 days.
102	Q4 - Response to Question 4	Access. The new contract should require plans to recruit and convene a cultural competence committee, through open invitation to relevant stakeholders, including but not limited to agency and department representatives, consumer advocates, consumers, disparities reduction experts, and providers for the purpose of reviewing and improving the cultural and linguistic program
103	Q4 - Response to Question 4	Access. The new contract must strengthen provisions on disability access. Need accessible physicians' offices with equipment needed for examining and treating PWD through cross reference to network adequacy standards. Unclear how the Community Advisory Committee relates to the Member representation in Ex A-1 Looks like they are two separate entities with this more of a stakeholder group. Might be difficult to get meaningful beneficiary participation in both. In any case, for both there should be some minimum requirements like meetings at least twice a year, etc.
104	Q4 - Response to Question 4	Access/Coordinated care. Require plans to enter memorandums of agreement – that include agreed upon screening and referral protocols- with community partnerships, including but not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.
105	Q4 - Response to Question 4	Access. Require plans to provide an additional incentive for an appointment conducted by a bilingual healthcare provider or qualified medical interpreter on the provider's staff.
106	Q4 - Response to Question 4	Access. Require plans to offer, upon initial assessment and on a regular basis thereafter, a Health Assessment including questions on behavioral and social risk factors in all threshold languages to all members over the age of 18, including those members that have previously completed such an assessment.
107	Q4 - Response to Question 4	Access. The current contract scope of services does not include requirements of plans to provide palliative care pursuant to SB 1004. Is a health assessment in 120 days enough. Shorter timeframe? Also the hospice provision says plan will cover all hospice. Doesn't mention that most of hospice for duals is covered by Medicare. Also, the scope of services does not include requirements of plans to provide palliative care pursuant to SB 1004.
108	Q4 - Response to Question 4	Access. The current contract Risk Stratification and Assessment for SPD section should be expanded beyond SPD as discussed in care coordination and CalAIM meetings.
109	Q4 - Response to Question 4	Access. Contract should specify that second opinions are to be provided by OON providers where applicable.
110	Q4 - Response to Question 4	Access/Coordinated care. DHCS should make clear that anyone who is receiving carved out services is entitled to enhanced care management and ensure that MCPs are responsible for providing this service to truly coordinate care and ensure access for their
111	Q4 - Response to Question 4	Access. The contract language in Exhibit A, Attachment 9, Access to Services with Special Arrangements, Family Planning section should clarify that OON coverage includes all FDA-approved methods of contraceptive pills, devices and supplies.
112	Q4 - Response to Question 4	Access. The contract language in Exhibit A, Attachment 9, Access to Services with Special Arrangements, STD section should be changed to "Sexually Transmitted Infections and Diseases (STIs and STDs)." The contract language in Exhibit A, Attachment 12, Local Health Dept Coordination should use the terms "STI and STD" services. Exhibit A, Attachment 13 Member Services, Member Rights and Responsibilities: Contract language should include members's rights to abortion services outside the contract's network, and "sexually transmitted infections and disease services." This terminology should be changed throughout the contract.
113	Q4 - Response to Question 4	Access. The contract language in Exhibit A, Attachment 9, Access to Services with Special Arrangements, Minor Consent Services should also list abortions.
114	Q4 - Response to Question 4	Access. Add a section on Abortion Services to the contract language in Exhibit A, Attachment 9, Access to Services with Special Arrangements. Per APL 15-020, "beneficiaries may go to any provider of their choice for abortion services, at any time for any reason, regardless of network affiliation." Contract language should also clarify that MCPs and all delegated entities must not require medical justification, referrals, or prior authorization for outpatient abortion services.
115	Q4 - Response to Question 4	Access/Care coordination. The contract language in Exhibit A, Attachment 12, Local Health Dept Coordination should require Subcontracts to meet the requirements for Abortion Services per APL 15-020
116	Q4 - Response to Question 4	Access. Modify the sample Contractor statement in Exhibit A, Attachment 13 on family planning services to: "Reproductive and sexual health services include but are not limited to a range of services needed to prevent or treat pregnancy (including all FDA-approved methods of birth control, emergency contraceptive services, pregnancy tests, prenatal care, abortion, and abortion-related procedures); screen, prevent, test, diagnose, and treat sexually transmitted infections and sexually transmitted diseases; diagnose and treat sexual assault; and family planning counseling and patient education. As a Member, you can pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN Specialists provide reproductive and sexual health family planning services however you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)] and at no cost. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get."
117	Q4 - Response to Question 4	Access. Remove "female" from Exhibit A, Attachment 13 on women's health specialists.
118	Q4 - Response to Question 4	Access. Exhibit A, Attachment 18, Implementation Plan and Deliverables: Replace "pregnancy termination" with "abortions."
119	Q4 - Response to Question 4	Access. DHCS should aim to reduce and eventually eliminate alternative access standard by evaluating (1) the number of approved requests for alternative access standards and approved allowable exceptions for the appointment time standard in the plan service area, by provider types, including specialists, and by adult and pediatric, in comparison to Medi-Cal managed care plans in a similar service area if have contracted with DHCS, (2) the approximate number of beneficiaries impacted by a plan's alternative access standards or allowable exceptions in comparison to Medi-Cal managed care plans in a similar service area if have contracted with DHCS, (3) the ability of a plan that has received approval to utilize an alternative access standard to assist an enrollee in obtaining an appointment with an appropriate specialist provider within the time and distance standards and the appointment time standards if have contracted with DHCS, (4) the ability of a plan to reduce the number of requests for alternative access standards and allowable exceptions for the appointment time standards if have contracted with DHCS, and (5) the percentage of providers in the service area, by provider and specialty type, that are under contract, or proposed to be under contract, with the plan in comparison to Medi-Cal managed care plans in a similar service area.
120	Q4 - Response to Question 4	Access. DHCS should set standards for in-office waiting times and require plans to monitor how long members wait in provider offices for their appointments.
121	Q4 - Response to Question 4	Access. Everywhere a provider is listed, Licensed Midwives, who may also contract with managed care plans should be included.
122	Q4 - Response to Question 4	Access. Exhibit A, Attachment 5 UTILIZATION MANAGEMENT add that the ability to get a second opinion must follow timeliness standards. Contractor shall ensure that the UM program allows for a second opinion following the Standards for Timely Appointments, from a qualified health professional at no cost to the Member.

123	Q4 - Response to Question 4	Access. Provider to member ratios are currently 1:2000 or 1: 1200 for total physicians. Make the ratios 1 FTE in each case.If provider has a private practice it the time available to Medi-Cal beneficiaries. NOT saying don't have a private practice, but don't get counted as one FTE provider then. Do not count providers as 1 FTE unless they are working 40 hours/week only for the plan enrollees.
124	Q4 - Response to Question 4	Access. For FQHC, RHC and FBC services, add timeliness and capacity as components of availability: Provision 7. If FQHC, RHC, and FBC services are not available timely or there is not capacity in the Provider Network, Contractor shall reimburse FQHCs, RHCs, and FBCs for services provided out-of-Network to Contractor's Members at a rate determined by DHCS.
125	Q4 - Response to Question 4	Access. For Exhibit A, Attachment 8 Provier Compensation Arrangements, add timely appointments and capacity as components of access to CNMs, CNPs and Licensed Midwives: If there are no CNMs or CNPs in Contractor's Provider Network, or if CNMs or CNPs in Contractor's Provider Network <i>do not have timely appointments or capacity</i> , Contractor shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than the applicable Medi-Cal FFS rates. If an appropriately licensed noncontracting facility is used, Contractor shall pay the facility fee. For hospitals
126	Q4 - Response to Question 4	Access. For Exhibit A, Attachment 9, Access and Availability, First prenatal visit should be within two weeks upon request <i>unless that member is in the last trimester of their pregnancy and/or has a high-risk condition or other urgent need for which Standards for Timely Appointments must be followed.</i>
127	Q4 - Response to Question 4	Access. In the case of a moral objection by a Contractor or Subcontractor, contractor shall arrange for the timely referral per Standards for Timely Appointments
128	Q4 - Response to Question 4	Contractor shall ensure the provision of Minor Consent Servicesfor individuals under the age of 18 within <i>and outside</i> the Provider
129	Q4 - Response to Question 4	Access. Wthin Linguistic Services, Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care <i>and affirmatively ask and document in the patient record that patient was asked whether they would like an interpreter.</i>
130	Q4 - Response to Question 4	Access. In Exhibit A, Scope of Services, Prenatal Care - add the italicized to include mental health and dental care and Freestanding Birth Centers: Contractor shall ensure that pregnant <i>members</i> at high risk of a poor pregnancy outcome <i>or who need mental health or dental services as determined by assessments, screenings, or patient request</i> are referred to appropriate Specialists including perinatologists, <i>mental health professionals and dentists</i> , and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate hospitals are available within the Provider Network to provide necessary high-risk pregnancy services and <i>appropriate Freestanding Birth Centers</i> are available for those members who wish one.
131	Q4 - Response to Question 4	Access. In Exhibit A, Attachment 15 Marketing, B. Coverage - add italicized language: Contractor shall provide Covered Services to a child born to a Member for the month of birth and the following month. <i>Thereafter, capitation shall be paid to the health plan chosen by the infant's parent or guardian via the enrollment process.</i>
132	Q4 - Response to Question 4	Access/Children. For the Children's Services goal, replace the EPSDT subsection under scope of services in contract and replace with the following: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) [Scope of Benefits] a. The CONTRACTOR shall cover services, products, or procedures for a Medicaid Member under the age of twenty-one (21) if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by any physician or other licensed practitioner). b. The CONTRACTOR shall ensure EPSDT services are furnished in an amount, duration and scope no less than the amount, duration, and scope for the same services under Fee-for-Service and as defined in the Department's EPSDT policies and guidance letters. c. The CONTRACTOR shall cover regular wellness visits to all children enrolled in Medicaid under the age of twenty-one (21) to allow health care providers to carefully monitor a child's overall health and development and to identify and address health concerns as early as possible. d. The CONTRACTOR shall clearly document that the EPSDT medical necessity criteria under state and federal law was considered in the course of their service authorization review process for Medicaid Members under twenty-one (21) years of age. e. The CONTRACTOR shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child. f. Upon conclusion of an individualized review of medically necessary services, the CONTRACTOR shall cover medical necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. § 1396d(r), regardless of whether such services are covered under state's Medicaid State Plan and regardless of whether the request is labeled as an "EPSDT service". g. The CONTRACTOR shall refer to and/or arrange for any medical service described in 42 U.S.C. § 1396d(r), when those services are not included within the scope of this contract, including when the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service. The final determination of medical necessity, per criteria specified in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62, is the responsibility of the CONTRACTOR responsible for delivery of the referred service, product, or treatment. The Contractor shall ensure coordination of such services and shall follow-up to ensure children receive the physical, behavioral health, vision, hearing, and dental services they need to treat health problems and conditions. h. 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 Medicaid Members less than twenty-one (21) years of age when those services are determined to be medically necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians
133	Q4 - Response to Question 4	Access/Children. Per the EPSDT contract language above the contract must 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) when those services are determined to be medically necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians."
134	Q4 - Response to Question 4	Access/Children. Per the EPSDT contract language above: Under authorization, should add "The MCP shall not make an adverse benefit determination on a service authorization request for a child until the request is reviewed per EPSDT criteria."
135	Q4 - Response to Question 4	Access/Children. Per the EPSDT contract language above: The plan shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed because of conditions disclosed during screenings and diagnosis. The referral assistance must include giving the family or Member the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family

136	Q4 - Response to Question 4	Access/Children.Per the EPSDT contract language above [or under provider relations section or access and availability section but prefer EPSDT section]: Add specifications of provider educational materials and training: "MCP will provide education and training materials relevant to the providers' area of practice on an annual basis. Training must include information related to: a) EPSDT benefits; b) EPSDT medical necessity review per federal criteria: standards and processes; c) AAP/Bright Futures Periodicity Schedule; d) Immunizations; e) Required components of an EPSDT screening service; f) Providing or arranging for all required lab screenings; g) Medical transportation services available to Members; h) Outreach activities, referral assistance and care coordination related to EPSDT provided by the MCP; and i) Necessary documentation required for reimbursement of EPSDT services."
137	Q4 - Response to Question 4	Access/Children. Per the EPSDT contract language above, add the MCP shall perform monthly outreach to Members who are due or overdue for an EPSDT well-child visit or screening service.
138	Q4 - Response to Question 4	Access/Children. The new contract should clarify Bright Futures as the Children's Preventive Services standard and periodicity schedule, unless a stricter standard, such as for blood lead screening applies.
139	Q4 - Response to Question 4	Access/Children. In addition to including the link to the Bright Futures guidelines and periodicity schedule, the contract should specify not only are MCPs responsible for covering these services but ensuring that they occur, via their utilization management system. The contract should also highlight not only the medical necessity clarifications under EPSDT for children but also to explicitly highlight the types of services included in the current Bright Futures guidelines with a note that these guidelines are evolving and the plan is responsible for updating its policies and procedures according to those change.
140	Q4 - Response to Question 4	Access/Children.The new contract should clarify that the health plans is responsible for ensuring the member is appropriately referred for diagnosis and treatment without delay.
141	Q4 - Response to Question 4	Access/Children. The new contract should modify or delete outdated references to CHDP assessments, standards, referrals, and reporting requirements.
142	Q4 - Response to Question 4	Access/Children. The new contract should require written descriptions of referral and follow up procedures, systems, processes, and partnerships in place to monitor the provision that "Contractor shall ensure that appropriate diagnostic and treatment services are initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up." Furthermore, DHCS should reassess if the 60 calendar day policy is in line with current timely access standards, and should adjust the standard accordingly.
143	Q4 - Response to Question 4	Access/Children. The new contract should require the MCPs' utilization management to track EPSDT preventive care and results and, if positive screens necessitate referrals and follow up the utilization management system will trigger correspondence or outreach to families about case management services and transportation available to them.
144	Q4 - Response to Question 4	Access/Children. The new contract should restate the federal definition of the EPSDT benefit and medical necessity
145	Q4 - Response to Question 4	Access/Children. LEA services: this section should be amended to reflect current DHCS policy, specifically MCPs must assess what level of medically necessary services the member requires, determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services.MCPs have the primary responsibility to provide all medically necessary services, including services which exceed the amount provided by LEAs. MCPs should not rely on a LEA program or other entities as the primary provider of medically necessary services. The MCP is the primary provider of such medical services except for those services that have been expressly carved out. MCPs are required to provide case management and coordination of care to ensure that members can access medically necessary medical services as determined by the MCP provider. For example, when school is not in session, MCPs must cover medically necessary services that were being provided by the LEA program when school was in session.
146	Q4 - Response to Question 4	Children/Coordinated care. 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 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 are communicated between medical and dental providers (per comments related to Exhibit A,
147	Q4 - Response to Question 4	Children/Coordinated care. 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
148	Q4 - Response to Question 4	Children/Coordinated care. The new contract establish a compliance and reporting requirement as it relates to referrals to WIC. An estimated 500,000 Medi-Cal enrollees – mostly children - are eligible for WIC but not enrolled, suggesting that compliance is low for this provision and more needs to be done to connect Medi-Cal enrollees with WIC.
149	Q4 - Response to Question 4	Children/Coordinated care. DHCS should specify that plans' specialty referral systems should also track the result of the referral (e.g whether a specialist appointment was held), and this information should be reported publicly.
150	Q4 - Response to Question 4	Children. For the Children's Services goal, a subsection should be added under the utilization management system section to track and monitor EPSDT for children, in particular the utilization of the Bright Futures' periodicity schedule for well-child visits and screenings as well as a reporting of the results of those screenings and any follow up/referral for positive screening results. The system shall be able to flag for the MCO underutilization such as missed well-child visits or screenings.
151	Q4 - Response to Question 4	Children. For the Children's Services goal, the specialty referral system should also track the result of the referral (e.g whether a specialist appointment was scheduled and held)
152	Q4 - Response to Question 4	Children. For the Children's Services goal with regard to EPSDT utilization reporting, the contracts should clearly articulate how and when plans must report encounter data documenting the provision of EPSDT services, including exactly what data elements (e.g., age, race/ethnicity of the child receiving the service, etc.) plans must submit.Make explicit in contract language that false EPSDT encounter data submission is a violation of the Federal and California False Claims Act. And DHCS should regularly report county-level utilization data by plan on children's "Bright Futures" preventive care services, and penalize plans that fall below certain minimum utilization thresholds on an annual basis. DHCS should post on a searchable page on its website this data relating to the performance of each plan in each county on their EPSDT responsibilities to children, including number of children enrolled and their EPSDT utilization broken down by age and race/ethnicity as well Child Core Set. In addition to this DHCS public reporting, plan level EPSDT encounter data should be made available
153	Q4 - Response to Question 4	Children. For the Children's Services goal, the contracts should clarify that MCOs are responsible for ensuring the member is appropriately referred for diagnosis and treatment without delay.
154	Q4 - Response to Question 4	Children. For the Children's Services goal, contracts should require plans to 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.

155	Q4 - Response to Question 4	Children. For the Children's Services goal, require health plans to spend a minimum portion (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. And establish a 5% withhold from MCO's monthly capitation attributable to children until encounter data submission the plan submits the encounter data and unless annual average EPSDT performance (utilization) metrics standards are met. (This will require DHCS to develop a EPSDT utilization measure(s) and to require plans to report data on them.)
156	Q4 - Response to Question 4	Children. For the Children's Services goal, establish and promote child/family health home models and require MCO to provide incentives for whole child/family health home models. Once DHCS definition of the tiers of Child/Family-centered Health Home functionality is established, contract language would read "the Contractor shall include in its network, to the greatest extent possible, Child/Family-centered health homes (CFHH). The Contractor shall develop and assist in advancing Providers along the spectrum of this model. Contract shall assist Providers within its delivery system to establish Child/Family-centered health homes and shall provide Value Based Payment arrangements. The Contractor shall provide per-Member-per-month (PMPM) payments to its CFHH centers as a supplement to any other payments made to CFHHs, be they fee-for-service or VBPs. Contractor shall also vary the PMPMs such that higher-tier CFHHs receive higher payments than lower tier CFHHs. The PMPMs must be meaningful amounts, increasing each year over the first five years.
157	Q4 - Response to Question 4	Children. For the Children's Services goal relating to providers to serve children and families, require MCPs to contract with 1) a sufficient number of providers and/or practices with the special skills and training to address the social and emotional health of children; 2) a sufficient number of pediatric providers with a team-based approach; and 3) community health workers serving children and their
158	Q4 - Response to Question 4	Children. For the Children's Services and Engagement goals, engage families in decision-making by requiring minimum percentage of representative families on MCOs' community advisory panels.
159	Q4 - Response to Question 4	Children. For the Children's Services goal, contracts should require MCOs to pay network providers (both primary care and specialist) Medicare-comparable rates for furnishing EPSDT services.
160	Q4 - Response to Question 4	Children. For the Children's Services goal, under the Implementation and deliverables section of the contract: For Scope of Services (#10), under 'E' add "oral health screening and preventive services" to the list or modify to read "Children's preventive services, including preventive oral health services." Under Case Management Including Coordination of Care (#11), for 'T' include "coordination of referrals to dental providers" so it reads "Submit policies and procedures for the provision of dental screening, coordination of referrals to dental providers and covered medical services related to dental services."
161	Q4 - Response to Question 4	Children. For the Children's Services goal, MCPs should have a EPSDT compliance officer to flag for MCP leadership EPSDT under-utilization and violations of MCP's EPSDT responsibilities. DHCS should also have a Medi-Cal children's EPSDT officer to focus DHCS oversight and enforcement of MCPs' EPSDT responsibilities.
162	Q4 - Response to Question 4	Children/SDOH. For the Children's Services goal, DHCS should institute a SDOH screening/assessment of Medi-Cal children and require an Individualized Care Plan for addressing identified concerns. The MCP EPSDT care coordination and assistance obligations apply. To implement this SDOH assessment for children, DHCS should develop clear guidance for MCPs on the standards and training needed for the MCP to implement as well as to include this SDOH assessment and training/education requirements in the MCO contracts as part of the Bright Futures schedule of well child care and of EPSDT.
163	Q4 - Response to Question 4	Children. The plans should be required by contract to conduct ACE screenings based on the following schedule: Children and adolescents under age 21 - periodic ACE screening once per year, per provider utilizing the PEARLS tool; and provide members with ACEs Aware Self-Care Tool for Pediatrics: https://www.acesaware.org/wp-content/uploads/2019/12/Self-Care-Tool-for-Pediatrics.pdf . ; the plan should be required to follow-up with appropriate treatment, a treatment plan and/or referrals when a member 's toxic stress risk assessment indicates patient is at intermediate or high risk.
164	Q4 - Response to Question 4	Children. For the Children's Services goal, DHCS should incorporate an EPSDT compliance officer into DCHS' Medi-Cal leadership, whose responsibilities are to monitor, analyze and enforce EPSDT underutilization and other EPSDT obligations, particularly relating to MCPs care coordination and referral/follow up assistance.
165	Q4 - Response to Question 4	Access/Children. For Children's Services, assure that Contractor assigns a case manager at one of the many levels of case management to each child with CCS to ensure that a child and their family, if denied services by CCS, are provided services by Contractor within Timeliness Standards
166	Q1 - Response to Question 1	Access/Children. 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.
167	Q4 - Response to Question 4	Children. For oral health care for children, do not start with eruption of first tooth or one year of age. Prior to annual dental referrals, the infant's provider shall provide anticipatory guidance, instruction and appropriate intervention according to ACOG-CDA guidelines and screening tools: https://www.cdafoundation.org/Portals/0/pdfs/poh_policy_brief.pdf
168	Q4 - Response to Question 4	Behavioral health. The new contract should improve reporting of utilization of the non-SMH benefit, specifically the number of unduplicated members who followed through on a referral from the MHP and engaged in treatment, the number of individuals who did not follow through on the referral from the MHP and engage in treatment and the rationale for lack of follow up. The contract should also require MCPs to exchange data monthly with MHPs. For suggested language on data reporting and exchange see AB 1175: http://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1175
169	Q4 - Response to Question 4	Behavioral health. The new contract must ensure that members can directly access mental health and SUD services without a referral. It must ensure that parties or entities outside of the network, including consumer advocates, can directly refer a member to a provider within their network.
170	Q4 - Response to Question 4	Behavioral health. Remove phrase "danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse" from the definition of children eligible for minor consent behavioral health services. This is not a requirement for minor consent services.
171	Q4 - Response to Question 4	Behavioral health. Section on mental health and substance use disorder services should be updated to reflect current DHCS guidance and to emphasize that plans have a responsibility to connect members to County MHP and SUDS programs as appropriate for specialty behavioral health services. Tracking these members when they seek "carved out" behavioral health services to ensure the member successfully accessed treatment or services should also be required.
172	Q4 - Response to Question 4	Behavioral health. SMHS: This section of the contract should provide more specificity about the referral process and plans' obligations to ensure members receive medically necessary SMHS. We recommend that DHCS include MOU requirements in the contract.
173	Q4 - Response to Question 4	Behavioral health. SUDS: This section of the contract should describe the SUDS that plans ARE required to provide. It should also provide more specificity about the referral process and plans' obligations to ensure members receive medically necessary SUDS. We recommend that DHCS include MOU requirements in the contract.
174	Q4 - Response to Question 4	Behavioral health. The new contract should require plans to expand use of Screening Brief Intervention and Referral to Treatment (SBIRT) for adults to include drugs other than alcohol.

175	Q4 - Response to Question 4	Behavioral health. The new contract should provide more specificity about the dispute resolution process between MCPs and MHPs when each claims the other is responsible for providing behavioral health services to a member. For suggested language on the dispute resolution process, see AB 910.
176	Q4 - Response to Question 4	Behavioral health. The contract should be amended to require the plans to issue a formal written notice of adverse benefits determination when a member requests mental health or SUDS that the plan denies based on a determination that the services are not the responsibility of the plan but instead another plan (e.g. SMHS or DMC-ODS services).
177	Q4 - Response to Question 4	Behavioral health. The plans should be required by contract to conduct ACE screenings based on the following schedule: Children and adolescents under age 21 - periodic ACE screening once per year, per provider utilizing the PEARLS tool; and provide members with ACEs Aware Self-Care Tool for Pediatrics: https://www.acesaware.org/wp-content/uploads/2019/12/Self-Care-Tool-for-Pediatrics.pdf ; the plan should be required to follow-up with treatment and/or referrals, when appropriate.
178	Q4 - Response to Question 4	Behavioral health. The plan should be required to provide enhanced care management to all members where a need for SMHS or SUDS services are identified that are beyond the responsibility of the plan.
179	Q4 - Response to Question 4	Behavioral health. Allow both physical and behavioral health to be billed in the same well child visit, for example, for dyadic care.
180	Q4 - Response to Question 4	Behavioral health. Eliminate the need for specific clinical diagnoses for children and families to access care.
181	Q4 - Response to Question 4	Behavioral health. Require plans to cover family-unit and dyadic care models and clarify in the MCP contract and DHCS guidance that under EPSDT there are no service limitations or caps on the new Family Therapy Benefit.
182	Q4 - Response to Question 4	Behavioral health. Finance peer-led interventions and services as developmentally-appropriate socio-emotional prevention and intervention services for youth
183	Q4 - Response to Question 4	Behavioral health. Expand eligible providers, particularly in care coordination and assessment, to include community workers, including peer support specialists
184	Q4 - Response to Question 4	Behavioral health/Coordinated care. The new contract should require public reporting on the Managed Care Accountability Set measures and Consumer Assessment of Healthcare Providers and Systems measures, stratified by individuals who are diagnosed with a SMI, to better measure if care coordination is better or worse for individuals with a SMI.
185	Q4 - Response to Question 4	Coordinated Care/SDOH. In Exhibit A, Attachment 11 Case Management and Coordination of Care, add SDOH: Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services and <i>Services addressing Social Determinants of Health</i> delivered both within and outside the Contractor's Provider Network.
186	Q4 - Response to Question 4	Coordinated care. In every situation in which a form of case management is discussed develop a standard floor for inclusion and for services provided , state must have minimal floor and standard of who is referred, and create distinction among case management – Basic, Complex, Targeted Case Management under Title 22, Person-Centered Planning for SPD beneficiaries – what are the differences and who is ALWAYS referred and who qualifies for which?
187	Q4 - Response to Question 4	Coordinated care. The new contract should require public reporting on the Managed Care Accountability Set measures and Consumer Assessment of Healthcare Providers and Systems measures, stratified by individuals who are diagnosed with a SMI, to better measure if care coordination is better or worse for individuals with a SMI.
188	Q4 - Response to Question 4	Coordinated care. For the Continuum of Care and the Coordinated Care goals, promoting care coordination and supports for “at risk” children will need more than a MCP health population management tool. MCPs should be required to promote and incent enhanced child/family-centered health home models for all Medi-Cal children, which includes at risk or “rising risk” children, not just those with specific high-needs. This child/family-centered model of care should have embedded a sufficient care coordination infrastructure and skill to navigate screening, address social determinants of health, provide family education, coordinate with community partnerships, complete referrals, and provide follow-up. This approach resembles the current Health Homes Program (HHP) model, though a child-specific model would serve the child for a shorter duration and require lower average intensity of support compared to high-utilizers in the existing Health Homes program. Similar to the current Health Homes Program, MCPs should partner by contract with “community-based care management entities” (CB-CMEs) to deliver specified functionalities such as screenings, family education, referral navigation and follow up outside the health sector, and conduct care planning and support functions using paraprofessional/peer models. In addition to their required inclusion in MCPs' systems of care, this child-centered health home program should be promoting as part of CalAIM.
189	Q4 - Response to Question 4	Coordinated care. For the Coordinated Care/Integrated Care goal: DHCS' original CalAIM proposed the use of bonus payments that are funded by a withhold from plan capitations of between 1-5% to pay for financial incentives for the enhanced care management benefit which will serve just 1% of the Medi-Cal population. Under the CalAIM proposal, DHCS is requiring plans to put a lot of work and money into implementing the new Enhanced Care Management benefit package which is geared towards the highest utilizers or the top 1%. However, the foundational preventive care and the overall care coordination infrastructure that serves the other 99% is in great need of attention and improvement. By not also proposing incentive payments to improve this infrastructure and reduce health disparities, DHCS is missing an important opportunity to strengthen preventive care which has the added benefit of saving costs by keeping people healthy. DHCS should expand its proposed financial incentive program and tie it to successful implementation of the new population health management initiative and quality performance thresholds more generally, which will benefit the <i>entire</i> Medi-Cal population.
190	Q4 - Response to Question 4	Coordinated care. For the Coordinated Care/Integrated Care goal: DHCS should develop and require MCPs report on a care coordination performance measure, perhaps using a proxy such as closed loop referral rates. DHCS with stakeholder input should also develop a care coordination performance standard.
191	Q8 - Response to Question 8	Coordinated care. In the section on Comprehensive Case Management, Including Coordination of Care Services, Exhibit A, Attachment 11, DHCS should standardize with a minimum standard that plans may go above of the identification of Members who may benefit from complex case management services. Too often, community agencies carry out this role.
192	Q4 - Response to Question 4	Oversight DE. Considering the issues with SynerMed/EHS and Agilon and to ensure services and notices are not delayed, utilization management program should not allow for editing date of request, approval, or denial.
193	Q4 - Response to Question 4	Oversight DE. To ensure that it can efficiently provide oversight of delegated entities, DHCS should limit how many time responsibility for a particular service may be delegated. Too often, DHCS contracts with an MCP, which then sub-contracts responsibility for service delivery to a sub-plan, who delegates responsibility for providing most services to an IPA or Medical Group, which then sub-capitates responsibility for providing a certain set of services to PCPs or other providers. When something goes wrong, it can be difficult to determine who is responsible and how the beneficiary can remedy the problem. DHCS should reduce the number of levels of delegation between the state and the provider delivering services to avoid this confusion.
194	Q4 - Response to Question 4	Oversight DE. In the new contract, DHCS should require plans to publicly report on MLR at the sub-plan / delegated entity level.

195	Q4 - Response to Question 4	Oversight DE. In the new contract, require plans conduct an annual medical audit, including unannounced audits, of subcontractors using a standardized process to be developed by DHCS.
196	Q4 - Response to Question 4	Oversight DE. In the new contract, require plans report adverse benefits determination, grievance, and appeal data by sub-plan/delegated entity that provides services or determines whether a service is approved or denied.
197	Q4 - Response to Question 4	Oversight DE. Concerns that existing contract allows plans to "accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations". Oversight should not be further delegated, especially when EHS was given a certificate of excellence by NCQA. California law is stronger than federal requirements in numerous instances, including for language access, network adequacy standards, and others. Deeming should only be considered where the review is entirely duplicative, both in the standards being tested, the specifics of the standards, and the processes used. Also, any deemed standards should be reviewed in a public process, and be revisited on a regular basis, given that NCQA standards often evolve and not necessarily in California and the public's interest.
198	Q4 - Response to Question 4	Quality/accountability. DHCS should regularly publicly report 1) MCPs Population Needs Assessments; 2) EPDST full utilization measures (to be developed by DHCS and reported by MCP) by MCP, county, age stages, race/ethnicity, and language spoken; and 3) MAS measures by MCP, county, age stages, race/ethnicity, and language spoken.
199	Q4 - Response to Question 4	Quality/accountability. DHCS should strengthen and increase its MCP enforcement administration. In addition, DHCS should instruct its EQRO to provide in its audit and report findings more actionable recommendations both for the MCPs and for DHCS and for DHCS to follow through on those actionable recommendations.
200	Q6 - Response to Question 6	Accountability. Accountability and Strengthened Enforcement should be included as an additional goal. Unfortunately, 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.
201	Q6 - Response to Question 6	Accountability. Accountability remains a major challenge in Medi-Cal, including under CPSP. The Department should implement a pilot project under "Managed Fee-for-Service" for pregnant women, a model that relies on an independent commission to facilitate data collection from providers, assess the data, and hone in on problem areas with technical assistance and resources to directly improve performance. In other states (2017 data), adopting the Managed Fee-for-Service model for the Medicaid population has reduced per patient costs from \$718 to \$670 and cut administrative costs from 12% to 5% while also increasing the participation of primary care providers by 7% and of specialists by 19% and improving patients' access to care. State of Conn (2/22/2016); <i>Wall Street Journal</i> (3/18/16); <i>Harvard Report: Innovations and Insights in Medicaid Managed Care</i> (March 2016); Connecticut Health Policy Project (Jan 2017). If a pilot of the model for pregnant individuals results in greater accountability and improved outcomes in Medi-Cal, the Department should then consider expanding "Managed Fee-for-Service" to pregnant beneficiaries generally as well as the rest of the Medi-Cal population.
202	Q8 - Response to Question 8	Accountability. Contract should specify that the plan must provide the name of the provider who made an adverse benefit determination upon request.
203	Q8 - Response to Question 8	Accountability. DHCS should require all Medi-Cal plans to become Knox-Keene licensed so that all plans adhere to the same state law and all Medi-Cal enrollees have access to the same consumer protections.
204	Q4 - Response to Question 4	Accountability. Concerns that existing contract allows plans to "be exempt from the DHCS medical review audit" if plan received a rating of "Excellent," "Commendable" or "Accredited" from NCQA. Oversight should not be delegated, and California law is stronger than federal requirements in numerous instances, including for language access, network adequacy standards, and others. Deeming should only be considered where the review is entirely duplicative, both in the standards being tested, the specifics of the standards, and the processes used. Also, any deemed standards should be reviewed in a public process, and be revisited on a regular basis, given that NCQA standards often evolve and not necessarily in California and the public's interest.
205	Q8 - Response to Question 8	Accountability. Create plan-specific dashboards that include data such as PNA results, quality data, summary-level encounter data, grievance and appeals data etc. and publish on DHCS website.
206	Q8 - Response to Question 8	Accountability. Strengthen provisions on sanctions, allowing DHCS to impose sanctions more quickly when MCPs fail to comply with contract provisions and performance measures.
207	Q8 - Response to Question 8	Accountability. Institute more robust monitoring of compliance with network adequacy standards, including "secret shopper" calls rather than calls by DHCS / plan representatives, and requiring plans to move toward appointment tracking systems that would allow for more automated tracking of appointment wait times.
208	Q8 - Response to Question 8	Accountability. Provide plans with more guidance about what services count as administrative for purposes of calculating MLRs, and how to account for costs incurred by delegated entities.
209	Q8 - Response to Question 8	Accountability. Create an online database of appeals and fair hearings, that includes a summary of the issues at stake, and a copy of the redacted hearing decision, where applicable, similar to DMHC's IMR database.
210	Q4 - Response to Question 4	Accountability. In Exhibit A, Attachment 15 Marketing, B. Coverage - add italicized language: Contractor shall provide Covered Services to a child born to a Member for the month of birth and the following month. <i>Thereafter, capitation shall be paid to the health plan chosen by the infant's parent or guardian via the enrollment process.</i>
211	Other	Everywhere the term "pregnant woman" is used, replace with "pregnant member" or "pregnant Individual".
212	General	RFI comment process. Limiting comments to Excel format is cumbersome and uncertain if this format is ADA compliant, so would recommend allowing other types of submissions to be considered.