



TO: Will Lightbourne, Director, California Department of Health Care Services; Mark Ghaly, Secretary, California Health and Human Services Agency

FROM: The California Alliance of Child and Family Services and the California Children's Trust

SUBJECT: Comments on Children and Youth Mental Health With Respect to Medi-Cal Managed Care Contracts and Procurement (DHCS RFI # 20-001)

DATE: October 1, 2020

The California Children's Trust (CCT) and the California Alliance of Child and Family Services (Alliance) are pleased to submit comments in response to the Managed Care Organization (MCO) Request for Information (RFI # 20-001) led by the Department of Health Care Services (DHCS). The CCT represents a broad statewide coalition of stakeholders committed to addressing the children's behavioral health crisis in California. The Alliance is a statewide association of more than 150 nationally accredited, private nonprofit agencies dedicated to achieving progressively better outcomes for vulnerable children, youth, and families in public human services systems.

The upcoming Medi-Cal managed care contract revisions and RFP offer a critical opportunity to reverse some of the problematic trends in children's mental health. With 90% of Medi-Cal children participating in managed care, managed care contractual arrangements are the lynchpin for effectuating the State's responsibility to ensure children receive legally mandated services. It is also critical to understand that the EPSDT benefit has not been implemented per federal law by the Managed Care Plans (MCPs). For example, the EPSDT eligibility criteria was not considered as MCPs added children and youth into their systems. *This has led to a lack of available mental health and substance use services through MCPs*, and as the recent auditors' report indicated, "Despite the importance of these services, the use—or utilization rate—of preventive services by California's children and youth in Medi-Cal has been consistently below 50 percent and is ranked 40th in the country—nearly 10 percentage points below the national average. In addition, despite efforts by the Department of Health Care Services (DHCS)—the state agency tasked with overseeing Medi-Cal—the utilization rate in California has not improved since fiscal year 2013–14." Further, children represent 42% of all Medi-Cal enrollees but only 14% of all expenditures; they have been short-changed and are not receiving critically needed mental health and substance use services.

Our comments center on the following main themes:

- Enforcing MCP compliance with the federal EPSDT statute
- Addressing racial inequities
- Removing diagnosis as a condition for treatment
- Implementing financing reforms tied to children's health performance
- Mandating meaningful community engagement with schools and other youth and family serving community-based organizations
- Expanding eligible provider class for reimbursement
- Oversight, promotion, and enforcement of EPSDT requirements and utilization (both mental health and substance use)

Additional comments and details on the themes above are outlined below. Thank you for the opportunity to provide feedback.

Recommendations for Managed Care Plan RFP and Contracting:

Enforcing MCP compliance with the federal EPSDT statute and coordination with MHPs.

First and foremost, DHCS must require greater accountability and transparency from both MCPs to meet the federal entitlement to behavioral health care under EPSDT. The MCP contracts should clarify that the MCP remains responsible for the provision of all medically necessary behavioral health services under EPSDT and has a case management obligation to communicate with the county Mental Health Plan (MHP) to ensure the member can access needed care without delay.

Requirements should include the following:

- Data sharing (by race, age, service type, setting, and intensity at a minimum) so that each plan is aware of the behavioral health services its member receives from mental health plans;
- Codify continuity of care for behavioral health services when Medi-Cal beneficiaries move from one system to another (MCP and MHP);
- Require MOUs between these entities on referral tracking and care coordination protocols, care coordination requirements for transportation services, and protocols to ensure enrollees have access to appropriate and coordinated services;
- Enforce the care coordination obligation already in MCP contracts and require that care and support be provided during transitions between systems, which entails making explicit that MCPs care coordination expenditures are not only allowable, but they are the MCP's *obligation*;
- Codify the MCP provision of necessary mental health services be provided prior to and during any dispute resolution between MCO and MHP; and
- Collect and disseminate DHCS report data about mental health access, quality, and spending to monitor and oversee the performance of plans responsible for delivering mental health services.

Clinical practice guidelines from leading medical societies and recommendations from federal agencies should constitute the floor of reasonable standards of medical practice for MCP accountability in administering EPSDT. The table below summarizes the guidelines for preventing children’s mental health conditions:

Source	Recommended Intervention	Age Range
Bright Futures Periodicity Schedule[i]	Psychosocial/Behavioral Assessment	All
	Depression Screening	12-21
	Maternal Depression Screening	1mo-6mo
	Anticipatory Guidance	All
Bright Futures Guidelines[ii]	Identifying social needs and connecting to community resources, including violence in the home and caregiver behavioral health	All
	Connecting to home visiting and/or group-based caregiver supports	Prenatal – 18mo
	Anticipatory guidance to caregivers – mental health promotion	All
	Anticipatory guidance to children – mental health promotion	5-21
	Connecting to early childhood service system, child care, preschools, and schools	2-8
AAP Clinical Practice Guidelines	Depression screening[iii]	12-21
AACAP Guidelines	Mental health consultation in schools (and early care)[iv]	4-21
APA (Psychological) Guidelines	Evidence-based mental health prevention[v]	All

USPSTF Recommendations[vi]	Interventions to prevent perinatal depression	Perinatal
	Depression screening	12-21
	Maternal depression screening	Perinatal
	Maternal intimate partner violence screening	All

[i] Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Workgroup. 2020 Recommendations for Preventive Pediatric Health Care. Pediatrics. 2020 Mar 1;145(3).

[ii] Hagan JF, Shaw JS, Duncan PM. Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, 4th Edition. Chicago: American Academy of Pediatrics. 2017.

[iii] Zuckerbrot RA, Cheung A, Jensen PS, Stein RE, Laraque D, GLAD-PC STEERING GROUP. Guidelines for adolescent depression in primary care (GLAD-PC): Part I. Practice preparation, identification, assessment, and initial management. Pediatrics. 2018 Mar 1;141(3).

[iv] Walter HJ, Berkovitz IH. Practice parameter for psychiatric consultation to schools. Journal of the American Academy of Child & Adolescent Psychiatry. 2005 Oct 1;44(10):1068-83.

[v] American Psychological Association. Guidelines for prevention in psychology. The American Psychologist. 2014 Apr;69(3):285.

[vi] U.S. Preventive Services Task Force. Published Recommendations [Internet]. U.S. Preventive Services Task Force. Accessed 21 Aug 2020.

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P

Addressing racial inequities is core to Medi-Cal children’s health care and many of our policy recommendations weave in health equity principles. We highlight a few core elements here. First, MCPs’ Population Health Assessments (PHAs) should be publicly reported on DHCS’s website, identifying where the greatest inequities exist, and expanding the collection, public reporting, and analysis of standardized utilization and performance measure data to regularly include race, ethnicity, language, sexual orientation, gender identity, and disability status. Developments in health information technology have significantly increased the feasibility of measuring disparities at the provider level. Second, equity also requires identifying and addressing the longstanding social inequities (often reflected in social determinants of health) that communities and families face to ensure children’s healthy development and social emotional wellbeing. This means regularly assessing in the context of children’s well child care their social determinants of health and incorporating and promoting managed care system investments in “upstream” interventions and strategies. Finally, equity will also *require* that MCPs engage, partner, and contract with community-

based organizations in the decision making, service delivery, governance and development of an MCP's systems of care.

Financing Tied to Children's Health Performance. The MCP payment structure must be directly aligned with and tied to the required EPSDT/preventive care utilization and quality outcomes expected under the MCP contracts. DHCS should restructure Medi-Cal payments for children's services under a new framework that will better ensure the State meets its legal requirements, and MCPs meet their contractual obligations, to deliver preventive care and treatment for children. DHCS should more effectively harness its purchasing power by applying value-driven purchasing approaches to Medi-Cal managed care rate setting for children. One such approach could construct child payment rates in the following way.

1. Full-utilization capitation payment that has a Medical Loss Ratio requirement applied specifically to the Medi-Cal child population capitation rate, and that includes a "minimum spend" MCP child capitation requirement for pediatric primary care medical spending, and a formula that better reflects full EPSDT utilization (not historical *underutilization*);
2. An explicit care coordination payment, potentially adjusted by risk or health of the child population that reflects the need to ensure managed care plan responsibility for coordinating timely access to prescribed medical and non-medical services provided by county mental health plans, community-based organizations, dental providers, regional centers, school districts, and other support agencies; and
3. A child health performance bonus opportunity, which should be made available after demonstrating year over year performance improvement on select child health indicators such as Bright Futures metrics and referral rates to EPSDT services, reductions in racial/ethnic disparities, and/or investments in social service supports. To bolster improved child outcomes, Oregon's Medicaid program enables plans to earn up to 4.25% above capitation payments if they perform well on various child measures. These performance incentives could include value-based payments, an increase in membership via auto-assignment logic, or other mechanisms. With this funding, MCPs could be incentivized to invest in "value-added" support services to address social determinants of health.
4. Same Day Billing. Collaborative care must be promoted and all barriers to provide integrated primary and behavioral health care must be removed. For example, there is a restriction in current law that does not allow for the billing of Medi-Cal for a primary care and mental health visit on the same day. If pediatricians conduct screenings and families have access to integrated mental health services, we could address many of the problems with access.

Oversight, Promotion and Enforcement of EPSDT requirements and utilization. Medicaid EPSDT requirements have been in place for decades, but absent explicit contract requirements, meaningful reporting and enforcement mechanisms, the State will continue to see lackluster outcomes. *Plans need to be held accountable that their child members receive all essential and referral services mandated through the EPSDT benefit.* This will only be possible by requiring plans to utilize care coordination and population health management information systems that link with the practices

and track preventive care visits, the need for follow up care and the receipt of that care. The MCPs have used prior authorizations for tracking care in the past, however most EPSDT-related services should not require prior authorization. The MCPs should also be required to link their management information systems to the Regional Centers, Mental Health Plans, DentiCal, and other contracted community service agencies providing support for family needs in order assure the receipt of follow-up and/or integrated services. We suggest the following recommendations to increase both transparency and relevance of performance outcomes:

- Include information about allowable and disallowable prior authorization processes for EPSDT and clarification on the applicable EPSDT medical necessity definition
- Reporting must include the number of children receiving EPSDT services, namely behavioral health
- Required frequency of MCP outreach and education, targeted communications and assistance to families with access to EPSDT services
- Clarify existing MCP preventive care responsibilities and compliance enforcements such as corrective action plans and penalties
- Clarify existing MCP care coordination responsibilities between physical and behavioral health, including defining standards for such protocols. Include child-serving systems such as schools, early care and education settings, and regional centers
- Adopting a developmentally and culturally appropriate understanding of children's mental and behavioral health. This is achieved by eliminating the need for a specific clinical diagnosis for children and families to access care, and by requiring plans to cover clinically appropriate family and other dyadic care service models.

We particularly emphasize the need for precise MCP reporting and enforcement mechanisms to ensure MCPs comply with Federal law, in order to track and redress chronic underutilization, and to ensure children have full access to screenings and any medically necessary services. Absent this requirement, it is difficult to imagine how DHCS/MCPs can comply with the requirement in federal law relating to informing families of children who have not used EPSDT services of the benefits of preventive health care.

We recommend that DHCS require MCP annual reporting on the percentage of members eligible for EPSDT who actually receive services, particularly for behavioral health, and publicly report this data by race, ethnicity, plan, age, gender, language and County. This data assists DHCS, MCPs and stakeholders in monitoring EPSDT screening rates, EPSDT service referrals rates, and EPSDT treatment rates for major service categories, such as mental/behavioral health, dental, speech, occupational therapy, and physical therapy. DHCS should develop a EPSDT dashboard to indicate EPSDT utilization as well as specific EPSDT features such as whether screenings are resulting in timely referrals to services.

SDOH Assessment as Part of EPSDT. Under the EPSDT benefit, MCPs should also be required, as part of their basic package of well-child care, to provide Medi-Cal children with an evaluation or assessment of social determinants of health and related individualized care plans, as needed. The most recent version of Bright Future recommends use of such tools at well-child visits. Bright Futures' periodicity schedule states the psychosocial/behavioral assessment portion of the well-child visit "may include an assessment of child social-emotional health, caregiver depression, and social determinants of health." (AAP, 2020). As such, Bright Futures, using AAP policies and relevant findings, now highlights the potential for social determinants of health screening to be medically necessary and an influential part of the well-child visit. Thus, in addition to recommending the MCP contracts require these SDOH assessments and individualized care plans, DHCS should provide clear guidance on assessment tool standards, including appropriate follow up, as well as on MCP and provider training and education such as what is being required in the ACES Aware Initiative.

Promotion of Child-Centered Health Homes: 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 incentivize 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 three critical components to assure that children and families in the practice receive needed services:

- 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.
- Incentives, training, and support to promote team-based care practices in delivering all of the components of care.
- Accessible community information exchanges and care management support to address the complex needs of their patients.

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 develop and maintain community-information exchanges that give practice teams access to available supportive resources and programs, as well as HIPAA-compliant referral and feedback mechanisms to those programs. DHCS should establish guidelines for the capabilities of these programs and establish policies for MCPs regarding regular auditing and reporting on the specifications and performance of these exchanges. MCPs should also be required to partner by contract with community-based organizations 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 promoted as part of CalAIM.

Effective Care Coordination. DHCS should assess the extent to which MCPs are currently providing/covering care coordination for “at risk” and “rising risk” children. For example, we recommend contracts require MCPs to assure that EPSDT care management and care coordination services are provided immediately after a suspected illness or condition is detected during an EPSDT screening versus waiting to engage after the plan learns that the member is receiving treatment at a carved-out or in-network provider. The plans can delegate this activity to the providers, with negotiated contractual additional payment for these services, or the MCP can assume direct responsibility for follow up of all EPSDT referrals. The contract should specify MCP’s responsibilities to assist families of Medi-Cal children with referrals and making appointments, and non-medical transportation (NMT), including for carved out services. The contract should require the MCP to submit policies and procedures regarding how the plan meets its responsibilities to notify providers and families about covered care coordination services, including support for referrals/follow-up, appointment assistance and transportation.

Require explicit inclusion through contracts with community-based organizations in the MCP networks who work with child serving agencies (schools, regional centers, etc) to provide a more comprehensive service array including wraparound services, mobile crisis response, and school-based mental health services to name a few. These services address a broader range of the social determinants of health.

Expand Eligible Provider Class for Reimbursement. DHCS should make it clear that clinical trainees under supervision should also be credentialed under MCPs just as they are for specialty mental health. Medi-Cal Update, Psychological Services, August 2016, Bulletin 491 allows for this. DHCS should also expand eligible providers to include non-clinical workers who are closest in proximity to children and families with least access to traditional services and are more reflective of member’s racial/ethnic, socioeconomic, cultural, and language backgrounds. Many of the health issues and care coordination California’s children and adolescents face (particularly mental health issues) cannot be addressed solely in clinical settings, and instead require a wraparound set of services and supports at home, school, and in the community -- all of which need to be adequately coordinated and reimbursed. These providers would include appropriately trained and culturally relevant Community Health Outreach Workers, Promotoras, Peer Counselors and Peer Support Specialists, Rehab Specialists, Health Advocates, and others. MCPs will need culturally-appropriate training to support these service providers outside of the medical setting. DHCS should require MCPs to make non-clinical supports available in their network to beneficiaries. In addition, contracts should clarify reimbursement guidelines for schools and community-based organizations to provide telehealth services, **via video and text** for children and families who face barriers to accessing care in traditional settings. Even more fundamental to clarifying Medi-Cal claim procedures is to alert and educate providers, MCPs and beneficiaries that Medi-Cal covers services provided in these settings.

Clarify and Promote Coverage for Health-Related Support Services for Children. As one of the RFI goals to integrate and address social determinants of health for Medi-Cal beneficiaries, we would recommend a focus and promotion of health-related support services that are particularly relevant for children. While In lieu of Services may have value for specific high-needs children, for the most part, support services contingent upon a cost-effective criteria will not capture many of those services of particular value for children. Moreover, many health-related support services are covered under the EPSDT benefit but plans and providers might not be aware of their coverage under Medi-Cal. And MCPs and their providers need the flexibility to incorporate a broad array of support services into care. For that reason, we recommend that DHCS clarify in contracts the types of health-related support services with community partners that could be included in the EPSDT benefit, such as dyadic care, parenting class and peer-to-peer support for young children’s caregivers, community navigators, home visiting, and health education from community health workers.

Measurement and Transparency for Quality and Accountability. We recommend that DHCS regularly and publicly report a plan by plan comparison of performance standards broken out by county and race/ethnicity. To reflect the stages of a child’s development, this data should also be reported by age stages. With regard to the RFP, prospective plan proposals should include plan performance from their Medicaid contracts in other states.

Some additional measures should also be developed to more accurately measure children’s health performance. Many of the existing measures in the Child Core set do not measure the receipt of necessary services, such as the receipt of further assessment or care for maternal or adolescent depression or of a complete developmental assessment following a concerning developmental screen. Existing measures should be revised, or additional measures adopted, to reflect that the child, teen or mother received the necessary services by the partner agency. This should include measures for care coordination, perhaps built upon mental health utilization and a measure of mental/behavioral well-being, with quantified performance standards. We would also recommend that DHCS and the MCPs implement a Child Quality Plan, which would include each stage of a child’s life. In addition, MCPs should be required in contract to complete at least two Performance Improvement Plans (PIP) for specified pediatric or maternal measures, such as developmental or depression screenings, referral and linkage, not to be limited to current HEDIS or Medi-Cal Accountability Set (MAS) metrics for both younger children and school-aged children and address chronically low performance in delivering and coordinating care. Another required PIP would be required to address a health disparity.

DHCS Managed Care Enforcement. We reiterate our recommendation that DHCS strengthen accountability provisions in the contract, *and* significantly increase DHCS’ administrative oversight and enforcement to ensure that MCPs comply with their responsibilities and requirements. We have concerns about the current approach predominantly using audit/compliance tools to ensure implementation of plan responsibilities. We recommend that DHCS build its oversight and enforcement administration. In addition, the External Quality Review Organization (EQRO) should

be instructed to provide more actionable findings, reporting, and follow up on previous recommendations to plans, in order to more effectively direct DHCS' enforcement efforts. In addition to more actionable reporting and greater transparency, DHCS will need to supplement its enforcement mechanism tools beyond corrective action plans and build in financial withhold and incentive payments structures based on plan performance on measures of quality, member satisfaction and contract compliance. DHCS should reward plans investing in rapid response and callback systems (24 hours or less) to members regarding access to EPSDT guaranteed services, including behavioral health. In addition, financial incentives should not only apply to enhanced case management programs for select high-use populations, as proposed in CalAIM, but also to population health management for preventive care for all Medi-Cal beneficiaries.

Thank you for the opportunity to submit comments and recommendations in response to the Managed Care Organization (MCO) Request for Information (RFI # 20-001) led by the Department of Health Care Services (DHCS).