



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

FROM: American Academy of Pediatricians – California, California Children's Hospital Association, California Children's Trust, Children's Defense Fund—California, Children Now, Children's Specialty Care Coalition, National Health Law Program, The Children's Partnership, United Ways of California

SUBJECT: Medi-Cal Children's Health Care Comments with respect to Medi-Cal Managed Care Contracts (DHCS RFI # 20-001)

DATE: October 1, 2020

As a collective of children's advocacy and child-serving organizations, we have submitted the following comments on children's health care in the context of Medi-Cal managed care plan contracts and RFP:

The upcoming Medi-Cal managed care contract revisions and RFP offer a critical opportunity to reverse some of the problematic trends in children's health outcomes and delivery of care. **Currently, too many children are not being adequately or appropriately served by Medi-Cal and the health care system.** According to the State Auditor, about half of Medi-Cal children are not receiving basic primary care. Data aggregated by the [Commonwealth Fund](#) indicate 30% of children did not receive needed mental health care in 2018, making it 48<sup>th</sup> in the nation for children's mental health care access and reflecting a steep decline from 16% in 2016. And many are not receiving referrals to needed services. And now COVID-19 is exacerbating these challenges, Medicaid children's service use has dropped dramatically due to COVID-19. With 90% of Medi-Cal children participating in managed care, managed care contractual arrangements are the linchpin for effectuating the State's responsibility to ensure children receive legally mandated services. Equally important to what is laid out in the contracts is DHCS' oversight and enforcement of those contracts.

While DHCS and this Administration has made some steps toward advancing children's health in Medi-Cal— a preventive care outreach campaign, adopting the child core set measures, plan guidance on EPSDT, and incentive payments for screenings, these are far from enough to shift the trajectory for Medi-Cal's poor record in children's health care. What is called for is fundamental reform of Medi-Cal delivery of care for children with a specific emphasis on a child-centered system of care. For example, a Population Health Management requirement alone is not a sufficient strategy for prioritizing children's preventive care. Below are a few core elements for what should be included in the Medi-Cal managed care contracts and RFP in order to set the groundwork for such fundamental reforms for children's health care. Our individual organizations are also submitting comments separately with greater detail on these recommendations for the RFP and contracts.

**Health Equity** is core to Medi-Cal children's health care and many of the policy recommendations below weave in health equity principles, however we highlight a few core elements here. First, MCPs' Population Health Assessments (PNAs) should be publicly reported on DHCS 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. DHCS could also identify disparity-reduction and community health performance measurements that drive alignment of value-based payment and health equity.

Second, equity also requires identifying and addressing the longstanding social inequities ( often reflecting in social determinants of health) that communities and families face in order 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 that focus on improving the fundamental economic and social structures in order to decrease barriers and improve support across basic needs like housing, food, education, and employment that allow children to achieve their full potential. To this end, plans should be required to assess whether members may qualify for additional supports and to appropriately share with consent beneficiary data (electronically) for the purposes of enrollment in public benefit supports such as CalFresh and WIC. Currently, 500,000 Medi-Cal enrollees -- mostly children -- are eligible for WIC but not enrolled. Plans should be part of an evolving electronic express lane eligibility IT systems pathway between Medi-Cal, WIC and other programs.

Third, while assessing need within the context of social determinants of health is particularly apparent for those with multifaceted needs, it is equally important when issues are diagnosed early. Some of the sources of trauma and behavioral concerns are more appropriately addressed at their source. For example, the toxic immigration environment is wreaking havoc on children in immigrant families and medical-legal partnerships (MLPs) can go a long way to help a family's stress. And thus, reducing health disparities necessitates coupling pediatric care with social and emotional supports. Toward that end, DHCS could create an Health Equity Fund similar to Oregon, from MCP remittances, withholds or levied penalty amounts, with which MCPs could reinvest such funds into health equity initiatives.

Finally, equity also includes community engagement and internal governance geared toward equity. MCP should be required to train MCP employees and network providers on structural

racism, implicit bias, health disparities, SDOH, and trauma-informed care. And MCPs should be engaging and partnering with accountable communities for health, community organizations and community Medi-Cal members themselves in the decision making, governance and development of MCP's systems of care.

**Financing Tied to Children's Health Performance.** The MCP rate or 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 ensures strong oversight and enforcement by the State, fosters accountability and aligns incentives for access and quality by MCPs, and pushes Medi-Cal to do better for children. One such approach could construct a 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" MCO 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, 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. Half of states nationally use a quality incentive payment/performance bonus structure: Colorado's Medicaid program provides an incentive for managed care entities to earn up to 5% of annual behavioral health capitation rate for reaching behavioral health measure targets like behavioral health screening or assessment for foster children. It also provides an ability for managed care entities to earn additional administrative PMPM for improvements in key performance indicators on deploying coordinated, community-based approaches. After 7 years as a quality incentive program, Oregon has recently transitioned to a withhold approach.

In addition, as a key tool to improving access to pediatric care, DHCS should require MCPs to pay child-serving providers in their network sufficient rates, which should be at least comparable to Medicare rates.

**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. Some of the specific responsibilities to be delineated are included in our individual organization comments, but here are a few core elements:

- Allowable and disallowable prior authorization processes for EPSDT and clarification on the applicable EPSDT medical necessity definition;
- MCP responsibilities on promoting access to oral health services;
- Required frequency of MCP outreach and education, targeted communications and assistance to families with access to EPSDT services;

- Clarify existing MCO preventive care responsibilities and compliance enforcements such as corrective action plans and penalties; and
- Clarify existing MCP care coordination responsibilities, including defining standards for such protocols include child-serving systems such as schools, early care and education settings, and Regional Centers; and
- Adopting a developmentally and culturally appropriate understanding of children's mental and behavioral health. This is achieved by eliminating the need for specific clinical diagnoses for children and families to access care, and by requiring plans to cover clinically appropriate family-unit and dyadic 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/MCOs 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. MCPs utilization management information systems should be designed to flag underutilization for EPSDT.

We recommend that DHCS require MCP annual reporting on the percentage of members eligible for EPSDT who actually receive services, including within County Mental Health, and publicly report this data by race, ethnicity, plan, age, gender, language and County. This data should be provided to pediatric care teams and to the public to assist DHCS, MCPs, providers 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 publicly available EPSDT dashboard to indicate EPSDT utilization by MCP as well as specific EPSDT features such as whether screenings are resulting in timely referrals to services.

Finally, in order to make EPSDT compliance operable and effective, DHCS must require action on identified and reported MCPs' underutilization in EPSDT. One small but important step would be to establish a EPSDT compliance officer within DHCS whose responsibility is to identify underutilization and other non-compliance with other EPSDT responsibilities (e.g. assistance with care coordination and follow up, targeted outreach and education) and has the authority to administer actionable enforcement to effectuate quick compliance from MCPs.

**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.

**Effective Care Coordination.** With regard to MCP’s care coordination obligations, 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 initiate EPSDT care management and care coordination services 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. Again, MCPs contracts should specify MCP’s obligation to coordinate carved-out and linked services and referral to appropriate community resources and other agencies regardless of whether the MCP is responsible for paying for the service. For example, MCPs are responsible for coordination of preventive dental care and yet such coordination is not currently happening or being tracked. 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. And MCPs should track its coordination activities and follow up as part of its utilization management system and report out to DHCS.

DHCS should also expand eligible providers in care coordination and assessment to include non-clinical workers such as school staff and community partners 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 set of services and supports at home, school, and in the community -- all of which need to be adequately coordinated. These providers would include appropriately trained and culturally relevant Community Health Outreach Workers, Promotoras, Peer Counselors, 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, or establish a minimum ratio of CHWs to beneficiaries and establish a minimum list of services that CHWs can provide. In addition, contracts should clarify reimbursement guidelines for schools and community sites to provide telehealth services, via video, text and store-and-forward, for children 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.

**Promotion of Child-Centered Health Homes:** Promoting care coordination and social supports for “at risk” children will need more than a MCP health population management tool and care coordination incorporated into utilization management systems. 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. These child/family health home structures would differ from traditional health home structures that serve only those with specific complex conditions. 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 promoted as part of CalAIM.

**Children’s Behavioral Health Integration, Coordination and Oversight.** First and foremost, DHCS must require greater accountability and transparency from both MCPs (and MHPs) 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 mental health services and has a case management obligation to communicate with the County Mental Health Plan to ensure the member can access needed care without delay. Requirements should include the following:

- Require data sharing (by race, age, service type, setting, and intensity at a minimum) so that each plan is aware of the mental health services its member receives from mental health plans;
- Codify continuity of care for mental health services when Medi-Cal beneficiaries move from one system to another;
- 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 is provided during transitions between systems, which entails making explicit that MCPs care coordination expenditures are not only allowable 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 DHCS report data about mental health access, quality, and spending to monitor and oversee the performance of plans responsible for delivering mental health services.

**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 MCOs 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; medical legal partnerships; community navigators, home visiting, and health education from community health workers.

In fact, we would recommend encouraging MCPs to provide additional health-related support services for children through the re-procurement process, whereby plans that propose providing value-added services for children are given higher ratings. In addition, if a MCP does not reach the MLR, the MCP could invest that remittance amount in social investments.

**Quality Measurement, Oversight, and Accountability.** Equally important to what is laid out in the contracts is DHCS' oversight and enforcement of those contracts. We would recommend that DHCS add an additional RFP goal relating to Oversight and Accountability. Below are a few recommended tools necessary for DHCS to strengthen contract compliance and performance:

- Quality and Measurement. We 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 for both younger children and school-aged children, and not to be limited to current HEDIS or Medi-Cal Accountability Set (MCAS) metrics. To address chronically low performance in delivering and coordinating care, PIPs would include one DHCS required pediatric area of concern, such as developmental or depression screenings, and referral and linkages. Another required PIP should be required to address a health disparity delineated in the MCP's PNA. Some additional measures should also be developed to more accurately measure children's health performance – such a measure for care coordination, perhaps built upon proxies like closed-loop referral rates, mental health utilization and a measure of mental/behavioral well-being, with quantified performance standards.
- Transparency. Core Medi-Cal tools for assessing managed care quality and accountability are measuring, monitoring and publicly reporting performance standards: What is measured, matters. With the important axillary: what is measured is reported. While MCPs have reported many performance measures to DHCS, it was UCSF's deep dive comparative analysis of performance across plans over time and Children Now's county-by-county comparison of MCP's child health indicators that has publicly demonstrated the systemic deficiencies of the State's Medi-Cal managed care system. As a result, we recommend that DHCS regularly and publicly report a plan by plan comparison of performance standards, PNAs, and EPSDT utilization, broken out by county and race/ethnicity. To reflect the stages of a child's development, this data should also be reported by such age stages, where relevant.
- DHCS Oversight and 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 slow and ineffectual corrective action plans and build in financial withhold and incentive payments structures based on plan performance on measures of quality, member satisfaction, data reporting and contract compliance. For example, DHCS should issue financial penalties for non-compliance of required data reporting or under-performing rapid response 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.
- Limits and Obligations of Plan Delegation. In its new contract, DHCS should require greater oversight of MCPs' delegated entities. DHCS should specify in contracts that

MCP delegated entities are subject to the same obligations and responsibilities as the MCP for their delegated functions. DHCS should also require MCPs to report on data, including quality, grievance, encounter, network, etc., at the delegated entity level for sub-plans, IPAs, and Medical Groups. In addition, DHCS should require MCPs to audit these entities regularly using a DHCS-approved audit tool. To ensure that it can efficiently provide oversight of delegated entities, DHCS should limit how many times responsibility for a particular service may be delegated. Too often, DHCS contracts with an MCP, which then sub-contracts responsibility for service delivery to one or more sub-plans, which 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.

**Children's Medi-Cal and RFP.** In the RFP, DHCS should develop targeted questions that MCPs need to respond to related to children and their proposed models of care for children, particularly EPSDT preventive care and social investments related to children. And the RFP scoring should appropriately weight these responses and evaluate for an understanding of children's needs. In addition a higher rating or weight should be given for prospective plans demonstrating and proposing social and "value-added" related to children's social support services. The RFP response evaluation committee must include those with specific expertise in children's health and care. We also recommend sharing the children and family specific sections of the RFP with CHHS, particularly the Deputy Secretary for Early Childhood Development for review and recommendations. Finally, the RFP should require prospective plan proposals include plan performance from their Medicaid contracts in other states, including performance in children's care.