



**First 5 Association Response to the California Department of Health Care Services (DHCS)
Request for Information (RFI) # 20-001**

General

The First 5 Association appreciates the opportunity to provide input to the Department of Health Care Services on its procurement process for managed care plans to serve the Medi-Cal population. We see this as a critical opportunity to fulfill Governor Newsom's vision of a California For All. The Medi-Cal program serves 64 percent of California's children ages 0 to 5, three-quarters of whom are children of color. Because of the rapid health and development that occurs during the first five years of life, and the high rates of adversity and trauma faced by too many California families, the health care delivery system represents a tremendously powerful tool to promote positive trajectories for lifetime health among all of our children, and to begin to reverse some historical and current systemic forces that harm children of color.

However, over the last several years it has become increasingly clear that too many young children are not being adequately or appropriately served by Medi-Cal. Many children enrolled in Medi-Cal do not receive basic primary care or referrals to needed services. By most measures, California is missing critical opportunities to improve the life-long outcomes of its children. For example, the American Academy of Pediatrics recommends all children be screened three times before age three with a validated screening tool to identify developmental delays and social-emotional challenges requiring follow up, yet only 26% of children in California receive such screenings. Children living in low-income households and children of color are less likely to receive developmental screening than more affluent, white children. With almost 90 percent of young children enrolled in Medi-Cal in managed care plans, the Department must increase accountability and requirements to meet quality measures for performance on child outcomes to change these trends and ensure that our youngest at-risk children receive timely help and support to prevent longer-term challenges.

California is home to over nine million children, of which three in four are children of color and half have at least one parent who is an immigrant. Overall, children of color endure higher rates of low birth weight, asthma, hospitalizations, homelessness, racism, and poverty -- all of which have devastating impacts on health. Women of color, particularly Black mothers, also face the significant adverse effects of structural racism. Even as California's rate of maternal mortality has dropped overall, for example, three times as many Black women still die during, or in the period following, childbirth as women of all other races. The inequitable health outcomes that have plagued families of color and their communities are rooted in oppression from racist or xenophobic systems, laws and policies that are a part of our state's history. We can only move forward to achieving a "California for All" if equity and a whole family approach is woven through the systems that touch the lives of children. These principles lay the foundation for a collective health and well-being equity framework that centers young children from marginalized communities.

We recommend that the Department structure requirements and incentives for health plans in recognition that a child lives and develops within the context of her family and community. Children's

optimal development requires secure attachment with adults, stability, and loving interactions. These ingredients for children to reach their full potential are found within families that themselves are supported by the community and environment around them. Research also shows that investing in the first five years of life produces positive returns over a child's lifetime in the form of decreased medical and mental health costs, greater educational achievement, higher likelihood of employment, and lower likelihood of incarceration. Health systems should proactively nurture healthy relationships and resilience of young children and their families, and identify and address developmental, social-emotional, behavioral and other related issues at the earliest stages, before they spiral into long-term, high-cost conditions in adolescence and adulthood.

The earliest years of a child's life present an urgent opportunity to set up healthy development, given the rate of brain development that occurs during those years. It is also a window of opportunity for the parents, as they are open to advice, coaching and behavior change following the birth of a baby. For these reasons, the Department and health plans should view infants and toddlers as a special population, with targeted strategies to best serve them. The recommended schedule of 12 well-child visits before a child's third birthday provides a platform to deliver positive, prevention-focused touchpoints, and these should be the focal point of a whole child and whole family approach to set children and families up for success.

Because social-emotional factors greatly contribute to children's health, it is critical that children are routed to timely and appropriate interventions so social-emotional problems do not adversely impact their functioning, development and school readiness. Risk of poor outcomes, and not a specific diagnosis, should drive referrals to services, both inside and outside of the clinical setting.

For these reasons, the First 5 Association's priorities for new managed care contracts include:

- 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals.
- 2) Specific health equity plans to address inequities and disparities, which should include specific data reporting requirements related to race, ethnicity and age group; access to community health workers, doulas and promotoras to offer culturally-relevant care, including home visiting; and specific plans for reducing birth outcome disparities that disproportionately affect Black families.
- 3) Financial incentives for practices that provide holistic services as a standard of care to strengthen the relationship between child and caregiver within the pediatric primary care setting, including behavioral health services and closed-loop referrals to community-based and clinical supports.

We offer specific responses to the identified questions posed by the Department. We thank the Department for its consideration and ongoing partnership.

1. What MCP contract changes or actions do you recommend DHCS consider to address health disparities and inequities, as well as, identify and address social determinants of health?

The First 5 Association's priorities for new managed care contracts include: 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals. 2) Specific health equity plans to address inequities and disparities. 3) Financial incentives for practices that provide holistic services as a standard of care. Health equity plans should include specific data reporting requirements related to race, ethnicity and age group; access to community health workers, doulas and promotoras to offer culturally-relevant care, including home visiting; and specific plans for reducing birth outcome disparities that disproportionately affect Black families.

We recommend the following specific improvements to managed care contracts related to social determinants of health:

1. Require health plans to develop and implement health equity plans to address inequities and disparities in the health systems and their enrollees' communities, and report on how these plans will be used to close disparities and improve quality and health delivery. These should include data quality reporting standards, with a focus on child data disaggregated by age group, race and ethnicity across key prenatal and child health reporting measures, as determined by the Department and the plan, so that health disparities can be understood. In developing California-specific standards and requirements, the Department can draw from the experience of Oregon, which requires its plans (referred to as Coordinated Care Organizations or "CCOs") to develop a health promotion and prevention plan that meets the needs of culturally responsive and linguistically diverse communities, with specific details on how the plan will reduce or eliminate health disparities. See Oregon's contract language related to health equity plans, pp. 262-265. <https://www.oregon.gov/oha/OHPB/CCODocuments/Final-CCO-contract-terms-for-5-year-contract-awardees.pdf>
2. In parallel with establishing new plan requirements in the revised Medi-Cal managed care contract, the Department should revise and clarify its own policies as needed to allow community health workers, promotoras, and doulas to serve as eligible providers and receive Medi-Cal reimbursement for providing paraprofessional care aimed at supporting families and children to maximize access to preventive and chronic care health services and assisting families with young children and pregnant women in all counties. The revised managed care contract should leverage community health workers and incentivize pediatric practices to coordinate referrals to community-based providers, mental health providers, and specialty care providers. Suggested contract language: "Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations or directly by the health plan that address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. Examples of CHW services include but are not limited to: 1) conducting home visits to assess health barriers and challenges, 2) coordinating behavioral and physical health medical visits, 3) accompany and/or participate in medical office visits, and 4) arrange social services and supports (e.g., housing assistance)." DHCS should determine and include in the contracts a CHW to member ratio, specifically for high-risk pregnant women and young children.

See p. 67 of Michigan’s contract for additional example contract language:

https://www.michigan.gov/documents/contract_7696_7.pdf

3. As part of the health equity plan, MCPs should be required to specifically address how they plan to reduce infant mortality rates among Black infants and perinatal morbidity and mortality among Black women and women of other ethnic minorities with high rates of morbidity. Plans should be required to identify high risk or potential high-risk pregnancies with a particular focus on women of color, which may include doula services, home visiting, case management at OB/GYN offices, or other culturally-relevant services that lead to improved outcomes. Infant mortality rates among Black infants should be included in quality improvement plans. DHCS should look to Wisconsin, Louisiana and Virginia for examples of Medicaid managed care programs to improve health disparities among vulnerable pregnant women. Wisconsin focuses on Black women’s health disparities, requiring each health maintenance organization to maintain an Obstetric Medical Home for High-Risk Pregnancy, defining high-risk as being Black, homeless, less than 18 years of age, and/or having a behavioral health condition or chronic medical condition. Women enrolled in the OB Medical Home receive enhanced case management through pregnancy to improve birth outcomes. See pages 104-106 of Wisconsin’s 2021 contract, available at <https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/Home.htm.spage>

Louisiana requires managed care plans to implement a Perinatal Case Management Program for “reproductive aged women with a history of prior poor birth outcomes and high risk pregnant women.” Virginia requires the State’s managed care organizations to “develop a comprehensive Maternity Care program for the provision of services to pregnant women,” including “ensure access to and increased utilization of early prenatal care, including identifying and serving high-risk pregnant women” through enhanced case management services. Virginia’s contract defines high-risk pregnancies as “the presence of co-morbid or chronic conditions, sexually transmitted infections, etc.,” as well as previous pregnancy complications, history of or current substance use, history or current depression or behavioral health concerns, and the woman’s safety.

4. As part of their needs assessments, require MCPs to conduct focus groups of members to better understand the experience of those members generally, and specifically that of caregivers of color and their children. Focus groups should comprise members who match the racial and ethnic distribution of the Medi-Cal population in that county or region, and include caregivers of children ages 0 to 5. Plans should use needs assessments and specifically the input of focus groups in their quality improvement initiatives to promote better outcomes for Black infants.

2. What MCP contract changes or actions do you recommend DHCS consider to increase MCP’s community engagement?

The First 5 Association’s priorities for new managed care contracts include: 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals. 2) Specific health equity plans to address inequities and disparities. 3) Financial incentives for practices that provide holistic services as a standard of care. Community engagement efforts should focus on improving systems and services for families with young children. Specifically, we recommend:

1. To create system-level change that supports stronger integration of services for young children, plans should be required to establish and maintain a formal relationship with at least one local early childhood organization that addresses the comprehensive needs of children ages 0 to 5 likely to be Medi-Cal eligible and their families. This must include, but is not limited to, establishing a formal relationship with the First 5 County Commission, including execution of an MOU, unless the First 5 County Commission elects not to enter into an MOU. In many counties, such partnerships exist, but they are not yet universal throughout the state. First 5 County Commissions, as mandated by voter-approved Proposition 10 (1998), build integrated systems of care for young children and families in each county, with an emphasis on community voice and collective impact. Given the central role that First 5 County Commissions play in their communities, it is important to build systemic coordination between Medi-Cal plans, First 5 and related partners. Agreements between First 5s and MCPs may involve improving data reporting between health systems and community-based organizations, strengthening family representation at MCP advisory committees, informing child and family-focused community investments and/or identifying emerging issues among members with young children.
2. Require a minimum percentage of representative parents or caregivers of young children on MCP's member advisory boards, and support their participation with reimbursement, training, and child care. Parents included on advisory boards should represent the racial and ethnic makeup of their specific communities, and should have lived experience seeking care for their children across multiple local systems (MCP, regional center, Mental Health Plan, child welfare, etc.).
3. Require plans to invest financially in their communities to support children's development and family well-being. Examples could include investments in parks or other open spaces, or community events or services for children and families. For example, Arizona requires its Medicaid managed care plans to reinvest six percent of their profits back into the community. Some plans directly fund housing or food banks, while others set up mini-competitive grant programs to finance community-based organizations. Plans could also invest to improve the local Medi-Cal pediatric provider workforce pipeline. In California, L.A. Care and Blue Shield Promise invested \$146 million over five years to jointly operate Community Resource Centers to help members locate community services such as food and housing assistance.

3. What MCP contract changes or actions do you recommend DHCS consider for emergency preparedness and response for disasters?

The First 5 Association's priorities for new managed care contracts include: 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals. 2) Specific health equity plans to address inequities and disparities. 3) Financial incentives for practices that provide holistic services as a standard of care. Young children and their families are particularly vulnerable to experiencing trauma and adversity as a result of disasters. The Department should encourage health plans to outreach to members, particularly vulnerable, rural and/or other hard-to-reach families, during and after disasters to offer mental health services and transportation to health services if necessary. In addition, plans should participate in state and local efforts related to disaster planning and response. Finally, plans should offer services without regard to prior authorization, in network or out of network requirements and service limits.

4. What MCP contract changes or actions do you recommend DHCS consider to achieve the other MCP goals listed?

GOAL: CHILDREN'S SERVICES

We thank the Department for establishing improved services for children as a priority in this process. The First 5 Association's priorities for new managed care contracts include: 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals. 2) Specific health equity plans to address inequities and disparities. 3) Financial incentives for practices that provide holistic services as a standard of care.

Contracts should clearly articulate the obligation of plans to provide children with the full array of recommended screenings, clearly outline the reporting requirements for children's services, disaggregated by race/ethnicity and other key demographic factors, and establish specific penalties for failure to meet these requirements. We emphasize the importance of clear accountability measures and of rigorous oversight and enforcement because earlier efforts to improve the provision of EPSDT have not worked effectively, leaving significant numbers of California's children without essential services.

Specifically, we recommend:

1. The Department should provide a 4.25% performance incentive bonus for plans that demonstrate they exceed quality standards on key pediatric metrics of quality. An incentive bonus for pediatric primary care is important, given the documented low rates of children accessing preventive health care in California, and the long-term benefits of preventive health care to the children themselves as they grow, but also to society and government systems at large. We encourage the Department to consider models that have been successful in other states; currently, half of states nationally use a quality incentive payment/performance bonus structure. Oregon's Coordinated Care Organizations (CCO) incentive program has included a 4.25% above capitation payment to CCOs that performed well on specific measures, one of those being child developmental screenings. See Oregon's contract language at pp. 167-169: <https://www.oregon.gov/oha/OHPB/CCODocuments/Final-CCO-contract-terms-for-5-year-contract-awardees.pdf>

North Carolina's Medicaid managed care program includes a social determinant of health performance measure, and requires its plans to conduct a care needs screening and refer beneficiaries with unmet needs to services. This performance measure is part of a withhold program, where a portion of each MCP's capitation rate is withheld and paid when the plan meets the performance standard. Plans have the opportunity to earn "partial credit" for this and other performance standards which are weighted according to importance and feasibility. 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.

2. DHCS should adjust the MCP auto-assignment formula to reward health plans that meet child health outcome standards. The auto assignment formula currently includes two quality measures related to child health: Childhood Immunization Status and Well-Child Visit in the 3rd, 4th, 5th, and 6th year of life. The Department should consider additional early childhood measures from the CMS Child Core Set that California will be required to report on in 2024, and the

Department is aligning with starting in 2020 with the updated Medi-Cal Managed Care Accountability Set, such as Developmental Screening in the First Three Years of Life (DEV-CH) and Well-Child Visits in the First 15 Months of Life (W15-CH).

3. The Department should make EPSDT obligations explicit in the MCPs' contracts, including a definition of medical necessity and authorization and affirmative obligation that child members receive all EPSDT services, including well child visits and screenings, care coordination, referrals and services, following the recommendations of the State Auditor's March 2019 report. DHCS should consider conducting audits specific to EPSDT to ensure compliance. In addition, it should require plans to identify enrollees who have not used EPSDT services to facilitate outreach with a focus on targeted outreach that is culturally appropriate. State Medicaid agencies are required to inform families annually that have not used EPSDT services of the benefits of preventive care and covered services under the EPSDT benefit. If DHCS delegates this responsibility to plans, it should require this outreach and impose penalties for failure to comply with this requirement. See NHLP's draft EPSDT contract language here <https://docs.google.com/document/d/1aVoCGirpQB4LXQ7a2ZRAwpUeTUIMPAlhcCuHUHSo1FM/edit>
4. MCP contracts should require reporting on EPSDT required screening, and treatment, including CMS Child Core Set Measures as required by CMS in 2024. Preventive service utilization rates are higher for services that are linked to DHCS performance measures, so these measures should be added for children's preventive services. DHCS should consider conducting audits specific to EPSDT to ensure compliance, including care coordination. Alongside these contract provisions, the Department should make public and easily accessible MCP-specific performance data on child-related quality indicators. DHCS has developed a robust reporting infrastructure, including a recent investment in automated reporting and a public Managed Care Performance Dashboard. However, there is limited plan-specific information available to the public. By plan reporting on child-related indicators could help parents choose plans, which would serve as an incentive for quality. The Department should include plan-reported EPSDT screening, treatment and care coordination data on the DHCS pediatric dashboard. See NHLP's draft EPSDT contract language here <https://docs.google.com/document/d/1aVoCGirpQB4LXQ7a2ZRAwpUeTUIMPAlhcCuHUHSo1FM/edit>
5. Require MCPs to provide regular training specific to prenatal and pediatric preventive care, including social and emotional development of young children, trauma-informed care, dyadic care models, perinatal mood and anxiety disorders, and related issues. Oregon Medicaid managed care contracts require that the plan's provider network, provider network staff, and employees be trained in implicit bias, language access, trauma-informed care, implementing trauma-informed practices, and screening for adverse childhood experiences (ACEs). See Oregon's contract language on pp. 266-267: <https://www.oregon.gov/oha/OHPB/CCODocuments/Final-CCO-contract-terms-for-5-year-contract-awardees.pdf>
6. Require that a specified percentage of a plan's payments to primary care providers caring for children ages 0 to 5 be value-based, through an enhanced capitation rate or a pay for performance model. These payments should reward pediatric practices that provide whole-child, family-based care with explicit strategies to combat Adverse Childhood Experiences (ACEs) and strengthen the social and emotional development of children. Examples include providing evidence-based dyadic care models in the primary pediatric setting, or employing social

workers/care managers or other community health workers to provide navigation, home visiting, and/or other services designed to improve family stability and reduce adversity and trauma. The percentage of payments to primary care providers for value-based services should increase over time, as Oregon, Washington and New York have all done.

7. The Department should encourage “in-lieu of” services for pediatric populations to provide targeted wraparound services to children and their families, including home visiting programs that provide enhanced services, screenings and community linkages. As with the high-cost adults that have been the primary focus of the Department’s in lieu of services work, children and their families can sometimes be served more effectively via an in lieu of service. Two examples of in-lieu of services for this population include: 1) Substitute asthma initiatives, including home remediation, for medical expenses associated with asthma flare ups. 2) Provide doulas for at-risk pregnant women in order to avoid NICU stays or perinatal admissions.

GOAL: QUALITY

The First 5 Association’s priorities for new managed care contracts include: 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals. 2) Specific health equity plans to address inequities and disparities. 3) Financial incentives for practices that provide holistic services as a standard of care. The Department should implement policies that incentivize high-quality services specifically for infants, toddlers and young children. The incentive program should accompany the release of annual utilization reports that include accountability metrics and reporting on EPSDT screening, coordination/follow-up and treatment services, by age, by race/ethnicity, by plan, and by geographic area.

In recognition of the importance of the earliest years of life, on a per-child basis, health plans should spend a minimum portion of the premium payments from the state on children’s preventive care to ensure that essential services are being delivered, especially for very young children.

Specifically, we recommend:

1. The Department should provide a 4.25% performance incentive bonus for plans that demonstrate they exceed quality standards on key pediatric metrics of quality. An incentive bonus for pediatric primary care is important, given the documented low rates of children accessing preventive health care in California, and the long-term benefits of preventive health care to the children themselves as they grow, but also to society and government systems at large. We encourage the Department to consider models that have been successful in other states; currently, half of states nationally use a quality incentive payment/performance bonus structure. Oregon’s Coordinated Care Organizations (CCO) incentive program has included a 4.25% above capitation payment to CCOs that performed well on specific measures, one of those being child developmental screenings. See Oregon’s contract language at pp. 167-169: <https://www.oregon.gov/oha/OHPB/CCODocuments/Final-CCO-contract-terms-for-5-year-contract-awardees.pdf>

North Carolina’s Medicaid managed care program includes a social determinant of health performance measure, and requires its plans to conduct a care needs screening and refer beneficiaries with unmet needs to services. This performance measure is part of a withhold program, where a portion of each MCP’s capitation rate is withheld and paid when the plan meets the performance standard. Plans have the opportunity to earn “partial credit” for this and other performance standards which are weighted according to importance and feasibility.

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.

2. DHCS should adjust the MCP auto-assignment formula to reward health plans that meet child health outcome standards. The auto assignment formula currently includes two quality measures related to child health: Childhood Immunization Status and Well-Child Visit in the 3rd, 4th, 5th, and 6th year of life. The Department should consider additional early childhood measures from the CMS Child Core Set that California will be required to report on in 2024, and the Department is aligning with starting in 2020 with the updated Medi-Cal Managed Care Accountability Set, such as Developmental Screening in the First Three Years of Life (DEV-CH) and Well-Child Visits in the First 15 Months of Life (W15-CH).
3. The Department should make EPSDT obligations explicit in the MCPs' contracts, including a definition of medical necessity and authorization and affirmative obligation that child members receive all EPSDT services, including well child visits and screenings, care coordination, referrals and services, following the recommendations of the State Auditor's March 2019 report. DHCS should consider conducting audits specific to EPSDT to ensure compliance. In addition, it should require plans to identify enrollees who have not used EPSDT services to facilitate outreach with a focus on targeted outreach that is culturally appropriate. State Medicaid agencies are required to inform families annually that have not used EPSDT services of the benefits of preventive care and covered services under the EPSDT benefit. If DHCS delegates this responsibility to plans, it should require this outreach and impose penalties for failure to comply with this requirement. See NHLP's draft EPSDT contract language here <https://docs.google.com/document/d/1aVoCGirpQB4LXQ7a2ZRAwpUeTUIMPAlhcCuHUHSo1FM/edit>
4. MCP contracts should require reporting on EPSDT required screening, and treatment, including CMS Child Core Set Measures as required by CMS in 2024. Preventive service utilization rates are higher for services that are linked to DHCS performance measures, so these measures should be added for children's preventive services. DHCS should consider conducting audits specific to EPSDT to ensure compliance, including care coordination. Alongside these contract provisions, the Department should make public and easily accessible MCP-specific performance data on child-related quality indicators. DHCS has developed a robust reporting infrastructure, including a recent investment in automated reporting and a public Managed Care Performance Dashboard. However, there is limited plan-specific information available to the public. By plan reporting on child-related indicators could help parents choose plans, which would serve as an incentive for quality. The Department should include plan-reported EPSDT screening, treatment and care coordination data on the DHCS pediatric dashboard. See NHLP's draft EPSDT contract language here <https://docs.google.com/document/d/1aVoCGirpQB4LXQ7a2ZRAwpUeTUIMPAlhcCuHUHSo1FM/edit>
5. Require MCPs to provide regular training specific to prenatal and pediatric preventive care, including social and emotional development of young children, trauma-informed care, dyadic care models, perinatal mood and anxiety disorders, and related issues. Oregon Medicaid managed care contracts require that the plan's provider network, provider network staff, and employees be trained in implicit bias, language access, trauma-informed care, implementing

trauma-informed practices, and screening for adverse childhood experiences (ACEs). See Oregon's contract language on pp. 266-267:

<https://www.oregon.gov/oha/OHPB/CCODocuments/Final-CCO-contract-terms-for-5-year-contract-awardees.pdf>

6. Require that a specified percentage of a plan's payments to primary care providers caring for children ages 0 to 5 be value-based, through an enhanced capitation rate or a pay for performance model. These payments should reward pediatric practices that provide whole-child, family-based care with explicit strategies to combat Adverse Childhood Experiences (ACEs) and strengthen the social and emotional development of children. Examples include providing evidence-based dyadic care models in the primary pediatric setting, or employing social workers/care managers or other community health workers to provide navigation, home visiting, and/or other services designed to improve family stability and reduce adversity and trauma. The percentage of payments to primary care providers for value-based services should increase over time, as Oregon, Washington and New York have all done.
7. Incentivize MCP participation in a statewide Pediatric Practice Improvement Network (PIN) to accelerate EPSDT practice transformation and modernize infrastructure. The PIN, coordinated by an academic institution or consultant to the Department, should accompany a requirement to complete a Performance Improvement Plan (PIP) for specified pediatric or maternal measures, such as developmental or maternal/parental depression screenings, referral and linkage, and should not be limited to current HEDIS or External Accountability Set (EAS) metrics. This initiative offers a vehicle for adopting many of the training and education recommendations outlined above, and could be modeled on similar initiatives in states such as South Carolina, which operates the Quality Through Technology and Innovation in Pediatric Practice (QTIP) program, providing technical assistance and peer-learning opportunities to support practice transformation, quality improvement, and mental health service integration into pediatric primary care. We recommend that plans be expected to play a major role in this initiative by offering funding and encouraging their providers to participate. For example, New York's Kids Quality Agenda aimed at improving children's first 1,000 days on Medicaid, and is designing a statewide PIP that requires each managed care plan to develop, implement, and evaluate a supplementary intervention to address: (1) Increase performance on child quality measures (using the State's Quality Assurance Reporting Requirements (QARR), inclusive of HEDIS, CMS Child Core Set Measures, and New York-specific metrics) measures (well-child visits, lead screening, child immunization); (2) enhance rates of developmental, vision, hearing and maternal depression screenings and/or evaluations; or (3) improve select performance on existing QARR perinatal health measures.

GOAL: ACCESS TO CARE

The First 5 Association's priorities for new managed care contracts include: 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals. 2) Specific health equity plans to address inequities and disparities. 3) Financial incentives for practices that provide holistic services as a standard of care. Well-child visits are particularly important during the current pandemic, particularly as rates of immunizations have fallen dramatically.

1. In parallel with establishing new plan requirements in the revised Medi-Cal managed care contract, the Department should revise and clarify its own policies as needed to allow community health workers, promotoras, and doulas to serve as eligible providers and receive

Medi-Cal reimbursement for providing paraprofessional care aimed at supporting families and children to maximize access to preventive and chronic care health services and assisting families with young children and pregnant women in all counties. The revised managed care contract should leverage community health workers and incentivize pediatric practices to coordinate referrals to community-based providers, mental health providers, and specialty care providers. Suggested contract language: “Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations or directly by the health plan that address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. Examples of CHW services include but are not limited to: 1) conducting home visits to assess health barriers and challenges, 2) coordinating behavioral and physical health medical visits, 3) accompany and/or participate in medical office visits, and 4) arrange social services and supports (e.g., housing assistance).” DHCS should determine and include in the contracts a CHW to member ratio, specifically for high-risk pregnant women and young children. See p. 67 of Michigan’s contract for additional example contract language:

https://www.michigan.gov/documents/contract_7696_7.pdf

2. Building on telehealth practices established during COVID-19, modify telehealth requirements for plans to expand access to permit children to receive portions of well-child visits and specialty care via video and telephone on a permanent basis, when appropriate and particularly for hard-to-reach or rural populations, to help families stay connected to care. These visits should be paid at comparable rates to in-person visits. Pediatric specialist shortages prevent MCPs from adequately meeting the needs of children and families, particularly in rural parts of the state.

GOAL: BEHAVIORAL HEALTH SERVICES

The First 5 Association’s priorities for new managed care contracts include: 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals. 2) Specific health equity plans to address inequities and disparities. 3) Financial incentives for practices that provide holistic services as a standard of care. Many of the health issues California’s children and adolescents face cannot be addressed solely in clinical settings, and instead require a wraparound set of services and supports at home, school, and in the community. Improving health disparities necessitates coupling pediatric care with social and emotional supports. Children’s physical health, as well as their social, emotional, and cognitive competence, require secure attachments to emotionally invested and protective adults who have the knowledge and psychological readiness to provide safe, stable, and developmentally appropriate care. The need for emotionally invested, protective care is particularly critical during pregnancy and the first five years after birth, when the architecture of the brain is being established and neural connections grow at the fastest rate of an individual’s lifetime. Research shows that investing in the first five years of life produces positive returns over a child’s lifetime in the form of decreased medical and mental health costs, greater educational achievement, higher likelihood of employment, and lower likelihood of incarceration.

1. Remove diagnosis as a prerequisite for mental health care. Young children rarely come to the doctor with mental health concerns significant enough to warrant a diagnosis. Instead, the most important way to monitor infant and toddler mental health is to check on family well-being. By focusing eligibility criteria on symptoms the child is experiencing, California misses the

opportunity to provide early relational health supports like dyadic care to children experiencing risk factors that impact long-term mental health.

2. Managed care plans should encourage the use of dyadic care models in primary care settings as a standard of care through trainings and incentives, including value-based purchasing arrangements. (See First 5 Association’s recommendation #6 in response to Question 4, Children’s Services.) Dyadic treatment is a form of therapy in which the infant or young child and caregiver are treated together. A clinician is present with the caregiver-child dyad, or in a nearby room, and coaches the caregiver to encourage positive interactions that can help improve parenting, the parent-child relationship, and the child’s behavior. Both the caregiver and child have the chance to experience more positive ways to interact with each other. There are several evidence-based models of dyadic treatment (e.g., HealthySteps, DULCE, Parent-Child Interaction Treatment and Child-Parent Psychotherapy). In this integrated care model, pediatric mental health professionals are available to address developmental and behavioral health concerns as soon as they are identified, bypassing the many obstacles families face when referred to offsite behavioral health services. Furthermore, in this model, health care for the child is delivered in the context of the caregiver and family (i.e. “dyadic health care services”) so that families are screened for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability. Families who are given referrals receive follow-up to make sure they received the services.

Specifically, DHCS should include H0025 (behavioral health prevention education service) as a Medi-Cal reimbursable code and plans should reimburse code H0025 for behavioral health prevention for all infants and young children ages birth to 5, similar to how routine encounters for wellness exams are available to all children in physical health. These services should be paired with expanded caregiver mental health screening, care management, and couples therapy where it could benefit the well-being of the child.

GOAL: COORDINATED/INTEGRATED CARE

The First 5 Association’s priorities for new managed care contracts include: 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals. 2) Specific health equity plans to address inequities and disparities. 3) Financial incentives for practices that provide holistic services as a standard of care.

1. 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. See NHLP’s draft EPSDT contract language here <https://docs.google.com/document/d/1aVoCGirpQB4LXQ7a2ZRAwpUeTUIMPAlhcCuHUhSo1FM/edit>
2. Managed care plans should be required to coordinate with Women Infant Children (WIC) agencies to ensure that beneficiaries enrolled in one program are enrolled in the other. An estimated 500,000 Medi-Cal enrollees – mostly children – are eligible for WIC but not enrolled, suggesting that more needs to be done to connect Medi-Cal enrollees with WIC. Beginning in 2021, North Carolina will require managed care plans to coordinate with the WIC program,

specifically that the health plan shall make referrals to the WIC program of pregnant women, women up to six months postpartum, women breastfeeding up to one year postpartum, infants, and children up to age five. Suggested contract language: “The Contractor shall establish relationships with the WIC entities” and “shall collaborate with the Office of the State WIC Director to establish a plan to coordinate these activities and share data, as needed, to accomplish join program goals.” See North Carolina’s contract language for additional examples on page 131 of 214: <https://files.nc.gov/ncdma/Contract--30-190029-DHB-Prepaid-Health-Plan-Services.pdf>

5. What, if any, of the listed MCP goals provide significant challenges and what should be done to address those challenges?

The First 5 Association’s priorities for new managed care contracts include: 1) Financial incentives and accountability measures, including a performance bonus incentive, to increase well-child visit utilization, as well as recommended screenings and referrals. 2) Specific health equity plans to address inequities and disparities. 3) Financial incentives for practices that provide holistic services as a standard of care.

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 a sub-plans, 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.

6. What additional MCP goals should DHCS consider?

No response.

7. What additional changes or actions do you recommend DHCS consider for the planned structural updates to the MCP contract?

No response.

8. What additional changes or actions do you recommend DHCS consider for the planned content updates to the MCP contract?

The following external documents and materials that should be incorporated or referenced in the contract.

1. **Senate Bill 1287 (Hernandez, Chapter 855, Statutes of 2018)** revised the Medi-Cal definition of “medically necessary” for purposes of an individual under 21 years of age to incorporate the

existing federal standards related to EPSDT services; to cover all medically necessary services, including those to "correct or ameliorate" defects and physical and mental illness conditions. The MCP contract should reflect this updated language and make clear that children are entitled to a broader range of services than adults, including comprehensive and preventive care.

2. **California State Auditor Report 2018-111** put forth recommendations on how to improve children's access to preventive health services. These recommendations should be reflected in the MCP contracts. In particular the report notes that DHCS must improve its oversight of MCPs in three ways: 1) Provide clearer communication with plans, providers, and families regarding the preventive services that plans must make available to eligible children. 2) Ensure that plans regularly identify and address underutilization of children's preventive services. 3) Expand performance measures to include all age groups for which plans must provide preventive services.
3. **Assembly Bill 1004 (McCarty, Chapter 387, Statutes of 2019)** requires MCPs to ensure that developmental screening services provided for Members as part of the Early and Periodic Screening, Diagnostic, and Treatment benefit comply with the AAP/Bright Futures periodicity schedule and guidelines.
4. **ALL PLAN LETTER 17-018 published October 27, 2017** explains the contractual responsibilities of Medi-Cal managed care health plans (MCPs) for the provision of medically necessary outpatient mental health services and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). MCPs must provide medically necessary non-specialty mental health services to children.
5. **ALL PLAN LETTER 19-010 published August 14, 2019** clarifies the responsibilities of Medi-Cal managed care health plans (MCPs) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible members under the age of 21.
6. **ALL PLAN LETTER 19-014 published November 12, 2019** provides guidance to Medi-Cal managed care health plans (MCPs) about the provision of medically necessary Behavioral Health Treatment (BHT) services for members under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and in accordance with mental health parity requirements.
7. **ALL PLAN LETTER 19-016 published December 26, 2019** provides Medi-Cal managed care health plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of standardized developmental screening services for children.
8. **ALL PLAN LETTER 19-018 published December 26, 2019** provides Medi-Cal managed care health plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of standardized Adverse Childhood Experiences (ACEs) screening services.