



# Organizations React to Medi-Cal Managed Care Procurement Request for Proposals

The California Department of Health Care Services (DHCS) administers Medi-Cal, the largest Medicaid program in the country.<sup>1</sup> The state's Medi-Cal program provides coverage to almost 14 million Californians statewide, including children, adults, families, seniors, and people with disabilities.<sup>2</sup> Over 11.6 million of these Medi-Cal enrollees get their health care through a Medi-Cal managed care plan (MCP).<sup>3</sup> Of these, approximately 70% identify as people of color, including Latinx, Black, Asian, and American Indian and Alaskan Native individuals.

In 2021, DHCS will spend over \$50 billion paying MCPs to provide Medi-Cal enrollees with a comprehensive set of health care services, including behavioral health services to those with mild to moderate mental illness. Of the 24 MCPs contracting with DHCS, 16 are locally sponsored plans (10 local initiative plans and 6 County Organized Health System plans). The remaining MCPs are a mix of for-profit and nonprofit commercial plans operating in 22 of the 58 California counties.

On June 1, 2021, DHCS released its Medi-Cal MCP draft request for proposals (RFP 20-10029), formally launching the first-ever statewide competitive procurement process for commercial MCPs. This procurement is a unique opportunity for DHCS to significantly revise and modernize the MCP contract and to critically assess the expertise and capabilities of prospective plans on behalf of a diverse Medi-Cal population.

DHCS provided a 30-day public comment period for the draft RFP. At the same time, the California Health Care Foundation (CHCF) invited anyone submitting comments to DHCS to also share their comments with CHCF. CHCF's goals were threefold: to listen to and learn from the feedback provided to DHCS, to make the feedback widely available by posting it online, and to foster greater

transparency and accountability by identifying and sharing common themes.

CHCF received 19 responses to DHCS's request for comments, 15 of which are posted on CHCF's website.<sup>4</sup> The number of individuals and organizations represented in the responses ranged from a single individual to a collection of over 400 organizations.<sup>5</sup> CHCF contracted with Bailit Health to analyze these responses and present a summary of key recommendations and themes.

This brief presents Bailit Health's analysis, consisting of an overview of the MCP procurement timeline, a description of the study methodology, the results of Bailit Health's analysis of the comments shared with CHCF, and a short conclusion.

In brief, Bailit Health identified three key recommendations for DHCS:

- 1. Release a complete and clear set of procurement documents for review and comment.** Many respondents expressed their disappointment that the draft RFP released for comment was incomplete and lacked clarity and wanted DHCS to release a full set of procurement documents for public review and comment prior to the issue of the final RFP.
- 2. Strengthen the MCP requirements related to improving access, quality, and equity.** Many respondents asked that the MCP contract requirements be strengthened, clarified, and expanded, particularly those relating to improving access to quality care, reducing racial and other disparities, and improving health equity for various groups and populations.
- 3. Ensure adequate and fair payment policies while fostering local partnerships.** Respondents remarked

that the MCP rates should reflect and require adequate payment at the county and provider level, commensurate with the expanded MCP requirements and expectations. Some respondents also encouraged DHCS to require successful bidders to partner with local providers, counties, and community-based organizations (CBOs) in a meaningful way to support, achieve, and sustain the goals set by DHCS and stakeholders for this procurement and for Medi-Cal managed care overall.

Woven throughout these three overarching recommendations are two cross-cutting messages DHCS received from commenters approaching the draft RFP through the lens of certain populations and services. A few groups of organizations specifically recommended that one or more of the recommendations be applied specifically to (1) invest in care for children across services and providers, including in schools; or (2) support access to high-quality maternal and child health and behavioral health (BH) services.

By 2024, DHCS intends to expand the Medi-Cal reforms established during this procurement beyond just commercial plans by executing new, consistent MCP contracts statewide across all types of Medi-Cal managed care models. The revamping of these MCP contracts is anticipated to result in one of the largest set of state contracts ever procured or negotiated at one time for any purpose. This is a rare opportunity to improve care for Medi-Cal MCP enrollees statewide and to ensure ready access to high-quality care.

*“These draft contracts represent a once in a childhood opportunity for DHCS to prioritize kids.”*

— Children’s Movement of California

## Medi-Cal Managed Care Procurement Process and Timeline

DHCS’s objective for the MCP procurement is “to procure commercial plans to provide high-quality, accessible, and cost-effective health care through established networks of organized systems of care that emphasize primary and preventive care.” DHCS sees this procurement as an important step for achieving its vision “to preserve and improve the overall health and well-being of all Californians, and particularly, to address the needs of populations experiencing disparities in health outcomes.”

*“We want to acknowledge DHCS for . . . signaling a commitment to health equity. . . .”*

— California Coalition for Youth

Table 1 provides a high-level timeline from June 2021, the release of the draft RFP, to January 2024, the anticipated date that the new MCP contracts with commercial plans become operational. Entities interested in being selected as an MCP for the Two-Plan Model, Geographic Managed Care Model, Regional Model, Imperial Model, or San Benito Model will be required to respond to the final RFP.

**Table 1. DHCS Medi-Cal MCP Procurement Timeline**

KEY EVENT	DATE
MCP draft RFP release	Jun. 1, 2021
RFP comments due to DHCS	Jul. 1, 2021
MCP final RFP release	Nov./Dec. 2021
Proposals due from commercial plans	Early 2022
DHCS notice of intent to contract	Mid-2022
MCP operational readiness	Late 2022–late 2023
Implementation	Jan. 2024

Source: *Medi-Cal Managed Care Request for Proposal (RFP) Schedule by Model Type* (PDF), DHCS, February 27, 2020.

The draft RFP posted for public review and comments included information on the procurement process and instructions on proposal development. DHCS also included some RFP attachments and a sample MCP contract. However, the draft RFP did not contain all the information that will be included in the final RFP. For example, DHCS did not include narrative proposal requirements, evaluation and scoring criteria, or information on MCP capitation rates.

While many commenters have expressed disappointment at the lack of detail in some areas of the procurement documents, the absence of specific language is understandable, as there are still over two years until the new MCP contracts will be executed and operational. DHCS has already indicated that the final RFP will include additional MCP contract requirements with regard to the following policy items:

- ▶ May 2021 budget revisions
- ▶ California Advancing and Innovating Medi-Cal's (Cal-AIM's) population health management, Enhanced Care Management, and In Lieu of Services
- ▶ Health disparities and health equity
- ▶ BH reforms, including but not limited to No Wrong Door
- ▶ School-based services, including but not limited to preventive early intervention for BH services by school-affiliated health providers

Prior and subsequent to the release of the final RFP, DHCS can revise the MCP contract, as needed, to reflect changes in federal and state rules and policies. It is typical for state Medicaid agencies to modify the model contract as they deem necessary or appropriate prior to its execution, including but not limited to adding details, attachments, and appendices.

## Methodology

CHCF contracted with Bailit Health to review the RFP comments shared with CHCF to identify common themes. CHCF also asked Bailit Health to highlight a few comments that appear to offer unique and

important perspectives on DHCS's draft MCP procurement documents.

CHCF received 19 responses. Of these responses, 8 sets of comments were from consumer advocacy groups, 8 sets of comments were from provider organizations or associations, and 3 sets of comments were from health plans or associations. Although the 19 responses shared with CHCF represent just under half of the number received by DHCS directly, the responses shared with CHCF represent a broad cross-section of organizations.

Bailit Health reviewed each set of comments, categorized them using DHCS's goals, and identified common themes across the comments. Comments on the MCP draft RFP that did not fall into a theme but seemed important to call out were also considered. Finally, Bailit Health grouped the themes under three overarching recommendations.

## Findings

The comments shared with CHCF about the draft MCP procurement documents were thoughtful and varied and ranged from broad-view feedback to line-by-line editing suggestions to the draft RFP and model contract documents. Commenters pointed out items in the procurement documents that they supported, items that their organizations felt were missing, and specific MCP requirements that commenters wanted strengthened.

Bailit Health identified 11 themes from the feedback to DHCS and grouped these themes into three types of recommendations:

- ▶ Release a complete and clear set of procurement documents for review and comment.
- ▶ Strengthen the MCP requirements related to improving access, quality, and equity.
- ▶ Ensure adequate and fair payment policies while fostering local partnerships.

In addition, Bailit Health identified two cross-cutting messages for DHCS that came through in some comments when the RFP is viewed through the lens of improvements focused on certain populations or services. Specifically,

some commenting organizations recommended that MCPs be required to (1) invest in care for children across services and providers, including in schools; or (2) support access to high-quality maternal and child health and BH services.

A description follows of the themes that fall within each of the three recommendations and their implications for the MCP procurement documents. In addition, the quotes from commenters help provide some insight into how these cross-cutting perspectives align with the three recommendation themes.

#### RECOMMENDATION 1

### **Release a complete and clear set of procurement documents for review and comment.**

#### **Theme 1: Release a complete set of MCP draft RFP documents for review and comment.**

Approximately half of the sets of comments shared with CHCF raised concerns over components of the managed care RFP that were not included in the draft RFP and therefore were not part of the public review and comment process. For example, commenters noted information missing from the RFP documents, such as CalAIM provisions related to MCPs, additional equity requirements, and schools and youth BH programs, including items from the May 2021 budget revisions.

*“We are concerned that the draft RFP and model contract as proposed do not reflect the necessary accountability strategies to effectively change course on current poor performance of Medi-Cal managed care plans as it relates to child health and does not establish criteria and requirements for plans to demonstrate continued progress in narrowing the equity gap.”*

— Coalition of Children’s Groups

Commenting organizations consistently expressed interest in stakeholders having the opportunity to review and comment on a complete RFP document prior to DHCS’s release of the final RFP. Some commenters expressed concerns that DHCS may make important additions or changes to the MCP final RFP that stakeholders will have had no opportunity to review. Some commenters also suggested that DHCS offer stakeholders the opportunity to review and comment on RFP evaluation questions prior to the RFP documents being finalized.

*“For a more complete process, we respectfully request DHCS to solicit public feedback on . . . missing elements before the RFP is finalized later this year.”*

— California Association of Public Hospitals and Health Systems

Some states do not share any information for public comment in advance of a Medicaid managed care procurement. In addition, Medicaid agencies that release draft RFPs often do not share a complete draft of all the procurement documents for review and comment before issuing a final RFP. Given the length of time until the contracts will be operational, draft procurement documents often do not include all the items that will be in the final version, such as specific rate information.

A trade-off exists between DHCS obtaining input on every aspect of a procurement process and still meeting its stated procurement timeline. DHCS must balance the value of conducting another full round of public review and comment with its desire to adhere to its 2021 procurement timeline and execute the new MCP contracts statewide prior to January 2024, including conforming changes to contracts with locally sponsored plans.

Additional stakeholder recommendations on the MCP model contract could be considered after DHCS posts the final RFP documents. The new MCP contracts will not be finalized and executed until 2023 in preparation for a January 2024 operational start date. After the RFP is posted, DHCS could solicit additional feedback on the MCP contracts within the constraints of the procurement process. An additional opportunity for public comment

may be able to occur without substantially affecting the proposed start date for MCP contracts, as long as the final MCP contract is completed in time for DHCS to initiate and complete MCP readiness reviews for a January 2024 start date.

**Theme 2: Ensure that the model contract reflects the full scope of MCP obligations.**

Commenters suggested that DHCS ensure that the MCP model contract released as part of the procurement process be expanded to reflect the full scope of MCP obligations. This is the first time the MCP contract has been overhauled in many years. Once implemented, the new MCP contracts may be the last opportunity for DHCS to make significant contract changes for years to come. Commenters specifically suggested that DHCS modify the model contract with the following recommendations:

- ▶ Incorporate policies from All Plan Letters (APLs) into the MCP contract.
- ▶ Include in the RFP more detail on the recent Child and Youth Behavioral Health Initiative.
- ▶ Include DHCS’s stated intent to require clinical and claims data sharing participation from all MCPs and providers.
- ▶ Reference existing MCP requirements, including abortion care and compliance standards for dental care.
- ▶ Define what MCP audits will consist of and the anticipated scope of such work.

*“Rather than clarifying or detailing existing contractual requirements, APLs are increasingly becoming the vehicle for communicating new MCP responsibilities. The MCP contract requires that plans comply with future APLs, making this particularly problematic. [Local Health Plans of California] recommends that new MCP obligations be incorporated into the contract.”*

— Local Health Plans of California

*“There is no mention of the new role schools will play in partnership with MCOs and nothing about contracting and who pays for what in providing school-based mental health services at the scale currently envisioned.”*

— Education stakeholders

In its meeting with the Stakeholder Advisory Committee on July 30, DHCS indicated that it will (1) incorporate more detail about the Child and Youth Behavioral Health Initiative in the RFP, and (2) review whether comments are best addressed through the RFP and MCP contract or through other guidance documents, such as APLs. DHCS also stated that it is not planning on incorporating all the APL requirements and their level of detail into the MCP contract.

Both DHCS and commenters have raised concerns about the scope of the MCP contract and the level of detail to be included in the contract in comparison to other communications between the state and MCPs, such as APLs. Given the time-consuming process of amending 24 different MCP contracts, DHCS has previously used APLs to implement policy changes that are not currently rooted in the MCP contract, including to implement time-sensitive changes in federal and state laws and regulations. However, it is challenging for MCPs, interested parties, and DHCS to understand the full scope of MCP obligations not specifically referenced in the MCP contract. Incorporating more detail into the MCP contract and relying less on APLs may make it easier for all parties to understand the full scope of MCP obligations and hold MCPs accountable. If the MCP contracts and related appendices grow too long, however, state and MCP staff will likely be less able to manage the contracts.

There are other disadvantages to including more detail in the MCP contracts. More detail in the contracts means fewer opportunities for DHCS and MCPs to innovate and evolve within the bounds of the MCP contract. In addition, updating MCP requirements via a contract amendment rather than through an APL is more arduous and time consuming. For these reasons, it is not uncommon for example, for states to include general

MCP contract requirements related to the Healthcare Effectiveness Data and Information Set (HEDIS) and other performance measure tools within the contract while maintaining separate technical specification documents with annually updated details on how the MCPs must report required performance measures and how specific benchmarks will be calculated.

### **Theme 3: Clarify the MCP requirements in the model contract.**

Health plan representatives and other commenters recommended that DHCS clarify several MCP contractual requirements across all aspects of health plan responsibilities. For purposes of illustration, Bailit Health focused on commenters' requests for more specifications on MCP care coordination responsibilities, which resulted in the following recommendations:

- ▶ Require MCPs to administer an individual risk assessment to those identified as low risk to help identify needed preventive services.
- ▶ Develop and implement strategies to improve care coordination and increase rates of referral completion and member engagement in specialty services.
- ▶ Utilize effective care coordination performance measures reflective of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).
- ▶ Require MCPs to include community health workers in care coordination or partner with CBOs.

Clarity in the MCP model contract is important to ensure that bidders understand what they will be held accountable to within the MCP capitation rates and contract. Clarity is also important to ensure equal benefits and access for all beneficiaries, regardless of the MCP in which they are enrolled. Finally, clear MCP contract requirements are needed for providers, subcontractors, and plans to better understand their roles and responsibilities under the contract.

## **RECOMMENDATION 2**

### **Strengthen the MCP requirements related to improving access, quality, and equity.**

#### **Theme 4: Hold MCPs more accountable for performance, and link their performance to financial consequences.**

While the model contract released with the draft procurement documents includes provisions to hold MCPs more accountable for performance, commenters encouraged DHCS to go further in defining MCP performance expectations and creating financial incentives for plans for improvement. The quality of care provided to Medi-Cal managed care enrollees is, on average, below that received by Medicaid enrollees in many other states. In addition, from 2009 to 2018, quality of care in Medi-Cal managed care was stalled on over half of 41 performance measures.<sup>6</sup> Among the 9 MCP quality measures currently in use for children, performance on 6 measures declined or stayed the same during this same period.

Quality and access challenges are not unique to Medi-Cal or managed care, but the current and proposed MCP payment policies do not create meaningful financial incentives for MCPs to improve. DHCS pays Medi-Cal MCPs based on per-member per-month capitation payments. DHCS generally does not offer financial incentives to MCPs based on improved performance and does not put a portion of MCP capitation payments at risk based on individual plan performance. In 2019, DHCS adopted new rules that require MCPs to perform at least as well as half of the Medicaid managed care plans nationally (up from 25%). However, MCPs not meeting this standard do not face significant financial penalties for noncompliance, and plans performing above this level receive no financial benefit. In contrast, at least 24 states with Medicaid managed care programs use a capitation withhold approach as a significant quality incentive.<sup>7</sup> Capitation withholds, typically in the range of 1% to 4% of the total health plan premiums, are set aside as incentive payments for Medicaid plans whose performance meets or exceeds predefined state benchmarks or improvement targets.<sup>8</sup> Plans can earn back some or all of the amount withheld, depending on their performance.

Commenters encouraged DHCS to define a clear, strong link between MCP performance and financial incentives in the final RFP documents. Commenters on the draft RFP specifically recommended the following changes:

- ▶ Payments to MCPs should be more explicitly tied to performance.
- ▶ The final RFP must reflect the administration's stated intention to hold MCPs accountable to benchmark measures. The contract should clearly enable DHCS to impose financial withholds for MCPs' failure to meet 50th percentile of performance on specified metrics.
- ▶ MCPs must be required to continue to improve quality, including improving performance relative to national Medicaid benchmarks and reducing disparities in performance among Medi-Cal enrollees.

*“Amend the rate development process to be a driver of quality improvement and impose financial withholds for failure to meet a minimum performance level of the 50th percentiles for adults and children’s preventive services.”*

— A coalition of consumer advocates

Adopting financial incentives for MCPs to improve quality is a best practice within Medicaid managed care programs. As noted in more detail in a Bailit Health report written for CHCF earlier this year, *Paying Medi-Cal Managed Care Plans for Value: Design Recommendations for a Quality Incentive Program*, DHCS could combine an MCP capitation withhold with an incentive payment for plans whose performance meets or exceeds predefined DHCS expectations.<sup>9</sup> The procurement documents should clearly authorize DHCS to define and determine how MCPs could earn back some or all of the amount withheld, depending on an individual plan's performance to specific metrics and benchmarks. Detailed technical specifications could be shared outside of the MCP

contract, but the final MCP contract should be explicit on DHCS's authority, approach, and expectations for MCP financial performance incentives. Ideally, the amount of the financial incentive earned by an MCP should increase as performance improves. In addition, DHCS should use a combination of aligned financial and nonfinancial incentives to increase MCP motivation and accountability for quality performance. Publicly sharing and reviewing MCP performance on metrics within external stakeholder meetings can be as powerful a motivation for quality improvement as offering direct financial incentives. The new MCP contracts should give DHCS multiple levers to incentivize improvement.

**Theme 5: Enhance the requirements for MCPs to have adequate networks and timely access to care.**

While DHCS has increased their oversight of MCP network adequacy in the past few years, commenters noted an ongoing need to further enhance both the MCP requirements and DHCS's oversight of adequate networks. Commenters specifically made the following suggestions to DHCS:

- ▶ Increase MCP accountability for assuring adequate networks and timely access to care.
- ▶ Clarify the MCP responsibilities for maintaining adequate networks and access to subacute facilities and other levels of step-down care.
- ▶ Require MCPs to demonstrate efforts to contract with existing providers before alternative network adequacy arrangements are approved.
- ▶ Ensure that MCPs have available and accessible substance use disorder treatment programs with proportionate capacity specifically for youth in the service area.
- ▶ Define in the procurement documents a comprehensive MCP network for long-term services and support.
- ▶ Increase the MCP oversight and contract requirements around functions delegated to providers and other subcontracted entities.

*“MCPs should not receive approval for the same alternative access requests year after year. Instead, MCPs should be required to specify the measures they are pursuing to actively improve their networks and to contract with additional providers.”*

— California Medical Association

Like most Medicaid programs, Medi-Cal is continuously working to improve access to services for its members. Maintaining network adequacy is an ongoing issue, in part due to the availability of specific provider types in areas across California and made more challenging based on providers’ willingness to participate in Medi-Cal and accept Medi-Cal payment rates. Of all the adults enrolled in Medi-Cal, the percentage reporting difficulty finding primary care increased slightly between 2013 and 2019, and the percentage reporting difficulty finding specialty care increased from 21% to 26%.<sup>10</sup>

A key role of DHCS and its contracted MCPs is to ensure adequate provider networks and timely access to quality care for all enrollees. It is important that MCP network adequacy and accessibility requirements be clear and that DHCS, MCPs, and delegated entities continue to focus on network adequacy and accessibility to primary, preventive, and specialty care.

**Theme 6: Enhance the MCP requirements to provide culturally competent and linguistically appropriate care.**

Organizations commenting on the draft RFP encouraged DHCS to use this procurement to improve Medi-Cal enrollees’ access to culturally competent and linguistically appropriate care. For example, commenters urged DHCS to modify the MCP procurement with the following suggestions:

- ▶ Add requirements for MCPs to actively recruit and retain culturally and linguistically competent providers and staff.

- ▶ Expand eligible providers to include nonclinical workers to be more reflective of members’ racial/ethnic, socioeconomic, cultural, and language backgrounds.
- ▶ Ensure that MCPs are aware of and complying with California’s language access law.

Several comments related to DHCS’s proposed requirement for MCPs and network providers to achieve the National Committee for Quality Assurance’s (NCQA’s) Distinction in Multicultural Care by 2026. While appreciating DHCS’s intent, commenters noted that this requirement may be overly burdensome for some providers and may have a negative impact on network adequacy if providers are unable or unwilling to meet these new network requirements. DHCS should carefully review these provider network concerns and the trade-offs of applying the NCQA distinction requirements below the health plan level.

*“While I appreciate DHCS’s vision and effort to standardize and ensure that plans achieve NCQA accreditation, I do not agree that all network providers require NCQA accreditation. This is an extreme duplication of effort.”*

— Health Center Partners

**Theme 7: Add contract requirements to hold MCPs more accountable for assessing disparities and improving health equity.**

The current [DHCS Comprehensive Quality Strategy](#) identifies improving health equity as one of four key goals.<sup>11</sup> DHCS’s strategy in this area to date has largely focused on examining and sharing Medi-Cal managed care data on health disparities and requiring MCPs to engage in targeted performance improvement projects designed to reduce disparities in certain areas. Several commenters supported the additional MCP requirements related to health equity and disparity in the proposed draft contract but encouraged DHCS to go further and be bolder, given the stark disparities made obvious during



the COVID-19 pandemic. Some commenters suggested that DHCS adjust the new MCP procurement with the following modifications:

- ▶ Define disparities more broadly to include age, disability, sex, sexual orientation, and gender identity in addition to race, ethnicity, and language.
- ▶ Hold MCPs accountable for reducing BH disparities and improving utilization rates among and across populations.
- ▶ Include reimbursement for community health workers, expand access to dyadic care, and include a new doula care benefit to promote birth equity.
- ▶ Require MCPs to regularly report progress on reducing child and maternal health disparities.
- ▶ Require MCPs to set year-over-year targets for elimination of disparities for both physical and behavioral health.
- ▶ Raise even higher the MCP requirements and expectations to advance health equity for Medi-Cal enrollees.

*“The state should lay out a robust vision and set a north star for improving quality of care for kids, reducing health disparities for children and youth, and responsible fiscal stewardship of valuable health care dollars.”*

— The Children’s Movement

*“We urge the state to use this RFP process to provide a vision and concrete targets for year-over-year quality improvement and disparities reduction tied to plan rates.”*

— California Pan-Ethnic Health Network (CPEHN)

Since the onset of COVID-19, Medicaid programs across the country have been making a more focused and public effort to address disparities and improve equity in the health care system. The additions included in DHCS’s draft contract and commenters’ additional suggestions are similar to requirements being discussed in many Medicaid programs. It is critical to move beyond measuring health disparities and start expecting to see improvements in reducing disparities.

### RECOMMENDATION 3 Ensure adequate and fair payment policies while fostering local partnerships.

#### **Theme 8: Ensure appropriate funding for MCPs and fair, timely payment to providers.**

Some commenters suggested that DHCS undertake a comprehensive financial review of the new MCP requirements, discuss the impacts of those requirements with MCPs, and commit to factoring the new requirements into the MCP rate-setting process accordingly. Specifically, commenters also expressed the need for MCP rates to reflect and require adequate payment at the county and provider level, commensurate with the expanded MCP requirements and expectations. Comments related to payment rates for specific services include the following recommendations for DHCS:

- ▶ Require MCPs to support comprehensive telehealth coverage and payment.
- ▶ Add a provision to address MCPs’ obligations to pay for emergency transportation.
- ▶ Require MCPs to pay sufficient rates to providers that serve children.

*“Local plans appreciate and support the priorities of DHCS, including its focus on prevention, health equity, quality, access, oversight, and reporting. However, the draft contract includes a multitude of new and significant requirements that will impact plan operations and require new staffing and resources. If DHCS proceeds with many of these proposed changes, plans will need additional administrative resources to implement them.”*

— LHPC

*“Payment and delivery system reform must be done at both the plan and provider level. DHCS will fall short of its goals if it is simply delegating responsibilities to health plans without supporting payment and delivery reform at the provider level.”*

— California Association of Family Physicians

The federal Medicaid managed care rule requires that states set actuarially sound rates and pay adequate rates to plans to allow them to appropriately provide the services included within the MCP contracts. There are many new requirements included within this contract, and it is essential that DHCS and its actuaries undertake a comprehensive process to ensure that the rates paid to MCPs are appropriate and allow MCPs the ability to make fair payments to their providers.

### **Theme 9: Require MCPs to support efforts to address social determinants of health (SDOH).**

Given evident health disparities among Medi-Cal enrollees<sup>12</sup> as well as relatively poor MCP performance compared to national quality benchmarks, it is not surprising that commenters called for DHCS to strengthen MCPs’ focus on health-related social needs. For example, commenters made these suggestions for the MCP contract:

- ▶ Require stronger cultural competency training.
- ▶ Require publicly reported population needs.
- ▶ Require that MCPs capture SDOH data uniformly, including collecting information in trauma-informed ways.
- ▶ Require MCPs to ensure that providers who serve children complete adverse childhood experiences (ACEs) training and conduct ACEs screenings.
- ▶ Require MCPs to partner with providers that serve youth experiencing homelessness.
- ▶ Require that MCPs fund street outreach, including providing licensed clinical staff who can provide immediate mental health, life skills, and social-emotional needs assessments that are both age-appropriate and culturally and linguistically appropriate.

*“We recommend that DHCS implement uniform standards for the MCPs for representing data related to social determinants of health, the data be easily extracted, and the collection of the data be incentivized through financial or quality measures.”*

— California Medical Association

Over the past several years, states have increasingly added requirements for MCPs to screen enrollees to identify potential social risk factors and connect enrollees with nonmedical services, programs, and community-based organizations that can assist them in addressing SDOH.

**Theme 10: Require MCPs to have a local presence and to engage and invest in the communities they serve.**

While this upcoming MCP procurement will solicit bids from commercial plans, a theme among commenters included the need for MCPs to have a local presence and to engage and invest in the communities they serve. Commenters noted that for MCPs to effectively improve care and health status for diverse populations of Medi-Cal enrollees, plans need to partner with local and community-based organizations in a meaningful way. Specific recommendations related to aspects of local presence and engagement include the following:

- ▶ Require MCPs to establish and maintain partnerships with school districts and county offices.
- ▶ Require MCPs to obtain county letters of support as part of the MCP RFP process.
- ▶ Strengthen community engagement and representation of children and youth on MCP advisory committees.

Some commenters also suggested that DHCS require MCPs to make specific investments in the communities they serve:

- ▶ Require MCPs to develop a plan to spend a minimum percentage of medical loss ratio (MLR) on nonclinical services and on coordination with CBOs.
- ▶ Require significant investments from MCPs in the safety-net delivery system.
- ▶ Require MCPs to report on how they are supporting providers' transition to advanced primary care models.
- ▶ Require MCPs to invest in community health to fix access and capacity issues and to support integration efforts with BH.
- ▶ Require MCPs to contribute to a locally governed community wellness and equity fund.

Given the unique geographies and local community resources in California, health plans bidding on the MCP RFP that have strong community ties and support strategies in the counties they propose to serve may be more likely to gain trust and make progress in engaging providers, community health workers, enrollees, and other stakeholders in a common effort to improve care and reduce disparities, particularly in considering the role of SDOH and other nonmedical factors influencing the enrollees' ability to access quality care and improve health status.

**Theme 11: Require MCPs to spend a minimum percentage of revenue on primary care, prevention, addressing SDOH, or other areas.**

Several commenters suggested that DHCS direct MCPs to report on the percentage of Medi-Cal capitation payments spent on specific types of services and create some minimum expectations and incentives for MCPs to invest in primary care, preventive care, and SDOH-related activities. For example, some commenters recommended that MCPs be required to report on their percentage of total spending dedicated to support and incentivize primary care. Other commenters suggested that MCPs be required to develop a plan to spend a minimum percentage of their MLR on preventive care, nonclinical services, and coordination with CBOs.

Many states have included similar minimum expectations on MCPs, including the required implementation of robust patient-centered medical home models and spending on SDOH-related activities if an MLR is within a specific range. For these types of requirements to be effective, it is important that the MCP capitation rate appropriately allows for MCPs to make these investments and still meet other contractual requirements.

*“DHCS should require that all applicants develop a plan to spend a minimum percentage of their minimum loss ratio (MLR) on nonclinical services and their coordination.”*

— California Accountable Communities for Health Initiative

## Conclusion

DHCS's Medi-Cal MCP procurement represents a rare and powerful opportunity to leverage state purchasing power to raise expectations and hold MCPs accountable for increasing access to quality care and reducing racial and other disparities in health and health care for 10 million Medi-Cal enrollees. In revamping all MCP contracts and payment policies, DHCS has the chance to ensure that all individuals enrolled in Medi-Cal managed care have access to high-quality care, regardless of where they live, who they are, or in which MCP they are enrolled.

A variety of commenters representing hundreds of organizations provided thoughtful feedback on different issues to DHCS's procurement draft RFP. Collectively, the RFP comments shared with CHCF result in the emergence of three key recommendations for DHCS:

- 1. Release a complete and clear set of procurement documents for review and comment.**
- 2. Strengthen the MCP requirements related to improving access, quality, and equity.**
- 3. Ensure adequate and fair payment policies while fostering local partnerships.**

While commenters appreciated the ability to provide DHCS with feedback on the draft procurement, they also expressed concern that a significant amount of information was missing and asked DHCS to publicly share additional and revised RFP procurement materials before the final RFP is released. Commenters sharing their feedback with CHCF strongly support DHCS's vision "to preserve and improve the overall health and well-being of all Californians, and, particularly, to address the needs of populations experiencing disparities in health outcomes" and offered specific feedback on ways that the state could modify the procurement documents and processes to better achieve this vision. Commenters also noted that MCP, county, and other provider rates should be commensurate with the expanded MCP contract requirements and expectations to achieve the meaningful goals that DHCS has for this procurement and for Medi-Cal managed care overall.

DHCS has an unprecedented opportunity to consider and act on stakeholder feedback prior to releasing the final MCP procurement documents later in 2021 and again when finalizing the version of the MCP contracts that will be implemented on January 1, 2024. Through this procurement and reform of MCP contracting requirements, DHCS has the chance to improve quality care for Medi-Cal members and make substantial progress toward eliminating racial and other disparities in care.

## About the Authors

This paper was written by Mary Beth Dyer and Beth Waldman, senior consultants at Bailit Health Purchasing. **Bailit Health** is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies.

## About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

## Endnotes

1. Margaret Tatar and Athena Chapman, *Medi-Cal Explained: The Medi-Cal Program — An Overview*, California Health Care Foundation (CHCF), February 2019.
2. "Medi-Cal Enrollment," California Department of Health Care Services (DHCS), July 28, 2021.
3. *Medi-Cal Managed Care Enrollment Report*, California Health and Human Services Agency, August 12, 2021.
4. Four organizations that submitted comments to CHCF to be included in this analysis requested that their comments not be posted online.
5. "Organizations Share Their Comments to DHCS on Medi-Cal Managed Care Procurement RFP," CHCF, July 1, 2021.
6. Philip R. Lee, *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade*, CHCF, September 25, 2019.
7. *Changes to Eligibility Standards in All 50 States and DC: FY 2019 and FY 2020* (PDF), KFF (Kaiser Family Foundation), October 2019, Table 1.
8. *Raising the Bar: How California Can Use Purchasing Power and Oversight to Improve Quality in Medi-Cal Managed Care*, CHCF, April 2019.
9. *Paying Medi-Cal Managed Care Plans for Value: Design Recommendations for a Quality Incentive Program*, CHCF, January 28, 2021.
10. *Medi-Cal Facts and Figures: Essential Source of Coverage for Millions*, California Health Care Almanac, CHCF, August 2021.
11. "DHCS Comprehensive Quality Strategy," DHCS, March 23, 2021.
12. *2019 Health Disparities Report* (PDF), DHCS, December 2020.