July 1, 2021

Will Lightbourne, Director Department of Health Care
Services 1501 Capitol Avenue
Sacramento, CA 95814
Submitted via email to: CSBRFP8@dhcs.ca.gov

Re: Medi-Cal Managed Care Plan Draft of RFP # 20-10029

Dear Director Lightbourne:

On behalf of the California Pan-Ethnic Health Network (CPEHN) and the undersigned organizations, we thank you for the opportunity to provide comments on the Department of Health Care Services' (DHCS) Medi-Cal Managed Care Plan Draft of RFP #20-10029.

California's procurement process is a critical opportunity for the state to revamp its oversight and accountability mechanisms to strengthen the quality of care and reduce disparities for the 11.3 million Medi-Cal beneficiaries in a Managed Care Plan (MCP). As sponsors and supporters of SB 936 (Pan), we strongly support a standard procurement timeline and a transparent, robust stakeholder procurement process as a way of ensuring greater health plan accountability.

DHCS has shared and requested stakeholder feedback on the following documents:
- Draft RFP Main
- Exhibit A, Attachments I, II and III
- Exhibits B-G

Our general comments are provided below. Our more detailed comments are included in a table attached to this letter.

General Comments: We strongly appreciate and support the many positive changes DHCS has made to the draft RFP to better integrate quality and equity requirements into state contracting, including requirements that health plans:

- Hire Health Equity Officers to provide leadership in the design and implementation of health plan strategies and programs to ensure Health Equity is prioritized and addressed
- Demonstrate full NCQA Accreditation no later than January 2026
- Fulfill Population Health Management activities including providing basic care management for the entire member population across the continuum of care and coordinating health and social services to address member needs and mitigate the social determinants of health
- Provide annual sensitivity, diversity, communication skills, and cultural competency training
- Provide detailed reporting on the provision of culturally and linguistically appropriate care including language assistance services and services for those with disabilities
- Be held accountable for the quality and Health Equity of all Covered Services including those provided by delegated entities for example by:
    - Assembling a Quality Improvement and Health Equity Advisory Committee comprised of providers that serve diverse populations and;
    - Ensuring Community Advisory Committees review PNA findings and have a process to discuss improvement opportunities with an emphasis on Health Equity and Social Determinants of Health. Contractor must allow its CAC to provide input on selecting targeted

health education, cultural and linguistic, and Quality Improvement (QI) strategies
- Report quality performance for all lines of business and in all states a plan operates in

These are important and critical steps to improving health plan accountability for the quality of care Medi-Cal recipients receive. However there are still areas where the state could push further to ensure Californians are getting patient-centered, quality, equitable care. We urge the state to use this RFP process to:

Health and Health Related Social Needs:

- **Provide a vision and concrete targets for year-over-year quality improvement and disparities reduction tied to plan rates:** DHCS' draft RFP allows plans that meet only minimum performance levels to contract with the state, a very low bar. The draft RFP should clarify that plans must meet and exceed minimum performance levels for both quality improvement and disparities reduction and tie capitation rates to meeting these goals. We appreciate that DHCS and DMHC plan to set targets for plans to meet moving forward. These should be referenced more clearly in the contract and DHCS should clarify that these targets are to encompass improvements in health care quality and disparities reduction for both physical and behavioral health care. In order to achieve these goals, additional targets should be set for self-reported demographic data collection and reporting of quality measures for a plan's entire Medi-Cal population including data on patient demographics and social and behavioral risk data. (Draft RFP Main, 1. Quality, page 11)

- **Solicit feedback on other key aspects of the draft RFP**: We appreciate that DHCS is still working on critical aspects of the RFP including Narrative Proposal Requirements, Evaluation and Selection, and Evaluation Questions which are to be provided late. These are critically important sections of the RFP and represent a missed opportunity to get feedback from stakeholders on draft language that would strengthen the final RFP and procurement process. For example, we have heard countless times from our community members that they continue to experience difficulty accessing culturally and linguistically competent and physically accessible care. We appreciate the addition of language in Exhibit A, Attachment III (R.0168-R0172 and R.0178) requiring plans to submit their policies and procedures to DHCS for providing access to these services, but would appreciate the opportunity to review evaluation questions as well in order to help ensure plans are properly held to account for providing these services. Additionally, we like to ensure health plans are complying with mental health parity laws *before* plans are permitted to contract with the state. It is imperative that stakeholders be provided with an opportunity to comment on narrative, evaluation and selection and evaluation questions. (Draft RFP Cover Letter, page 2)

- **Strengthen provider cultural competence training and referrals for patients in need of culturally and linguistically appropriate, LGBTQ+, physically accessible services:** We appreciate DHCS' new requirement that plans provide annual sensitivity, diversity, communication skills, and cultural competency training. We urge DHCS to require plans to add new continuing medical education training on implicit bias to these efforts and to ensure providers know how to provide and make referrals to culturally and linguistically appropriate, LGBTQ+, physically accessible services. Additionally, we urge DHCS to require plans to establish language assistance departments that can help providers and consumers locate interpreter services in local areas. (Exhibit A, Attachment III, Subsection 5.2.11.C)

- **Require MCPs to publicly report their Population Needs Assessment results:** We appreciate additional contract language clarifying requirements on plans to incorporate PNA data into plan-specific dashboards and quality improvement strategies. However while PNAs must be shared by plans internally with their Community Advisory Committees, there still is no public reporting requirement.

We urge DHCS to require plans to share this information with external stakeholders for review and evaluation. Other states are already reporting this type of data publically and are even starting to establish new measures for equity. For example, the state of Oregon, through its Coordinated Care Organizations, has developed a health equity measure designed for people with LEP, Meaningful Language Access to Culturally Responsive Health Care Services, and incentive payments are based on measuring plan performance in providing quality interpreter services. (Exhibit A, Attachment III, 4.4.3)

- **Require health plans to capture social determinants of health information in "trauma-informed ways:** We strongly support DHCS requiring health plans to assess every member for health-related social needs in order to mitigate the social determinants of health. However we have concerns that the collection of this data, without appropriate training, guidance from DHCS, on how to collect this information and store it in appropriate ways, could have an unintended chilling effect for members. We urge DHCS to ensure information is collected in trauma informed ways and efforts to collect this information are not duplicative of other similar efforts by providers across other platforms. (Draft RFP Main, 11. Addressing the Social Determinants of Health, page 12)

- **Establish a standard 5-year procurement schedule** for eligible managed care plans as other major purchasers like Covered California and CalPERs have done, using contracts to more effectively implement policy changes tied to quality improvement, disparities reduction and population health management. We appreciate the addition of language specifying a 60 month time frame for procurement contracts. However, given the uneven track record of many health plans, we feel strongly that stakeholders should be notified if DHCS intends to extend a contract beyond 60 months and should be provided with an opportunity to comment on the extension and urge DHCS to amend the contract accordingly. (Draft RFP Main, Contract Term, page 17)

Behavioral Health:

- **Require health plans to be held accountable for reducing behavioral health disparities and improving utilization rates:** We appreciate additional language in the RFP holding plans accountable for improving quality and reducing disparities. However behavioral health needs to be explicitly called out. Six years after its implementation, the behavioral health benefit in MCPs should be considered mature and health plans should be held accountable for poor performance. DHCS should use its regulatory authority to strengthen contract language to improve health plan performance specifically with regard to access to behavioral health care. This may include rate adjustments, penalties, or corrective action plans. For example, Arizona's Medicaid program utilizes a quality structure that includes Medicaid and the Children's Health Insurance Program and encompasses their acute and long-term care contractors, the Arizona Department of Health Services, the Division of Behavioral Services, and Children's Rehabilitative Services. Arizona Medicaid establishes minimum performance standards, goals and benchmarks based on national standards for which each contractor is held accountable across each state agency. Failure to meet minimum performance standards results in contractors receiving a Correction Action Plan. Arizona Medicaid requires contractors to evaluate each corrective action on an annual basis to determine if improvements have been made. The Arizona Medicaid agency also evaluates the effectiveness of the CAP during annual site visits. (Draft RFP Main, 7. Reducing Health Disparities, page 12)

- **Require plans to demonstrate that they are informing their providers of the behavioral health care benefit, and behavioral health providers in their networks:** CPEHN's provider survey found that many Medi-Cal providers are not aware of a plan's behavioral health care benefit, provider networks and how to make referrals. We urge DHCS to require plans to submit policies and procedures demonstrating how they inform providers of this benefit and available behavioral health providers in order to make timely referrals. (Exhibit A, Attachment II, 3.2 Provider Relations)

- **Require plans to share how they market behavioral health care benefits and services to their members:** Although California was an early leader in enforcement of federal mental health parity law, both the utilization data and our focus group findings demonstrate that the majority of members remain unaware of the availability of mild to moderate services or their rights to access them. We appreciate the requirement in the draft RFP that plans share their marketing plans with DHCS including copies marketing materials. This is an important step. However we urge DHCS to include explicit contract language requiring plans to annually share their marketing plans and materials for both health and behavioral health care benefits. (Exhibit A, Attachment II, 4.1 Marketing, R.0077)

  Additionally, DHCS should explicitly require plans to:

  - Publicly post on their websites; the contact information of every MCP behavioral health administrator; the contact information of every MCP staff member (ie. mental health navigators, care coordinators, etc.) who assist with accessing behavioral health services, as county MHPs already do: http://file.lacounty.gov/SDSInter/dmh/1071321_SANavigatorContactList_Revised3-_4-2020.pdf ; and the outpatient behavioral health referral forms of all MCPs. DHCS should also aggregate and post this information on its own website (similar to what is already done for County MHPs: https://www.dhcs.ca.gov/services/MH/MHSUD/Pages/CountyProgAdmins.aspx).
  - Undertake significant outreach efforts through a culturally and linguistically competent statewide awareness campaign.
  - Partner with trusted community messengers and should ensure that their providers are equipped to respond to an increased demand for care. Health plans should also conduct outreach to primary care providers to ensure that they have the tools to make effective referrals to behavioral health care. People of color often first report behavioral health challenges in primary care so it is essential that providers are equipped to assist their patients in navigating the system.

- **Use more inclusive language when referring to "evidence-based" behavioral health practices:** We urge DHCS to use a broader term "community-defined evidence practices" in referring to new contract requirements for plans to expand access to behavioral health services. These types of promising "community-defined evidence practices" developed, evaluated and sustained by the Office of Health Equity have been practice for hundreds of years by BIPOC, LGBTQ+ communities but have been historically left out by researchers and evaluators when building an evidence base within the dominant systems of care. (Draft RFP Main, 5. Behavioral health services, page 11)

Oral Health:

- **Require plans to submit policies and procures for coordination of dental referrals, conducting of dental assessments and use of dental liaisons:** California must comply with the requirements outlined in AB 2207, which requires health plans to make dental referrals for their members, conduct a dental assessment as part of a member's initial health assessment, and put dental liaisons in place to facilitate access to care. Despite these longstanding requirements, the state has not provided compliance standards or outcome metrics by which to measure these requirements. We appreciate the general RFP requirement that plans "submit policies and procedures for providing required dental services and Medically Necessary dental-related services." However the specific duties above, must be called out in RFP contract language in order to properly hold plans accountable for providing these services. (Exhibit A, Attachment II, R.0119)

Other Issues:

- **Require health plans to establish provider incentive programs or other alternative -payment mechanisms that reward better health care:** Current Medi-Cal reimbursement rates are very low for primary and behavioral health care. Behavioral health therapists, including licensed professionals for example, are paid at most $25 for a session. This does not include billing time for the extensive paperwork that is necessary to properly manage patient care. As a result, the only therapy beneficiaries can get is from places staffed by associates or interns where there is high turnover and the quality of therapy varies. Further, these low reimbursement rates limits diverse providers from participating. DHCS' requirement that plans submit descriptions of provider incentive programs is a good first step. However, DHCS must go further by requiring plans to establish and demonstrate its plans for providing incentives to providers in order to improve health care quality and reduce disparities. (Exhibit A, Attachment II, 3.3 Provider Compensation Arrangements, page 7).

- **Require health plans to provide information on death benefit for burials:** Low-income families particularly during COVID, are suffering trauma and are left to bear the burden for burials and funeral arrangements. These same families are forced to hold car washes and sell dinners or crowd fund final expenses for infants or seniors. COVID-19 has left low income families burying multiple family members and funeral homes are turning them away. We understand that FEMA is providing some relief for families to bury their loved ones but that assistance can be difficult to access. We urge DHCS to include additional contract language requiring health plans to inform members of this assistance. (Exhibit A, Attachment III, 5.1 Member Services)

- **Strengthen member grievance and appeal systems:** We appreciate greater clarity in the draft RFP of health plan requirements for providing members access to grievance and appeals processes. We urge DHCS to consider strengthening these requirements for example, but encouraging plans to establish ombudsperson programs to help members understand their legal rights. Additionally, plans should encourage safety-net providers as part of population health management programs to establish more medical/legal partnership to connect members to regional and local legal aid services so members can receive appropriate assistance navigating their benefits and services. (Exhibit A, Attachment III, 4.4. Member Grievance and Appeal System)

Conclusion:
Thank you again for this opportunity to provide our comments on DHCS Draft RFP and ways to leverage DHCS' contracting authority to improve health care quality, reduce disparities and address the social determinants of health. Procurement is a critical lever to improving health care quality and reducing disparities. However for contract requirements to be most successful they must also be paired with financial incentives and payment reform.[ix] This step - financially incentivizing plans for their performance - has been a consistent recommendation of national and state experts looking at the Medi-Cal managed care program for several years and is particularly important given the fact that most Medi-Cal plans are county-affiliated plans which do not face competitive re-procurement. For questions about these comments, please contact Cary Sanders, Senior Policy Director/CPEHN at: csanders@cpehn.org.

Sincerely,

Arcenio Lopez, Mixteco/Indigena Community Organizing Project (MICOP)
Doreena Wong, Asian Resources, Inc.
Caroline Sanders, California Pan-Ethnic Health Network (CPEHN)

Hannah Bichkoff, Cal Voices
Iliana Soto Welty, Multi-Ethnic Collaborative of Community Agencies
Joel Ervice, Regional Asthma Management and Prevention
Luis Pardo, Worksite Wellness LA
Mandy Diec, Southeast Asia Resource Action Center (SEARAC)
Mayra E. Alvarez, The Children's Partnership
Mike Odeh, Children Now
Montana Weekes, California Consortium for Urban Indian Health
API-Equality LA
Natalie Ah Soon, Regional Pacific Islander Taskforce
Pysay Phinith, Korean Community Center of the East Bay
Ryan Tieu, Individual
Saleta Darnell, Miracles-n-Progress Foundation
Sarait Martinez, Centro Binacional para el Desarrollo Indígena Oaxaqueño
Shannon Huddleston, Individual
Silvia Yee, Disability Rights Education and Defense Fund (DREDF)
Suzanne Im, Individual
Tavae Samuelu, Empowering Pacific Islander communities (EPIC)
Theresa Zamora, Mi Familia Vota
Tiffany Huyenh-Cho, Justice in Aging
Virginia Hedrick, California Consortium for Urban Indian Health, Inc
Yeri Shon, Korean Community Center of the East Bay

[i] Healthy People 2020. https://www.cdc.gov/nchs/healthy_people/hp2020.htm

[ii] Lown Institute Hospitals Index: https://lownhospitalsindex.org/why-this-matters/

[iii] Med-Cal Managed Care Performance Dashboard https://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx

[iv] Pacific Southwest Mental Health Technology Transfer Center Network. Resource Compendium: Evaluating Community-Defined Evidence Practices. Retrieved from: https://mhttcnetwork.org/centers/pacific-southwest-mhttc/home

[v] For a comprehensive list of Native American and Alaskan Native Community-Defined Evidence Practices, See Appendix: Catalogue of Effective Behavioral Health Practices for Native American Communities (pg. 36) in Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans. Retrieved from https://cpehn.org/sites/default/files/native_population_report.pdf

vi For a comprehensive list of Asian Pacific Islander Community-Defined Evidence Practices, See Table 5: Summary of Promising Program and Strategy Submissions (pg. 67) in Asian Pacific Islander (API) Population Report: In Our Words. Retrieved from: https://cpehn.org/sites/default/files/api_population_report.pdf.

vii For a comprehensive list of LGBTQ Community-Defined Practices, see "Community Defined & Promising Practices" (pg. 181) in First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual Transgender, Queer and Questioning Populations in California.
Retrieved from: https://cpehn.org/sites/default/files/ lgbtq_population_report.pdf

viii For a comprehensive list of Latino Community-Defined Evidence Practices, see "Latino SPW Matrix of Organizations with Community-Defined Evidence Programs" in Community-Defined Solutions for Latino Mental Health Care Disparities. Retrieved from: https://cpehn.org/sites/default/files/latino_population_report.pdf
For a comprehensive list of "D4. Models: Community-Defined PEI Practices for Blacks" (pg. 188) in We Ain't Crazy! Just Coping with a Crazy System: Pathways into the Black Population for Eliminating Mental Health Disparities. Retrieved from: https://cpehn.org/sites/default/files/african_american_population_report.pdf

ix "Oversight and Accountability of Medi-Cal Managed Care Plans," CPEHN, February 2020: https://cpehn.org/sites/default/files/cpehn_data_oversight_and_accountability-_final_.pdf

CPEHN and Partners Joint Comments on DHCS Draft RFP

Draft RFP Main

RFP Reference	Section and Page Number	Issue, Question or Comment	Remedy Sought
Draft RFP Main	1.Quality, page 11	Contractors should be held to higher standards than solely meeting minimum performance levels.	Change "Meet or exceed" to "Meet and exceed"
Draft RFP Main	2.Access to care, page 11	No reference to linguistically appropriate care. Health plans are required to provide timely access to interpreter services yet many do not. We would like to see this called out.	Add: Ensure comprehensive networks that provide all members timely access to appropriate, culturally and linguistically competent, and high-quality care, within time and distance standards, including timely access to interpreter services and auxiliary aids.
Draft RFP Main	5. Behavioral health services, page 11	We urge you to use more inclusive language when referring to "evidence-based" practices in reference to the types of promising "community-defined evidence practices" developed, evaluated and sustained by the Office of Health Equity that have been practice for hundreds of years by BIPOC, LGBTQ+ communities but have been historically left out when building	Add: Expand access to emerging best practices, particularly those that are community-defined, such as those piloted at the Office of Health Equity, focused on earlier identification and engagement in treatment for children, youth, and adults.

		an evidence base within the dominant systems of care.	
Draft RFP Main	7. Reducing health disparities, page 12	Contractors should be required not only to identify and address health disparities but to set year-over-year targets for the elimination of health disparities for both physical and behavioral health.	Add: Identify health and behavioral health disparities and inequities in access, utilization, and outcomes among racial, ethnic, ~~language~~, limited English Proficient (LEP), and Lesbian, Gay, Bisexual, and Transgender and Questioning (LGBTQ) groups, set year-over-year targets for disparities reduction and have focused efforts to improve health outcomes within the groups and communities most impacted by health disparities and inequities.
Draft RFP Main	8. Increase oversight of delegated entities, pg. 12	Contractor should also be required to communicate to consumers and stakeholders which services parent plans delegate to delegated entities. CPEHN and stakeholders are unsure of which parent plans utilize delegated plans like Beacon to coordinate behavioral health services rather than using their plan networks.	Add: Provide increased oversight of all delegated entities to ensure members receive quality care and service in accordance with the MCPs contractual obligations to DHCS. This will include communicating to consumers and stakeholders which services parent plans delegate to delegated entities.
Draft RFP Main	11. Addressing the Social Determinants of Health, page 12	Plans must be required to use DHCS' standardized screening tool to assess SDOH. Trainings on the collection of SDOH should	Add: Meet the health needs of a members through methods designed to understand the overall circumstances of

		include a focus on trauma-informed screening.	members including capturing SDOH through "trauma-informed standardized risk assessments and coding" and articulating a care coordination strategy inclusive of SDOH.
Draft RFP Main	Contract Term, Page 17	Stakeholders should be notified if DHCS intends to extend a contract beyond 60 months and should be provided with an opportunity to comment on the extension.	Add: "DHCS will notify public stakeholders of its intent to extend a contract and solicit public comment on the merits of such an extension."
Draft RFP Main	3. National Committee for Quality Assurance, page 27	Encourage optional reporting of NCQA Distinction in Multicultural Health Care as this is a best practice	Add: a. Proof of NCQA accreditation including NCQA Distinction in Multicultural Health, or
Draft RFP Main	4. Annual Quality Performance Measure	Thank you for requiring Contractor reporting of quality performance for all lines of business and in all states a plan operates in. Poor plan performance in other states should be a contract consideration.	N/A
Draft RFP Main	f. Proposing Firm's Capability Section, 3) f)	Add regional multi-payer experience.	Add: Previous experience and current investment in working collaboratively with local stakeholders including consumers...multi-payers...etc."

Draft RFP Main	f. Proposing Firm's Capability Section, 3) g)	Ask about commitment to addressing SDOH and disparities. Ensure SDOH is trauma-informed.	Add: "Previous experience, current investment, commitment and knowledge of one or more examples of identifying and addressing the social determinants of health in trauma informed ways and reducing Health Disparities and Promoting Health Equity."
Draft RFP Main	S. Narrative Proposal Requirements, pages 45-48	The 21 Narrative Proposal Requirements do not list local presence and/or community engagement.	Add: 22. Local presence and Community Engagement as a Narrative requirement.
Draft RFP Main	State 2-Narrative Proposal Evaluation Scoring	There is no information about how the scoring committee intends to weigh the various factors.	Add: Allow public stakeholders, including consumer stakeholders and CBOs the opportunity to review and provide input on DHCS' scoring criteria and weighting of different factors in RFP selection. Allow CBOs to weigh in on RFPs.
Draft RFP Main	Y. DHCS Rights, 1. RFP Corrections, g., page 59	We agree that DHCS should have broad discretion to cancel an RFP at any time if it deems the proposal is not in the best interest of the state.	N/A
Draft RFP Main	Background, pg. 10	DHCS should ensure the tools members can use to navigate to services, including but not limited to websites and phone trees, are easy to use and culturally and linguistically competent.	Add: Navigation of Services
Draft RFP Main	X. Contract Award and Appeals, 1. Contract Award, page 55	We strongly support the addition of language allowing DHCS to	N/A

		reserve the right to not award a contract to any Proposer(s), subcontractors or affiliated entities in a county if DHCS determines that decision is in the best interest of the State.	

Exhibit A, Attachment i (Scope of Work – Definitions/Acronyms)

RFP Reference	Section and Page Number	Issue, Question or Comment	Remedy Sought
Exhibit A, Attachment I.	1.0 Definitions, pg. 25	Systemic racism: the systemic distribution of resources, power, and opportunity in society to the benefit of people who are white and to the exclusion of people of color. Systemic racism is not the result of individual animus, or lack thereof, but is a result of how institutions and structures are designed.	ADD: Systemic Racism
Exhibit A, Attachment I.	1.0 Definitions, pg. 12	"Implicit bias" is a bias in judgment or behavior that results from subtle cognitive processes, including implicit prejudice and implicit stereotypes that often operate at a level below	ADD: Implicit Bias

		conscious awareness and without intentional control (123630.2. of the Health and Safety Code)	
Exhibit A, Attachment I.	1.0 Definitions, page 12, Health Equity	Use Healthy People 2030 definition and add reference to "systemic racism"	"The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, which includes systemic racism, and the elimination of health and health care disparities."

Exhibit A, Attachment ii (Scope of Work – Operational Readiness)

RFP Reference	Section and Page Number	Issue, Question or Comment	Remedy Sought
Exhibit A, Attachment II	R.0005	Health systems, providers, and plans can advance health equity by engaging diverse patients, families, and caregivers more directly in efforts to improve health care quality and strengthen systems of care through collaboration, communication, consultation, and co-ownership. Patients	Add underline: "Submit policies and procedures describing the representation and participation of Medi-Cal members on public policy advisory committee, including adoption of shared-decision making models of governance and supports such as orientation and training, interpretation and auxiliary aids, childcare, incentives such as

		should be provided orientation, technical assistance, and other supports to facilitate participation.	stipends, transportation and remote access to facilitate patient engagement."
Exhibit A, Attachment II	R.0008	Patients should be provided with opportunities to engage in organizational governance.	Add: "Identify the composition and meeting frequency of any committee participating in establishing the Contractor's public policy including the percent of patient/member consumers. Describe Contractor's Governing Board, including the percent of patient/member-consumers, the frequency of the committee's report submission to the Contractor's Governing Board, and the Governing Board's process for handling reports and recommendations after receipt.
Exhibit A, Attachment II	R.0009	Add a requirement that contractors monitor compliance with new CME requirements for cultural competence and implicit bias.	Add: "...policies and procedures for ensuring that all appropriate staff and Network Providers receives annual diversity, Health Equity, and inclusion training (sensitivity, diversity, communication skills and cultural competency training) relating to members including completion of required CME education on

			cultural competency and implicit bias."
Exhibit A, Attachment II	R.0021	What is an MCO baseline assessment form?	Add an explanation.
Exhibit A, Attachment II	3.2 Provider Relations	CPEHN's provider survey found that many Medi-Cal providers are not aware of a plan's behavioral health care benefit, provider networks and how to make referrals.	Add new R.0064: Submit policies and procedures for informing providers of behavioral health care benefit, and provider networks in order to make timely referrals.
Exhibit A, Attachment II	3.2 Provider Relations, page 7	CPEHN members continue to describe difficulty finding quality interpreters at provider offices including hospitals.	Add new R. 0065. Submit policies and procedures for ensuring providers have undertaken implicit bias and cultural and linguistic competency training and are aware of language assistance services for limited English Proficient Californians and how to refer to patients to those services as required by law.
Exhibit A, Attachment II	3.3 Provider Compensation Arrangements, page 7	Health plans should require providers to adopt Alternative Payment Mechanisms and Patient Centered Medical Homes.	Add: Submit description of any Provider financial incentive programs (including but not limited to Physician incentive plans as defined in 42 CFR section 422.208) or other Alternative Payment Mechanisms.
Exhibit A, Attachment II	4.1 Marketing, R.0077	Marketing behavioral health services is different than marketing health services. Effective marketing in behavioral health address stigma, for example. A contractor should be required to submit their plan for	Add: Submit Contractor's Marketing plan, including plan for marketing both health and behavioral health services to members.

		marketing both health and behavioral health services to members.	
Exhibit A, Attachment II	4.3 Population Health Management and Coordination of Care, R.0082	Add consumers and public health	Add: "...including but not limited to, local consumers, public health, behavioral health..."
Exhibit A, Attachment II	4.3 Population Health Management and Coordination of Care, R.0084	Contractors should be judged on completeness of demographic data.	Submit policies and procedures for ensuring quality and completeness of all data submitted to DHCS, including member demographic data and for improving the data's quality and completeness over time.
Exhibit A, Attachment II	4.3 Population Health Management and Coordination of Care, R.0086	Will DHCS provide additional guidance to plans on designing their algorithms?	Add: Submit Contractor's mechanism or algorithm for stratifying population into risk groups or segments that takes into account state requirements and DHCS guidance on eliminating bias.
Exhibit A, Attachment II	4.3 Population Health Management and Coordination of Care, R.0087	This seems to leave enforcement for mitigating bias entirely up to the plans.	Amend to: "Submit the comparable/standardized method of algorithm used and policies for mitigation of racial and other biases through consideration of disease burden relative to utilization and other patient risk factors beyond cost and historical utilization."
Exhibit A, Attachment II	4.3 Population Health Management and Coordination of Care, R.0099	Reference trauma-informed practices.	Add: Submit policies and procedures for identifying and addressing Members' health and health related social needs using trauma-informed practices and approaches.

Exhibit A, Attachment II	4.3 Population Health Management and Coordination of Care, R.0107	Reference interpreter services	Add: "C. Referrals in terms of effectiveness in tracking timeliness, cultural and linguistic appropriateness, <u>including timely access to interpreter services</u>..."
Exhibit A, Attachment II	4.3 Population Health Management and Coordination of Care, R.0133	We appreciate seeing this. Add quality and timely to ensure Contractors are aware of and complying with CA language access law.	Add: Submit policies and procedures for providing <u>quality, timely</u> communication access to Members in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, electronic format, plain language or written translations and oral interpreters, including Limited English-Proficient (LEP) Members, or non-English speaking.
Exhibit A, Attachment II	5.2 Network and Access to Care, R.0183	The state must comply with the requirements outlined in AB 2207, which requires health plans to make dental referrals for their members, conduct a dental assessment as part of a member's initial health assessment, and put dental liaisons in place to facilitate access to care. Despite these longstanding requirements, the state has not provided compliance standards	Add R.0182 Submit policies and procures for coordination of dental referrals.

		or outcome metrics by which to measure these requirements	

Exhibit A, Attachment iii (Scope of Work - Operations)

RFP Reference	Section and Page Number	Issue, Question or Comment	Remedy Sought
Exhibit A, Attachment III	1.1.7 Health Equity Officer	CPEHN appreciates the new requirement that Contractors hire a Health Equity Officer. We suggest the following amendments to the duties of the Contractor.	Add: D. Implement strategies designed to identify and address root causes of Health inequities "which includes systemic racism."
Exhibit A, Attachment III	1.1.7 Health Equity Officer	The kind of data we collect and report ensure everyone has a fair and just opportunity to live their healthiest life possible. looking at health outcomes through the lens of broad racial or ethnic categories (e.g., Asian Americans) doesn't paint an accurate enough picture of health and well-being. It masks what's happening within subgroups and glosses over the nuanced experiences that greatly influence outcomes in these populations.	Add: 8. Data Collection and Reporting
Exhibit A, Attachment III	1.1.7 Health Equity Officer	Health plans should be required to design equitable models of consumer engagement that are not just reflective of the communities they serve but	Add 9. Design and Establishment of Consumer Engagement Strategies

		structured in a way to maximize patient and community involvement through shared-decision making and ongoing assessments of community health needs. Health Equity Officers should be consulted in the design of these strategies and updated on the progress of these advisory bodies in assessing and addressing community health needs.	
Exhibit A, Attachment III	5 Services-Scope and Delivery	Being able to seamlessly navigate and access care through a plan should be a top concern for all plans. Too often we hear members and community advocates detail hardships in finding in-network providers because the websites are too confusing or the member representatives do not grasp the additional needs of LEP members and members of color.	Add to Section 5: The Contractor must make improvements in website and care coordination navigation that includes simplification of website verbiage and navigation to an appropriate grade level, a culturally and linguistically accessible phone answering system, translated web pages and phone answering system, clear and explicit language on all consumer facing material explaining language access rights (including websites), and the recruitment and retainment of culturally and linguistically competent member services staff.
Exhibit A, Attachment III	5.2.11 Cultural and Linguistic Programs and Committees	This section of the RFP stipulates the several steps and services Plans must provide for their	Add to section 5.2.11: The Contractor must be active in recruiting and retaining culturally

		members. A missing piece to achieving cultural and linguistic proficiency that meets the needs of members is an active practice of recruiting culturally and linguistically competent providers and non-providers. The RFP states, "Contractor must take immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted." Deficiencies in mental health utilization by LEP beneficiaries have been noted through data and the Plans must be proactive in correcting these deficiencies.	and linguistically competent providers and non-providers that reflect the needs of the local Medi-Cal population. Some of these needs include language and cultural experience/understanding.
Exhibit A, Attachment III	5.3.7 Services for All Members	The state must comply with the requirements outlined in AB 2207, which requires health plans to make dental referrals for their members, conduct a dental assessment as part of a member's initial health assessment, and put dental liaisons in place to facilitate access to care. Despite these longstanding requirements, the state has not provided compliance standards or outcome metrics by which to measure these requirements.	Add: J. Dental Services
Exhibit A, Attachment III	4.1.2 Marketing Plan	The contractor's marketing plan should include a marketing plan	Add: B. 10) A marketing plan for all services covered by the

		for all services covered by the contractor.	contractor, including a marketing plan for health and behavioral health services.
Exhibit A, Attachment III	4.1.2 Marketing Plan	CPEHN appreciates reference to all marketing materials the contractor will use for both English and on-English speaking populations. In addition to marketing materials for non-English speaking populations, the contractor's marketing plan should contain marketing materials to reach cultural groups, including racial, ethnic, and Lesbian, Gay, Bisexual, and Transgender and Questioning (LGBTQ) groups. .	Add: B. 11) All marketing materials contractor will use for racial, ethnic, and Lesbian, Gay, Bisexual, and Transgender and Questioning (LGBTQ) groups.