CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE

CACHI

To: The California Department of Health Care Services

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On Behalf of: The California Accountable Communities for Health Initiative (CACHI)

Subject: Comment on Draft Request For Proposal # 20-10029, Medi-Cal Managed Care Plans (MCP)
Date: July 1, 2021

There is broad agreement among stakeholders that California's current health care system is costly, unnecessarily complex, and falls short of producing desired health and equity outcomes. California has been a leader in implementing Medicaid managed care and expanding coverage through the Affordable Care Act. However, given that health care only affects an estimated 20 percent of an individual's overall health, care delivered in clinical settings alone is insufficient to improve health, control costs, and increase health equity across the state.

The CalAIM initiative laid out ambitious goals (extend Whole Person Care, increase flexibility and reduce complexity, improve quality and health outcomes) that would push the Medi-Cal system to better respond to social needs and address community-level social determinants of health. Reprocurement is a second key lever to affect the second part of the state's stated vision of "paying for health, not just healthcare." Given the tsunami of social needs resulting from the COVID-19 pandemic, there is an imperative for the public health and health care sectors to marshal resources immediately while integrating their efforts into an overall recovery plan. Not addressing these social needs now can lead to worsening chronic and acute health conditions, and more expensive clinical treatment later. In fact, we've seen this play out in the past. Historically, increases in California's spending on Medi-Cal has created budgetary pressure that has led to *reduced* spending on social services and on improving community conditions.

At the same time, many Medicaid and Commercial health plans have done well over the last several years as a result of the Medicaid expansion and lowered health care utilization during the pandemic. Therefore, it is an opportune time for DHCS to use the commercial plan contracting process to begin to reverse the trend described above, advance policies that address the health, safety, and equity priorities of communities, and, thereby, further CalAIM goals. Through this process, we can enhance both the level and kinds of investments managed care plans make in the communities they serve, and, equally important, incentivize a higher level of engagement with those communities. Below are submitted comments* about how to strengthen specific aspects of the commercial plan reprocurement process.

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*The policy ideas contained herein are solely the product of CACHI and do not necessarily reflect the view of CACHI funders or partners.

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RFP Reference	Section and Page Number	Issue, Question or Comment	Remedy Sought
RFP Main	D. Purpose and Background D.2; pg. 12	The RFP text states that DHCS is looking for Managed Care Plans that demonstrate their ability to: "9. Establish and expand a stable local presence and collaborate and engage with local community partners and resources to ensure community needs are met." There is an opportunity for DHCS to expand on this "stable local presence" by encouraging adoption of core tenets of the Accountable Communities for Health model; in particular, a locally governed community wellness and equity fund could fulfil this need.	**DHCS should require plans to contribute to a locally governed community wellness and equity fund**. The fund would focus on improving health at a community scale (not just for individual plan members), addressing a set of priority health and social issues (e.g., trauma, resilience, housing stability, economic opportunity) through comprehensive strategies, and supporting an enduring platform for better coordination and alignment of resources across sectors. The fund and its collaborative governance could also support communities toward an equitable recovery from COVID-19 and build resilience to address future emergencies. Medi-Cal resources could be leveraged through alignment with other funding streams such as federal recovery funds and local stakeholders who wish to invest in collective action approaches in their respective communities. This is not an entirely novel idea. DHCS has raised the idea of a flexible fund to better address health priorities. Other states and California counties have already set up such community investment requirements. Arizona requires its Medicaid Complete Care plans to contribute six percent of their annual profits to community reinvestment and submit an annual Community Reinvestment Report. Oregon's Community Care Organization 2.0 application requires a portion of revenue be spent on addressing SDOH in communities. In Imperial County, California Health & Wellness agreed to a per-member per-month community health investment and end-of-year shared savings contribution as part of the State's rural expansion contracting. The funds are overseen by a local health commission comprised of stakeholders representing a range of sectors and constituencies.

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			There is growing evidence that the development of multisector collaboration and alignment leads to health improvements, including preventable mortality. Other states, including Oregon, have reported positive outcomes from requiring investments in cross-sector collaboration to address social determinants in communities. In California, Hearts of Sonoma was able to bring partners together to make significant improvements in HEDIS scores related to high-blood pressure. In Imperial County, in addition to successful strategies to address asthma prevalence and severity (such as home remediation and multidisciplinary care teams that include community health workers and promotoras) supported by the Wellness Fund, the health plan is an active partner with the county, health care providers and CBOs in their collective efforts to improve health and equity.
RFP Main	D. Purpose and Background D.2; pg. 12	The RFP text states that DHCS is looking for Managed Care Plans that demonstrate their ability to: **"**7. Identify health disparities and inequities in access, utilization, and outcomes among racial, ethnic, language, and Lesbian, Gay, Bisexual, and Transgender and Questioning (LGBTQ) groups and have focused efforts to improve health outcomes within the groups and communities most impacted by health disparities and inequities."	**DHCS should require plans to identify a set of disparity measures that they will establish incentive targets for and report on publicly. The measures should be a subset of the adult and child core set measures for which they will identify disparities in outcomes as well as one new health equity measure, set incentive-driven improvement targets, develop a plan for reducing the disparities, and involve community members in disparity reduction activities and monitoring.** This approach would extend accountability beyond monitoring disparities to making progress on closing gaps in health outcomes between subpopulations/groups (e.g., race/ethnicity and language proficiency). It is also in line with the 2016 Medicaid Managed Care Final Rule, which encourages "managed care quality strategies to identify and reduce health disparities." Applicants should be encouraged to collaborate with community partners for selection, target setting, and action-planning to achieve the incentives. Disparity metrics, even if connected to modest incentives, drive interest and attention to the role health care can play in improving health at a community

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		There is an opportunity to provide additional guidance and extend accountability beyond monitoring disparities to closing gaps.	or population level and the role that community organizations play in addressing health care priorities and ensuring health plan accountability for continued improvements. In order to increase community engagement, plans should be required to report transparently on their disparity-reduction efforts on an annual basis (including related pay-for-performance incentives for providers). In order to drive attention to the need for non-clinical community-based strategies to truly move the needle on disparities, in the annual report, plans should be required to report not only on status for their enrolled members but also on related measures at a population level (e.g., all residents of the county). Ultimately, the focus on the core sets is practical but also limits attention to upstream factors and health equity since the measures are entirely clinical. This should be seen as an incremental step toward developing a defined set of health equity measures. The one new health equity measure could be drawn from numerous examples of such Medicaid program incentives from around the country, for example: African American maternal mortality rate reduction in Michigan, kindergarten readiness in Oregon, and progress on annual SDOH plan in Kansas. Additionally, national accreditation and accountability organizations such as the National Committee for Quality Assurance are exploring ways to include social determinant and health equity measures in their standards and performance measures. NCQA accreditation, which will be required by all Medi-Cal plans by 2026 will likely include equity-focused measures by that date. We applaud DHCS for mandating NCQA's Distinction in Multicultural Healthcare product and assume that when it becomes a Health Equity Accreditation in July 2022 that will serve as the requirement. There will be an extended version of this accreditation that goes even further to include the social determinants of health.

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Exhibit A, Attachment III	Exhibit A, Attachment III - 1.2 Financial Information 1.2.5. Medical Loss Ratio; pg. 10 and pgs. 15 - 22	In the Medical Loss Ratio requirements, there is an opportunity to emphasize the importance of non-clinical services and coordination of those services.	**DHCS should require that all applicants develop a plan to spend a minimum percentage of their medical-loss ratio (MLR) on non-clinical services and their coordination.** There is a pressing need for coordination and linkage between clinical institutions and a range of community organizations that work on social needs related to health. The social needs (food security, housing stability, economic resources, etc.) of the Medi-Cal population have increased as a result of the COVID-19 pandemic and are very likely to remain elevated throughout the recovery. Health plans have consistently said that a crucial barrier to their spending on social needs and community determinants of health is predictability in the rate-setting process. Requiring spending as part of MLR would address this issue and create a level playing field across the state. A number of plans are already participating in model approaches. For example, the Neighborhood Networks initiative in San Diego functions as a "social IPA" for multiple plans by creating an effective interface between clinical and community providers, reducing complexity, and incorporating community health workers to support successful navigation. Neighborhood Networks was developed and is managed by Be There San Diego, a community-based California Accountable Communities for Health Initiative site. Social IPA—type approaches located outside of the health care system, through community-based organizations, ensure that power-sharing and priority-setting reflect community interests and that partnerships and infrastructure are built to work on issues and with populations beyond the managed-care plan's covered lives. Additionally, many of the commercial plans operating in California are in the process of launching social-needs screening and referral platforms such as Unite Us and Aunt Bertha. Analyses of adoption of such platforms have consistently found that engaging community agencies as partners from the outset is a critical factor for success. In order to bolster the development of systems that effectively identify and respond to social risks, DHCS could establish quality metrics related to social-risk assessments for all members and percent of successful referrals to community providers.

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Exhibit A, Attachment III	Exhibit A, Attachment III - 1.1 Plan Organization and Administration 1.1.7. Health Equity Officer; pgs. 5 - 6	Exhibit A, Attachment III on pgs. 5 - 6 notes that the Contractor must maintain a full time Health Equity Officer whose responsibilities include (but should not be limited to): - Leadership in the design and implementation of strategies to ensure Health Equity is prioritized and addressed - Implement strategies designed to identify and address root causes of Health Inequities - Among other responsibilities. There is an opportunity to indicate that this Health Equity Officer should have knowledge of and meaningful relationships with the community.	**DHCS should provide additional guidance to indicate that the Health Equity Officer should be engaged with community leaders and community representatives. Existing Accountable Communities for Health sites could serve as an important bridge to community leadership.** This could ensure the Health Equity Officer is engaged with important constituencies in the community and apprised of existing community efforts to prioritize health equity and prevent health inequities and disparities. **Additionally, DHCS could provide additional guidance to institutionalize the priorities of the Health Equity Officer within the organizational structure**, ensuring continuity of efforts in the event that a Health Equity Officer leaves the organization. In other words, it is imperative that this crucial charter be embedded in organizational priorities rather than with an individual.
Exhibit A, Attachment III	Exhibit A, Attachment III - 1.1 Plan Organization and Administration	Exhibit A, Attachment III states that the Contractor shall ensure that Medi-Cal members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions, Limited English	**DHCS should provide further guidance for situations where Accountable Communities for Health (ACH) exist within managed care plans' respective jurisdictions; managed care plans should be incentivized to partner with ACHs as a means to meaningfully engage with community members.** Through ACH partner organizations, ACHs have been able to adeptly respond to community needs. For example, the East San Jose Peace Partnership rapidly responded to evolving community needs throughout the COVID-19

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	1.1.10 Member Representation, pg. 8	Proficiency (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives are included and invited to participate in establishing public policy within Contractor's advisory committee or other similar committee or group. There is an opportunity to engage existing Accountable Communities for Health in this process, given their meaningful community relationships.	pandemic and was able to do so due to strong and long-lasting community partnerships and meaningful community engagement. ACHs' existing and strong relationships with community members could help selected managed care plans ensure that community representatives are included and invited to participate in establishing policy. Authentic community engagement needs to move beyond advisory bodies and soliciting input. Ideally, managed care plans will serve on ACH leadership teams in order to better understand the needs and priorities of communities and collaborate on strategies to achieve them.