July 1, 2021

Delivered via email: CSBRFP8@dhcs.ca.gov

RE: Health Consumer Advocate Comments on Draft Request For Proposal #20-10029, Medi-Cal Managed Care Plans

To Whom It May Concern:

As statewide consumer advocacy organizations interested in the health and outcomes of Medi-Cal members, we are writing in response to the Draft Request For Proposal #20-10029 on Medi-Cal Managed Care Plans released for comment by the Department of Health Care Services. In addition to detailed comments in the table below, we wanted to highlight these major issues for consideration.

Foremost, the draft RFP and contract do not do enough to **improve health plan accountability** and enforcement, particularly to ensure they meet their goal of improving health equity. We appreciate that DHCS will require more of contracted plans, but without clear and specific provisions for accountability and enforcement, DHCS is unlikely to achieve its health equity goals. We are disappointed that these drafts envision that payment rates would be developed the same way they always have been, untethered to plan performance and health outcomes. This procurement needs new strategies to improve the stubbornly low performance among Medi-Cal managed care plans. We strongly recommend that the state make the rate development process a central *driver* of quality improvement and disparities reduction for both physical and behavioral health care, and impose financial consequences for plans with repeatedly poor performance. The state should provide a vision and concrete targets for year-over-year quality improvement and disparities reduction tied to plan rates. This will necessitate collection of self-reported race, ethnicity, language, sexual orientation and gender identity by DHCS and plans for the entire Medi-Cal managed care population. Additionally, the draft RFP sets a very low bar for plans to participate in the procurement, so we recommend that DHCS clarify that as part of the procurement process and the contract, plans must meet and exceed

minimum performance levels for both quality improvement and disparities reduction in physical and behavioral health and tie capitation rates to meeting these goals.

Further, while we appreciate this opportunity to comment, we expect **greater transparency** both in the development of the RFP language and the implementation of the contracts. For instance, as it relates to the RFP, the state should make scoring criteria and evaluation questions available for public comment and input; hold to a standard five year procurement schedule (which aligns with other states including Florida and Massachusetts, Covered California, and CalPERS); and require any future contract extensions to go back to stakeholders for input. Currently, DHCS and plans fail to make large amounts of data about plan performance and contract arrangements available to the public, even pursuant to a public records act request. And yet this information can have significant impacts on people's access to quality care, and could inform people's decisions about plan and provider selection. Components of plan contracts, such as required Utilization Management programs and data should be public record; and other contractually required plan documents, like the Population Needs Assessment, quality records, provider financial incentive arrangements, and the Quality Improvement and Health Equity reports should be made public. Public reporting requirements should be applied to plans *and* delegated entities, and results should be reported out plan-by-plan to allow for localized and comparative understanding of plan performance. We would also like clarification on how DHCS plans to address changes in health plan requirements during the 60 month contract duration and recommended five year procurement schedule. Specifically, will significant policy decisions like Population Health Management services and assessment of and data collection on Social Determinants of Health changes be handled primarily through All Plan Letters as has been DHCS' practice in the past, or will changes be memorialized through contract amendments. Whichever mechanism is utilized, we request stakeholder input be included in crafting policies and the opportunity to review draft documents.

DHCS can increase transparency of its oversight and accountability in two key ways: First, DHCS should collect and review plans' policies and procedures annually and the results of their review should be publicly available; second, DHCS should make the MCP audit tool publicly available and invite stakeholder input on the tool annually. DHCS has employed such an extensive public process for stakeholder review of the triennial review tool that is used to review County MHPs, and we believe that DHCS could implement a similar process to review and invite stakeholder input on the tool used to review MCPs. In addition, DHCS should publicly post the actual tool on its website, rather than only publishing "technical assistance guides" for the audit categories. This information is crucial so that beneficiaries and their advocates can understand and provide input on how DHCS reviews plans and holds them accountable to their contract obligations.

Children are the only population specifically listed among the five "demonstrated abilities" that are called out in the draft RFP. This is appropriate because the state's data has shown that Black, American Indian or Alaskan Native, Native Hawaiian or other Pacific Islander, and children living in households that speak a language other than English are even less likely to receive crucial preventive services to which they are entitled. The contracts need to include much more specificity about the obligations of plans plus effective enforcement strategies to meet all of the elements of EPSDT, from outreach to screening to care coordination to treatment. For example, plans must be required to engage in specific and effective outreach and education with families or caregivers of children and youth to ensure they

know what services are available under EPSDT and how to access them. Plans must also be required to undertake follow-up actions to ensure children not regularly receiving care are utilizing prevention and screening services to achieve health equity goals.

In addition, as the RFP relates to pregnant and postpartum individuals, although social determinants of health and other benefits under Medi-Cal's Comprehensive Perinatal Services Program (CPSP) have been required by state law for decades, DHCS has never audited any plan for CPSP compliance. The maternal mortality rate in California is nearly four times as high, and the infant mortality rate twice as high, for African-American families than for white families. This highlights the need for timely audits and enforcement, and the results promptly made public.

Many substantive changes to the plan responsibilities are being made through the 1115 and 1915(b) waivers while none of those are reflected here in the contract. Many of these changes will impact how plans coordinate and deliver behavioral health services to beneficiaries, including tracking and referral of beneficiaries' needs and utilization of services as well as the provision of culturally and linguistically appropriate care. There needs to be real time data-sharing between MCPs and MHPs/DMC programs so as to ensure behavioral health outcomes, disparities and quality of care are accurately measured. Finally, where there are overlapping plan responsibilities for these services or for services where both the MCP and MHP are responsible (such as for eating disorders), greater detail and clarity in the contract is required. This is also part of the CalAIM and 1915(b) "no wrong door" promise.

We appreciate that in both Sacramento and San Diego counties (GMC counties), reducing the number of plans may present an opportunity to increase quality and accountability for plans which have proven best able to meet the needs of the communities they serve. If done well, narrowing of plans could also reduce churn between plans among enrollees in these counties and instead provide a stable selection of higher-quality options. We are concerned however, that there must be a clear process established in which DHCS meaningfully and consistently engage Sacramento and San Diego County stakeholders in the development of the metrics used to evaluate RFP responses and permit feedback throughout the selection process. Both of these counties' local needs and experiences are distinct. As they have for years, those regional distinctions should inform the selection process for the plans chosen to operate in their area. Before proceeding DHCS should establish a stakeholder engagement process for each of these distinct counties and engage stakeholders, especially Medi-Cal Managed Care Advisory bodies for San Diego (i.e. Healthy San Diego) and Sacramento counties, to solicit input on these changes. For example, Healthy San Diego has decades of local collaborative experience and lessons learned that should inform DHCS' decision-making process. We also recommend transition planning that includes consumer supports and collaboration with local organizations as previous plan and large provider exits have been very disruptive.

We are disappointed that important sections of the RFP, including critically important information about how applications will be reviewed and evaluated, are missing from this draft. 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. Without this

information we cannot provide DHCS with feedback, and we are deeply concerned that DHCS is making key decisions about the RFP process behind closed doors without input from stakeholders.

Moreover, the draft language does not reflect our understanding of the lynchpin Population Health Management service/platform and social determinants policies that DHCS intends to adopt. We also note that there are also other significant pieces from new benefits included in the recently passed FY 2021-22 budget that need to be reflected in the final RFP and contract, such as doula services, dyadic care, and Community Health Workers. Given these significant gaps, **we respectfully request that before promulgating a final RFP DHCS issue new drafts for stakeholder review that incorporate policy proposals that will have positive impacts on the health care experience of Medi-Cal members**.

Sincerely,

Children Now
California Pan-Ethnic Health Network
Health Access
*Health Consumer Alliance (HCA)**
Justice in Aging
Maternal and Child Health Access
The Children's Partnership

**The Health Consumer Alliance (HCA) is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, with two Statewide organizations providing substantive support. Members include: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Community Legal Aid SoCal, Greater Bakersfield Legal Assistance, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, and Neighborhood Legal Services of Los Angeles County. Substantive support for the Alliance is provided by the National Health Law Program and the Western Center on Law and Poverty.*

Detailed comments:

RFP Reference	Section and Page Number	Issue, Question or Comment	Remedy Sought
RFP Main	§ D. Purpose and Background D.2; p. 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." DHCS could expand on this "stable local presence" by encouraging accountable communities for health practices such as investing in locally governed community wellness and equity funds.	DHCS should require plans to contribute to a locally governed community wellness and equity fund, where available. 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.
RFP Main	§ D. Background, p. 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
RFP Main	§ R(3)(e), p. 39	The draft RFP states that "additional requirements are currently under development and will be available in the final RFP release." Without more information about what these requirements will be we cannot provide meaningful feedback on them. We are concerned that there may several important additions to the RFP when it is final that stakeholders have had no opportunity to review or provide feedback on.	Provide a draft of these sections to the public for stakeholder review before the final RFP is released.
RFP Main	§ T-U, p. 48-52	This section (Evaluation and Section) is marked as "under development and will be available in the final RFP release." The evaluation and selection criteria and process are critically important and it is disappointing that DHCS is not making these available to stakeholders for review in advance.	Provide a draft of these sections to the public for stakeholder review before the final RFP is released.
RFP Main	§ T(2), p. 49-51	DHCS does not specify how plans found "inadequate" in any evaluation area will be ranked or rated.	Any plan that is determined "inadequate" in any of the evaluation areas should be

			disqualified and not eligible for a contract award pursuant to this RFP.
RFP Main	§ D.2.1.Quality, p. 11	Contractors should be held to higher standards than solely meeting minimum performance levels.	Change "Meet or exceed" to "Meet and exceed"
RFP Main	§ D.2.2.Access to care, p. 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.
RFP Main	§ D.2.5. Behavioral health services, p. 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 an evidence base within the dominant systems of care.	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.
RFP Main	§ D.2.5. Behavioral health services, p. 11	We would 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.	Clarify that bidders and plans are compliant with mental health parity laws.
RFP Main	§ D.2.7. Reducing health disparities, p. 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.

RFP Main	§ D.2.8. Increase oversight of delegated entities, p. 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.
RFP Main	§ D.2.11. Addressing the Social Determinants of Health, p. 12	Plans must be required to use DHCS' standardized screening tool to assess SDOH. Trainings on the collection of SDOH should include a focus on trauma-informed screening.	Add: Meet the health needs of a members through methods designed to understand the overall circumstances of members including capturing SDOH through "trauma-informed standardized risk assessments and coding" and articulating a care coordination strategy inclusive of SDOH.
RFP Main	§ G. Contract Term, Page 17	We appreciate the addition of language specifying a 60 month time frame for procurement contracts. In doing so, DHCS joins other states and major purchasers like Covered California and CalPERs in using contracts to more effectively implement policy changes tied to quality improvement, disparities reduction and population health management. 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. We also recommend setting a procurement schedule and a process to work with stakeholders to publicly evaluate a plan's ability to meet these basic standards as a condition of contract renewal.	Add: "DHCS will notify public stakeholders of its intent to extend a contract and solicit public comment on the merits of such an extension."
RFP Main	§ O.3. National Committee for Quality Assurance, p. 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

RFP Main	§ O.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.
RFP Main	§ O.5.a and 5.b on p. 27-28	Data and disclosures on financial stability can be informative about a proposer's past business practices in other states or markets. Proposals should explicitly require disclosure about sanctions and liquidated damages assessed in other states or in other markets.	Add language in 5.a.5 and 5.b.2 to include disclosure of a proposer's past or pending sanctions or liquidated damages assessed in other regulated markets or states.
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."
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."
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.
RFP Main	State2 - 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 the opportunity to review and provide input on DHCS' scoring criteria and weighting of different factors in RFP selection.
RFP Main	§ Y. DHCS Rights, 1. RFP Corrections, g., p. 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
RFP Main	§ X. Contract Award and Appeals, 1. Contract Award, p. 55	We strongly support the addition of language allowing DHCS to 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.	N/A
Exhibit A, Attachment I.	§ 1.0 Definitions, p. 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	ADD: Systemic Racism

		color. Systemic racism is not the result of individual animus, or lack thereof, but is a result of how institutions and structures are designed.	
Exhibit A, Attachment I	§ 1.0 Definitions, p. 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 conscious awareness and without intentional control (123630.2. of the Health and Safety Code)	ADD: Implicit Bias
Exh A, Attachment I	§ 1.0 Definitions, p. . 12	There is no definition of dual eligibles.	A definition of dual eligible should be included as duals will be part of managed care. Attachment II references the DSNP transition and its effect on duals.
Exhibit A, Attachment I	§ 1.0 Definitions, p. 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	In general	We appreciate the detail in terms of documents, policies, procedures, etc. that plans will be required to submit pursuant to this RFP. Absent from this section (or anywhere in the draft we received for review), however, is a discussion of how DHCS will evaluate these submissions. Information about how DHCS will review and evaluate plans' submissions is critical to ensuring that this RFP process is adequate to select plans that can meet DHCS's high standards and goals for this procurement process. It is also critical that the written policies and procedures be publicly posted or made available to advocates and other interested consumer groups to ensure compliance with state and federal legal, policy and contract standards.	Explain in this section or elsewhere how DHCS will review and evaluate submissions, and what steps it will take to monitor compliance on a regular basis. These documents (policies and procedures) should also be required to be posted or otherwise made available for public review so advocates and consumer groups can identify legal compliance or other concerns.
Exhibit A,	§ 2.1, R.0021, p. 4	What is an "MCO Baseline Assessment Form"?	We request the opportunity to review this form and provide feedback on it.

Attachment II			
Exhibit A, Attachment II	§ 1.2, R.0017, p. 3	This is an important requirement to ensure that plans do not improperly delegate their obligations and have systems in place to monitor and oversee delegated entities. We would like to see more detail in terms of how DHCS will review the policies submitted by plans and ensure that they comply with DHCS requirements.	Explain in this section or elsewhere how DHCS will review and evaluate documents submitted, and what steps it will take to monitor compliance on a regular basis.
Exhibit A, Attachment II	§ 2.2, R.0032, p. 5	It is not clear what is DHCS' objective and scope for the QIHECs. We support their creation but to be effective it is necessary to clarify where this committee is in the organizational decision making process (and what authority it has) within the plan.	Amend: "Submit policies for and placement in the organizational governance chart of the Quality Improvement and Health Equity Committee (QIHEC) including membership, activities, roles and responsibilities, and decision making-authority.
Exhibit A, Attachment II	§ 2.3, R.0050, p. 6	This is the only mention of any effort to identify underutilization. More is warranted to demonstrated plans' procedures for redressing underutilization of preventive care, such as children's EPSDT well child care and screenings.	either add to R.0050 or create a new subsection under utilization management systems: "Submit policies and procedures to detect and redress both under- and over-utilization of health care services. In particular, submit policies and procedures for responding to underutilization of preventive care, such as children's well-child care and screenings under EPSDT."
Exhibit A, Attachment II	§ 2.3, R.0042, p. 6	DHCS should require plans to show both that their UM processes AND the criteria used in UM are appropriate.	Add the phrase "and criteria" after the word "processes" in this section.
Exhibit A, Attachment II	§ 2.3, R.0005	Health systems, providers, and plans can advance health equity by engaging diverse patients, families, and caregivers more directly in efforts to improve healthcare quality and strengthen systems of care through	Add underline: "Submit policies and procedures describing the representation and participation of Medi-Cal members on public policy advisory committee, including

		collaboration, communication, consultation, and co-ownership. Patients should be provided orientation, technical assistance, and other supports to facilitate participation.	adoption of shared-decision making models of governance and supports such as orientation and training, interpretation and auxiliary aids, childcare, incentives such as stipends, transportation and remote access to facilitate patient engagement."
Exhibit A, Attachment II	§ 2.3, 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	§ 2.3, 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 receive 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	§ 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, p. 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	§ 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 marketing both health and behavioral health services to members.	Add: Submit Contractor's Marketing plan, including plan for marketing both health and behavioral health services to members.
Exhibit A, Attachment III	§ 4.3 on Population Health Management	We are disappointed that Exhibit A, Attachment III § 4.3 does not include key components that DHCS has stated it intends to implement, and does not reflect our understanding of the PHM policy DHCS intends to adopt. We request that DHCS promulgate this section again for public comment when it has been amended to reflect DHCS policy. We understand that DHCS intends to implement an ambitious PHM policy statewide, to ensure consistency in terms of service delivery and outcomes throughout the state. We support this approach, and recommend that DHCS adopt a single algorithm for PHM throughout the state that is developed with stakeholder input through a transparent process, and that is not subject to any trade secret or other privacy protections but can be shared publicly with plans, advocates, researchers, beneficiaries, and the general public. This process should result in a state-owned algorithm for risk stratification, that is validated, has been tested to ensure that it addresses, rather than reproduces, health disparities, and that can be studied and tweaked over time. To ensure that its PHM program produces consistent results, DHCS must establish specific categories of data that it will collect from plans, and work with plans to ensure they have the capacity to appropriately and respectfully collect this data and transmit it securely to DHCS. Specifically, we recommend that DHCS create a single validated beneficiary questionnaire that includes a core set of questions that DHCS has	Accurately reflect the PHM policy DHCS intends to adopt and establish consistent metrics to measure the success of thePHM program. In addition, DHCS should provide an updated draft of this section to stakeholders for review before the Final RFP is promulgated.

		identified as most fundamental to achieving its goals, which can be translated in all threshold languages. DHCS should allow plans flexibility to add on additional questions designed to meet the specific needs of the plans. While plans may also adopt their own PHM programs to fulfill NCQA requirements or for other purposes, DHCS's standard PHM program should be used to place members in tiers. DHCS should establish its PHM program as a "floor," while allowing individual plans to go beyond the floor and implement additional components to their population health management strategies to account for local needs. In addition, the contract language should clarify how PHM output information will be used. While the PHM program may provide a way to identify members who may benefit from particular services such as ECM or ILOS, it should not be used as a substitute for individual medical necessity determinations for each service. Moreover, even though MCPs are already required to be providing services to each of these populations, audits and disparities reports indicate preventive care is not sufficiently being provided. Just adding another requirement in the form of the PHM will not necessarily alone move the dial in improving the underutilization and care coordination infrastructure. Thus, DHCS must ensure that plans do not only focus interventions only on beneficiaries who are deemed high or emerging risk, but that they also identify lower risk beneficiaries who might particularly benefit from preventive services. DHCS must also monitor plans' implementation of PHM to ensure it is done in an appropriate and consistent way, such that all beneficiaries are getting the services they need.	

		Finally, DHCS must establish consistent metrics to measure the success of its PHM program including health outcome measures, quality measures, and measures of consumer satisfaction. We recommend that DHCS look for strong, validated public health measures in addition to measures that it already uses for plans such as HEDIS and CAPHS measures.	
Exhibit A, Attachment II	§ 4.3 Population Health Management and Coordination of Care, R.0082	Add consumers and public health and community based organizations	Add: "...including but not limited to, local consumers, community based organizations, and 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	Social needs and social support utilization should be included into the risk stratification for purposes of ensuring that those social needs are taken into account and responded to.	Amend: "Submit a list of the data used by Contractor's risk stratification mechanism or algorithm that include the following, at a minimum. Each type of data listed must include a description and how the data (including serious

	of Care, R.0088		mental health, substance use disorder, pharmacy, CCS, social needs, etc.) will be incorporated into the risk stratification algorithm: : 1) Screening and assessment results; 2) Disengaged Member reports; 3) Claims and Encounters, including Fee-For-Service; 4) Available social needs data; 5) Referral data; 6) Electronic health records; and 7) Utilization data, including available social supports utilization data.
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, including timely access to interpreter services..."
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 quality, timely 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	§ 4.3.3 (F) Population Health Management and Coordination of Care	As per the State Audit (2018-111), plans have not been reporting on progress of previous PNA proposed actions or strategies. (F) should include assessments of previous PNA's proposed strategies and what changes will be made to improve upon those strategies if they have not been working.	Amend: "(F) Based on the PNA, Contractor must annually review and update the targeted health education, cultural and linguistic, and QI strategies to address specific Member needs, and report on the effectiveness of previous QI strategies implemented in response to previous PNAs"
Exhibit A, Attachment II	§ 4.3, R.0089, p. 9	How much detail will plans be required to submit about their mechanism or algorithm for stratification? For more about why information about algorithms is important, see https://healthlaw.org/resource/ensuring-that-assessment-tools-are-available-to-enrollees/.	Recommend this section be expanded to specify what plans must submit in detail.
Exhibit A, Attachment II	§ 4.4, R.0127, p. 12	Before finalizing this RFP, we recommend that DHCS update and expand its current grievance log template to collect additional demographic information about members filing grievances. In addition, we recommend that DHCS explore requiring plans to track complaints beyond the resolution of its internal grievance process so that DHCS has data to indicate how many grievances proceed to IMR, DMHC Complaint, SFH, writ, etc.	DHCS should review its existing grievance log requirements and expand them to ensure that it is collecting adequate data to address systemic issues.
Exhibit A, Attachment II	§ 5.2, R.0176, p. 16	This section does not appear to account for the full scope of plans' obligations with respect to continuity of care.	Expand this section to include all policies related to continuity of care, or add a new section that includes continuity of care requirements beyond those in Knox Keene.
Exhibit A, Attachment II	§ 5.2, R.0168-R0172 and R.0178, p. 16	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 II (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	Ensure RFP evaluation questions reflect culturally and linguistically competent care in order to ensure plans are properly held accountable.

		to help ensure plans are properly held to account for providing these services.	
Exhibit A, Attachment II	§ 5.5, R.0206, p. 18	Why are monthly reports for outpatient mental health services providers only required for the first six months of a new contract?	Ensure that reports are collected regularly on an ongoing basis - if not monthly, than at least quarterly.
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 or outcome metrics by which to measure these requirements	Add R.0182 Submit policies and procedures for coordination of dental referrals.
Exhibit A, Attachment III	Throughout	While incorporation and references to All Plan (Policy) Letters is useful and important, these guidance letters are subject to change so detailing these requirements in the contract itself is important to avoid confusion and make it potentially too general and difficult to enforce. We have provided DHCS with extensive suggested contract language in the past to address our concerns in this area yet the RFP still remains vague and does not contain these recommendations, for the most part.	Rather than merely referencing APLs, incorporate the relevant language from the APL into the Contract.
Exhibit A, Attachment III	Throughout	DHCS must do much more to address disparities among its LGBTQ+ members, especially Black, Indigenous and People of Color (BIPOC) members who also identify as LGBTQ+. The health disparities among California's LGBTQ+ community are both well-documented, and there is also a need for more data about the LGBTQ community's particular needs. *See, e.g.,* Out4MentalHealth, *Mapping the Road to Equity* (2018), https://secureservercdn.net/104.238.68.130/1mi.abd.myftpupload.com/wp-content/uploads/2018/12/O4MH-Mapping-the-Road-to-Equity.pdf; UCLA Williams	DHCS must take action to address these inequities and ensure that LGBTQ+ beneficiaries have full access to the services they need. DHCS must: (1) ensure that cultural competency training is required for all plan staff, delegated entities, and network providers, and that such training includes training on working with the LGBTQ+ community and treating LGBTQ+ people with respect and dignity; (2) that network adequacy reviews account for the availability of LGBTQ+ competent providers and providers able to provide the full range of covered gender-affirming

		Institute, Economic Vulnerabilities to COVID-19 Among LGBT Adults in California (2020), https://williamsinstitute.law.ucla.edu/publications/covid-economics-lgbt-ca/. In our experience, too often, LGBTQ Medi-Cal beneficiaries meet barriers at every level when they attempt to access care -- plan customer service staff call trangender or non-binary members by the wrong name and pronouns or ask LGBQ members about their partners or spouses using incorrect pronouns; plans' networks do not contain sufficient numbers of providers who are culturally competent in interacting with LGBTQ+ people leading to members experiencing at best uncomfortable or awkward and at worst discriminatory and harmful treatment by network providers, including providers and their staff using incorrect names and pronouns, making assumptions about people's gender identities, sexual orientations, sexual partners, etc., up to network providers refusing to provide care to members based on their sexual orientation or gender identity, or making them use a separate waiting room or exam room; plan networks often fail to contain sufficient numbers of providers with experience providing reproductive and sexual health care to LGBTQ people, and gender affirming care to transgender, non-binary, and gender non-conforming people. These barriers are especially pronounced for LGBTQ+ BIPOC who experience multiple layers of discrimination based on the intersecting facets of their identities.	services, including hormone therapy, mental health care, hair removal, surgical interventions, voice training, and any other ancillary services related to gender affirmation; (3) require plans to ensure that they identify providers who have attained a very high level of cultural competency in serving the LGBTQ+ community (by, for example, completing extensive training beyond the basic cultural competency training requirements) and designate these providers as LGBTQ+-serving in their provider directories (this should include a subset of all provider types); (4) establish a process whereby DHCS and its plans must regularly monitor compliance with these requirements, and ensure that plans, delegated entities, and providers take corrective action when appropriate.
Exhibit A, Attachment III	Throughout	We appreciate that DHCS has explicitly designated "Network Provider Agreements or Subcontractor Agreements, the Network Provider Agreements and Subcontractor	DHCS should similarly designate in the contract other information as public records: § 2.0 (quality records); and §§ 3.3.3, 3.3.7(B)(7),

		Agreements, and all information received in accordance with the Network Provider Agreement and Subcontractor Agreement" that it will collect pursuant to this contract as public records (e.g., Ex. III, Attach A § 3.1.10). We recommend that DHCS add similar provisions to several other sections within Exhibit III Attachment A.	3.3.13 (provider financial incentive arrangements).
Exhibit A, Attachment III	§ 1.1.7 Health Equity Officer	We appreciate 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 should 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; p. 5 - 6	Other Health Equity Officer responsibilities should explicitly include knowledge of and meaningful relationships with the community.	Add to the Health Equity Officer responsibilities: "to engage with community leaders and community representatives and be aware of existing community efforts to prioritize health equity and prevent health inequities and disparities." Additionally, the contractor should specify how the priorities and role of the Health Equity Officer fit within the organizational decision-making structure
Exhibit A, Attachment III	§ 1.2.5. Medical Loss Ratio;	In the Medical Loss Ratio requirements, there is an opportunity to emphasize the importance of preventive care and non-	DHCS should require that all applicants develop a plan to spend a minimum percentage of their medical-loss ratio (MLR) on

	p. 10 and p. 15 - 22	clinical services and coordination of those services. There is a pressing need for focusing on increasing preventive care utilization and on coordination and linkage between clinical institutions and a range of community organizations that work on social needs related to health. Health plans have consistently noted 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.	preventive care and non-clinical services and their coordination.
Exhibit A, Attachment III	§ 2.2, p. 43	Empowering the Ombud Office with the responsibility to identify recurrent or systemic problems offers the opportunity to respond more rapidly to problems in addition to the regular reporting of quality metrics.	We recommend that DHCS improve its existing Ombuds program so that it is able to identify and resolve enrollment or access issues in more-or-less real time. DHCS should also consider contracting with outside organizations to assist the Ombuds Office and expand its capacity to reach beneficiaries, especially BIPOC, LGBTQ+, and LEP beneficiaries. While performance measures are an important part of any QI system, the data are typically reported with significant lag. To be effective, the ombuds program should run independently from MCO influence. Still, the managed care contract may need a requirement that the plans will cooperate with the ombuds program to ensure it can do its job.

Exhibit A, Attachment III	§ 2.2.1, p. 43	QIS Accountability section has a typo.	Change "Overnight" to "Oversight" at Section 2.2.1.A
Exhibit A, Attachment III	§ 2.2.3, p. 44	The RFP requires plans to convene a committee to monitor care quality and prioritize health equity activities. However, we believe the RFP could go further to ensure that beneficiaries themselves are more directly involved in planning and advice on Quality Improvement activities. It appears that the QIHEC members are exclusively providers. While the contract calls for participation of providers who serve marginalized communities, the best way to understand the health and health care experiences of people of color and other groups who regularly experience discrimination is to include beneficiaries themselves on the committee. We also suggest adding representation on the QIHEC that brings expertise in equity issues more broadly, such as leaders of Black-led racial justice organizations or social scientists or consultants with expertise in diversity, equity, and inclusion, onto these committees. Beyond representation, it is not clear from the contract what the role and specific purpose of the QIHEC will be. The draft Contract stipulates that the committee shall issue regular reports with recommendations and summaries of its activities, but does not specify what, if any, decision-making power this committee will have. It appears from § 2.2.6.E. that the contract leaves the "role, structure, and function of the QIHEC" up to the discretion of the Contractor. Without clearly defined responsibilities, this opens the door for Contractors to create	● Add membership requirements for beneficiaries and for health equity experts who may not be providers; ● Define a clear purpose and at least minimal decision-making or accountability power for the QIHEC; and ● Ensure that QIHEC reports are publicly reported to give legitimacy and accountability to the committee's actions

		weak committees that will have little actual impact on quality and health equity outcomes. We recommend that the contract describe at least a minimal level of decision-making authority to the QIHEC – particularly if the plan is not meeting its equity and quality goals. Finally, the QIHEC's meeting reports should be publicly available to improve transparency and accountability of their activities.	
Exhibit A, Attachment III	§ 2.2.5, p. 46	To ensure Medi-Cal members have access to the covered services they need, we recommend DHCS require plans to publicly report on quality measures at the delegated entity level to ensure that beneficiaries can choose the plan and network that will meet their needs and provide high quality care, require plans to publicly report on MLR at the delegated entity level, require plans conduct an annual medical audit, including unannounced audits, of subcontractors using a standardized process to be developed by DHCS, and require plans report adverse benefits determination, grievance, and appeal data by sub-plan/delegated entity that provides services or determines whether a service is approved or denied. For transparency, and to ensure that beneficiaries can make informed choices about the plan they enroll in, all of this reporting should be available to the public.	Add under A2) including audit, unannounced and planned. Add under A3) including publicly reporting quality measures, MLR, and adverse benefits determination, grievance, and appeal data.
Exhibit A, Attachment III	§ 2.2.6-2.2.7, p. 45-47	If California is serious about tackling historic inequities in its Medicaid managed care system, then it needs to develop a quality and accountability framework that allows the State agency to identify and monitor health disparities across key demographic groups, and to release those results to the public. Unfortunately, this draft does not include these assurances.	● Require Contracted plans to collect data and report quality measures for physical and behavioral health care stratified by key demographic groups, including race, ethnicity, disability status, age, gender, preferred language, sexual

		For example, in § 2.2.7, the draft contract requires plans to submit an annual Quality Improvement report to DHCS. This requirement should explicitly include in that report performance measures stratified by key demographics, such as race/ethnicity, preferred language, or disability. There is no indication in this quality section that such reporting will be a contractual responsibility. Any QI initiative that foregrounds health equity should include stratified data reporting as a necessary first step to establish a baseline. Health disparities outcomes should also explicitly factor into setting the Minimum Performance Levels for quality metrics defined at § 2.2.9.A.3. As written, this requirement appears to refer to an aggregate MPL for each measure, which provides little to know information about how plans are addressing health equity. Compliance with this MPL appears to be the only thing that plans can be sanctioned for. By incorporating health disparities into Minimum Performance Levels, the State retains the right to subject plans to potential sanctions if they do not materially improve health disparities over time. If not explicitly noted elsewhere, this contractual language allowing sanctions for poor performance should be extended to other features of the QI program, including PIPs, poor network adequacy, failure to respond to recommendations from the QIHEC or problems identified by an independent ombuds, and so forth. We know of several states that have implemented PIPs related to health equity that have failed to meaningfully reduce	orientation, gender identity, and geography. ● Require plans to meet year-over-year targets for quality improvement and disparities reduction for physical and behavioral health care as a condition of contracting. ● Include in § 2.2.7.A. a requirement that the Contractor summarize how it responded to needed improvements identified in prior reports and the efficacy of that response in its annual report. ● Require Contractor to publicly post the annual Quality Improvement and Health Equity Annual Report with plan by plan data, or have DHCS commit to publicly posting the report by a date certain (as it does with the annual external quality review technical report.

		targeted disparities.[1] But to our knowledge, none of the plans faced any repercussions for their failure to achieve meaningful progress over the course of three years. Adding the potential of sanctions could help plans focus more resources on creating successful interventions. We also recommend adding a requirement to the annual report that each plan summarize its response to identified areas for improvement from prior QI and Health Equity annual reports and External Quality Review reports and compliance reviews as part of the annual report described in § 2.2.7. Finally, while the draft contract requires the plans to submit a copy of this report to DHCS, nothing in the Contract suggests that the report will be available to the public and it should be. Accountability requires public transparency to build trust in the QI procedures and to ensure that poor results are not simply buried.	
Exhibit A, Attachment III	§ 2.2.9, p. 49-50	This section refers to APL 17-014 that refers to an MPL at the 25th percentile. DHCS has verbally committed to a 50th percentile MPL, so this reference is inappropriate. Furthermore, the MPL is only one type of benchmark and DHCS should also reserve the opportunity to set *improvement* benchmarks or standards.	Revise Section 2.2.9.A.3 to read: "Contractor shall, at a minimum, meet the DHCS established Minimum Performance level (MPL) or other benchmark of improvement for each required performance measure selected by DHCS in APL 19-017. Unless a higher standard is set forth in subsequent guidance, the MPL shall be no less than the 50th percentile of the national average."
Exhibit A,	§ 2.2.9, p. 49 and §	The draft contract does not reflect the Administration's stated intention to hold health plans accountable to benchmarks on	Add language to clearly reflect the Administration's stated intention to hold health plans accountable

[1] See, e.g., David Machledt, *Addressing Health Equity in Medicaid Managed Care Quality Oversight*, (May 2021), https://healthlaw.org/resource/addressing-health-equity-in-medicaid-managed-care/ [Discussing Minnesota and Michigan's lack of substantial progress to diminish racial disparities].

Attachment III	5.3.4.B, p. 199;	the Children's Preventive Services Report measures.	to benchmarks on the Children's Preventive Services Report measures and the mechanism(s) to do so).
Exhibit A, Attachment III	§ 2.2.9.C, p. 50	Consumer Satisfaction Surveys are important pieces of information, but these results are unlikely to get the attention they are deserved without any sort of standards, benchmarks, expectations to use findings, or consequences for poor consumer experience. Consumer satisfaction surveys should also be collected annually.	Add two more subsections to Section 2.2.9.C; one subsection will say that Contractor shall comply with any benchmarks or standards set by DHCS, including annual consumer satisfaction survey requirements; and the other subsection will impose sanctions for noncompliance with either data collection or performance.
Exhibit A, Attachment III	§ 2.3(F), p. 55	We appreciate the requirement to track specialty referrals. This tracking should be required for any service subject to prior authorization regardless of whether it is considered a "specialty" service.	Remove the word "specialty" from this section. Perhaps replace with "prior authorization"?
Exhibit A, Attachment III	§ 2.3 p.55 Utilization Review	E. Standing Referral process allows minimal seven days for referral - what is urgent referral process?	Add process for Urgent Referrals needed within 24-48 hours. If that is "Specialty Referral system" in F, add timeframes
Exhibit A, Attachment III	§ 2.3.1 Prior Authorizations and Review Procedures	"Prior Authorization requirements must not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, or initial mental health assessments; "	Define basic prenatal care
Exhibit A, Attachment III	§ 3.3.15, p. 86-89	This section does not specifically mention emergency transportation. We continue to see Medi-Cal beneficiaries who are billed by providers of emergency transportation and we believe this service must be addressed explicitly.	Add a provision to address plans' obligations to pay for emergency transportation and prevent billing by emergency transportation providers to the extent possible.

Exhibit A, Attachment III	§ 3.3.6(B), p. 81	We support this provision to require plans to hold members harmless and indemnify them if providers improperly balance bill members.	
Exhibit A Attachment III	§ 3.3.8 Non-Contracting Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Providers on p. 84	In accordance with 22 CCR section 51345 *et seq*., and APL 16-017, if there are no CNMs or CNPs in Contractor's Network, Contractor must reimburse non-contracting CNMs or CNPs for services provided to Members at no less than the applicable Medi-Cal FFS Rates.	Add corresponding requirement for Licensed Midwives. Explain that the contracting plan must also reimburse non-contracting CNMs or LMs or CNPs for services provided if there is inadequate timely access to either CNMs, CNPs or LMs, even if there is one (1) contracted and regardless of the number contracted.
Ex. A, Attach. III	§ 3.3.8, p. 84	The cited APL 16-017 has been superseded by APL 18-022. The requirements of APL 18-022 are not currently included in the Medi-Cal contract.	In accordance with APL 18-022, the Medi-Cal contract language must require that the MCP have a minimum of one CNM (certified nurse midwife) and one LM (licensed midwife) in its provider network. Moreover, the contract language must require that where the MCP is not able to provide access to these provider types in-network (not only when there is no CNM or LM in the network at all), they must reimburse out-of-network CNMs and LMs at no less than the applicable Medi-Cal fee-for-service rate, in accordance with the MCP contract, for services provided to its members. Similarly, in accordance with APL 18-022, the Medi-Cal contract

			language must require that the MCP include a minimum of one FBC (freestanding birth center) in its provider network. If the MCP is unable to provide such access, they must reimburse out-of-network FBCs for services provided to its members, in accordance with the MCP contract. The Medi-Cal contract must also include the specific notice requirements the MCP has to ensure that enrollees are made aware of the availability of these services, and access when the services are not available in-network.
Ex. A, Attach. III	§ 3.3.9, p. 84-85	There is no mention of abortion care as part of family planning services. Nor is there anywhere in the Medi-Cal contract that mentions abortion care, either as such or as "pregnancy termination." Here, Section 3.3.9 mentions only services "to temporarily or permanently prevent or delay pregnancy."	Medi-Cal covers abortion care and requires that managed care plans permits all enrollees to seek abortion care services from any qualified Medi-Cal provider, without prior authorization or need for a referral. This is the case even if the provider of choice is outside of the enrollee's Medi-Cal managed care plan. We are aware of instances of some managed care plans in California not being aware of this requirement. This requirement must be included in the Medi-Cal contract language.
Exhibit A, Attachment III	§ 4.1.2 Marketing Plan	The contractor's marketing plan should include a marketing plan for all services covered by the contractor.	Add: B. 10) A marketing plan for all services covered by the contractor, including a marketing plan for health and behavioral health services.

Exhibit A, Attachment III	§ 4.1.2 Marketing Plan	We appreciate 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.
Exhibit A Attachment III	§ 4.2.1 - Enrollment, E. 2) Coverage, p. 102	"Contractor must provide Covered Services to a child born to a Member for the month of birth and the following month. No additional Capitation Payment is owed Contractor for the services provided to the newborn child for month of birth and the month following birth."	Explain the circumstance in which the child is defaulted to mother's plan within month of birth or month after and no provider is chosen, a "B-1" enrollment, and child sees a provider in another plan or medical group. Explain that Contractor must pay that provider.
Exhibit A, Attachment III	§ 4.3.4(A)(5), p. 109	This section does not require any IRA questionnaire be administered to members identified as low risk.	DHCS should require plans to administer an IRA to those identified as low risk to help identify preventive services they may need.
Exhibit A Attachment III	§ 4.3.4 A. Member Risk Assessment	Entire section does not reference existing assessments	Explain how this process will coordinate with with the Comprehensive Perinatal Services screenings, assessments and CPSP's provision of SDOH services
Exhibit A, Attachment III	§ 4.3.4(A) (maybe supposed to be (B)), p. 110	Incorrectly states that population risk stratification will be used "to determine the appropriate level of case management and/or targeted, person-centered interventions for all Members." This statement incorrectly suggests that risk stratification will serve as a substitute for individualized medical necessity review	Rewrite as follows: "to <u>initially screen for</u> ~~determine the appropriate~~ <u>level</u>s of case management and/or targeted, person-centered interventions for all Members. <u>Contractor shall conduct an individualized assessment of each member initially screened for case management and/or targeted, person-centered interventions to determine whether those services are appropriate for the member</u>."

Exhibit A, Attachment III	§ 4.3.4(A)(b), p. 112	This subsection should specify the extent of the care coordination, namely that plans are required to assist members make appointments, provide non-medical transportation as needed and follow up on that care.	Amend: "Coordinate health and social services for the Member, including coordination, setting up appointments, and follow up with external entities outside of the Contractor's Provider Network to address Member needs and to mitigate impacts of Social Determinants of Health"
Exhibit A, Attachment III	§ 4.3.4(A)(d), p. 112	This subsection should include WIC as Medi-Cal is required to coordinate with WIC for members	Add "WIC" to subsection (d)
Exhibit A, Attachment III	§ 4.3.5(B)-(E), p. 117-18	This section should specify who is qualified to serve as case manager.	This section should specify who is qualified to serve as case manager.
Exhibit A, Attachment III	§ 4.3.5, p. 110; and § 4.3.6, p. 119; and and § 4.3.7, p. 120; and § 4.3.8, p. 121; and § 4.3.9, p. 121; and § 4.3.10, p. 122; and § 4.3.12, p. 124; and § 4.3.14, p. 125; and § 4.3.16, p. 127;	The contract also needs to define the expectations for coordinating children's health and behavioral health care and how plans will be held accountable for access to all aspects of care (including behavioral health and dental care but also coordination of non-covered services such as social support services), outcomes, and quality measures. The need for additional clarity and detail concerning care management is especially important for children with classic California Children's Services (CCS) coverage as well as those CCS-eligible children receiving services through a Whole Child Model (WCM) program that the state currently pays plans a separate rate for.	Define the expectations for coordinating children's health and behavioral health care and how plans will be held accountable for access to all aspects of care (including behavioral health and dental care but also coordination of non-covered services such as social support services),
Exhibit A, Attachment III	§ 4.3.14, p. 125	An identified Contractor liaison for dental referral assistance should not only be available to Medi-Cal dental providers, but also to medical providers, members, and member representatives to aid in the coordination of dental referrals and care. In order to ensure that the dental liaison can easily be reached, the Contractor and DHCS should be required to post contact information for dental liaison services for providers, members, and stakeholders to	Clarify the roles, functions, and accountability for a dental liaison.

		easily find on both the health plan website and DHCS' website. DHCS also needs to specify the roles, responsibilities, training requirements, measures to track the dental liaison activities, and periodic reporting requirements of these measures.	
Exhibit A, Attachment III	§ 4.4, p. 131		The Appeal and Grievance section should include mention of a dual's option to pursue both Medicare and Medi-Cal appeal avenues for overlapping benefits, as well as the appeal rights for Medi-Cal only benefits provided by the MCP. With the enrollment of duals into managed care under CalAIM, notices should provide information that notifies enrollees of the option to pursue a service under Medi-Cal.
Exhibit A, Attachment III	§ 4.4.2, p. 132-33	We appreciate the addition of this section.	We request the opportunity to review the forthcoming APL implementing the discrimination grievance requirements.
Exhibit A, Attachment III	§ 4.4, p. 130	"..APL 21-XXX" in the first paragraph is incomplete.	Add the specific section number.
Exhibit A, Attachment III	§ 4.4.A, p. 130	There may be times that Member's conservator or legal guardian (who would not have member's written consent) needs to file a grievance or request an appeal on behalf of the member. The existing language only includes those with Member's written consent.	Add "or legal authority" after "Authorized Representative with the Member's written consent."
Exhibit A, Attachment III	§ 4.4.G, p. 131	"…APL 20-XXX…" is incomplete.	Add the specific section number.

Exhibit A, Attachment III	§ 4.4.J, p. 131	Currently language does not specify how frequently the data analysis needs to be.	Provide more guidance on how frequently the data analysis shall be.
Exhibit A, Attachment III	§ 4.4.K, p. 131-32	Currently language does not specify how the records should be kept and for how long.	Provide more guidance or add reference to specific code section, such as Section 4.4.8.C on recordkeeping
Exhibit A, Attachment III	§ 4.4.1.C, p. 132	"… appropriate Contractor staff…" It is unclear who appropriate Contractor staff is and whether the person is a designated person.	Add language to define who is "appropriate" or add a section that mirrors section 4.4.2.A ("Contractor must designate a Discrimination Grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating Discrimination…")
Exhibit A, Attachment III	§ 4.4.2, p. 132-33	Current language does not mention any requirement to provide notice on Discrimination Grievances.	Add language or reference to the code sections that require notice for discrimination grievances
Exhibit A, Attachment III	§ 4.4.2.C, p. 133	It is unclear what APL 21-XXX is.	Add the specific section number.
Exhibit A, Attachment III	§ 4.4.3.A, p. 133	The term "Working Days" is used throughout the exhibit but can be confusing, as in the healthcare industry, working days do not necessarily mean Monday through Friday. Also, even though the term "Working Days" was defined in Exhibit A. Att. I (as "State working days as identified in the State	Define "Working Days" here (even if it's defined in the definition list) and include the "State Appointment Calendar," as an attachment.

		Appointment Calendar"), the State Appointment Calendar is not attached anywhere. This creates an additional burden on consumers, especially for this section (appeals and grievance), where time is of the essence.	
Exhibit A, Attachment III	§ 4.4.3.A, p. 133	"1) Is appropriate… but no longer than five Working Days from…". There is an extra blank space between "Days" and "from."	Remove the extra space.
Exhibit A, Attachment III	§ 4.4.4.A, p. 137	The current language only allows "The Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent" to request an Appeal. However, it should also include authorized representatives acting on behalf of the Member with legal authority but without Member's written consent.	Add "or legal authority" after "… the Member's written consent."
Exhibit A, Attachment III	§ 4.4.4.A, p. 137-38	Contractor's NAR should also be made in a language that meets the Member's needs.	Add a 6) to address the language need.
Exhibit A, Attachment III	§ 4.4.5.A, p. 139	The current language only allows "The Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent" to file an expedited Appeal. However, it should also include authorized representative acting on behalf of the Member with legal authority but without Member's written consent.	Add "or legal authority" after "… the Member's written consent."

Exhibit A, Attachment III	§ 4.4.6.A 4), p. 140	The term "actively participate" is vague and may not ensure sufficient representation of the facts of the case. For example, is one-time telephone contact considered "active participation"?	Define "actively participate."
Exhibit A, Attachment III	§ 4.4.6.B 2), p. 142	The term "actively participate" is vague and may not ensure sufficient representation of the facts of the case. For example, is one-time telephone contact considered "active participation"?	Define "actively participate."
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	§ 5.1.1 A, 1) c), p. 148	"To be able to choose their Primary Care Service Provider..." might not sufficiently ensure Member's ability to select their preferred Primary Care Provider at any time.	Add language to allow switching Primary Care Service Provider at any time (or reference Section 5.1.3 I. 4) e)).
Exhibit A, Attachment III	§ 5.1.1 A, 1) j), p. 149	Abortion care is not mentioned here as part of the family planning services.	Include abortion care in this section.

Exhibit A, Attachment III	§ 5.1.1 A, 1) k), p. 149	FQHCs, RHC, and IHS are not defined in this exhibit. Also, “federal law” does not provide sufficient guidance.	Recommend: (1) Define or provide the full name of the FQHC, RHC, and IHS programs. (2) Provide corresponding statute or code section in the federal law
Exhibit A, Attachment III	§ 5.1.3(H)(3), p. 155	Consistent with current rules, this section should specify that plans’ online directories are publicly available including to non-members, no need to log in etc.	Consistent with current rules, this section should specify that plans’ online directories are publicly available including to non-members, no need to log in etc.
Exhibit A Attachment III	§ 5.1.3(I)(3) - Handbook. p. 161	Handbook does not incorporate access to community health worker services.	Add a subsection under the handbook: “The availability of, and procedures for obtaining services from community health workers”
Exhibit A, Attachment III	§ 5.1.3(J), p. 164	Assuming that the Rx Carve Out will happen, it is cumbersome for beneficiaries to manage two separate cards.	DHCS should require plans to include beneficiaries’ BIC information on the plan card to obviate the need for two cards.
Exhibit A, Attachment III	§ 5.1.3 F 4) c), p. 153	APL 21-XXX is incomplete.	Add the specific section number.
Exhibit A, Attachment III	§ 5.1.3 F 5) a), p. 153	Primary language, immigration status, and citizenship should be included as well.	Add Primary language, immigration status, and citizenship.
Exhibit A, Attachment III	§ 5.1.3 F 6) a), p. 155-156	At times there are additional fees, such as “facility fee” for in-Network providers. Such fee should also be disclosed to the Member in the Provider directories.	Add a section to require information about additional fees to be included in the Provider directories.
Ex. A, Attach. III	§ 5.1.3, p. 162	Recommend replacing this section: "Family planning services are provided to Members of childbearing age to enable them	With the following revised language:

		to determine the number and spacing of Children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN Specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name] without having to get permission from [Plan Name]. [Plan Name] will pay that doctor or clinic for the family planning services you get."	"Family planning services ~~are provided to Members of childbearing age to enable them to determine the number and spacing of Children. These services~~ include all methods of birth control approved by the Federal Food and Drug Administration, <u>contraceptive counseling, services to screen and treat sexually transmitted infections, and other related services</u>. As a Member, you pick a provider who is located near you and will give you the services you need. Our Primary Care Providers and OB/GYN Specialists are available for family planning services. For family planning services, you may also pick a provider or clinic not connected with [Plan Name] without having to get permission from [Plan Name]. [Plan Name] will pay that provider or clinic for the family planning services you get."
Exhibit A, Attachment III	§ 5.1.4 D on p. 165	"Direct outreach" does not provide sufficient guidance.	Define "direct outreach" or add language to require written or oral notification. Also, add requirement of timeline that Contractor must inform Members the explanation for the reason the Member could not be assigned to their selected PCP.
Ex. A Attachment III	§ 5.2, p. 167-195	We appreciate that DHCS has made several strides to improve its monitoring and oversight of plan networks over the last	The direct testing should not only measure provider contact information, but also other factors

		several years, with the input of stakeholders including the legislature. Still, the multitude of approved Alternate Access Standards makes navigating plan networks confusing and frustrating for beneficiaries and advocates. Now that the existing time/distance standards have been in place for several years, DHCS should be meticulous about corrective action plans up to and including sanctions for plans that have been repeatedly unable to contract with sufficient numbers of providers in their geographic area. In addition, DHCS should require plan provider directories to clearly indicate where a particular service is subject to an alternate access standard and explain how members can access that service, including by calling the plan to obtain help with transportation, or finding a suitable out-of-network provider as appropriate. Inadequate provider networks represent one of the biggest barriers to accessing health care. However, measuring exactly what is an adequate network is not a simple process. Most states use time/distance standards to identify provider shortages and ensure all individuals in a plan's catchment area can find providers if they have a need for a covered service. Unfortunately, time/distance standards cannot function properly if a plan's provider directory is inaccurate or out of date. And experiences across multiple states have shown that provider directories are wildly inaccurate. We appreciate that DHCS will require plans to comply with the EQRO's validation of network adequacy, but we believe the state needs to do more to directly evaluate provider availability. The draft contract does	such as whether providers are taking new patients or whether their offices and medical equipment are accessible to people with disabilities and people with Limited English Proficiency, and whether the provider's office can provide culturally competent care. Several states conduct such secret shopper surveys through their EQR process, and this would not necessarily be a specific responsibility of the plan. However, the contract provisions might have to be altered to allow DHCS to hold Contractors accountable for persistent poor performance on secret shopper surveys. One example would be to tie performance to potential sanctions in line with the sanctions laid out in § 2.2.9.A.4.

		require that the contractor have mechanisms, policies, and procedures in place to ensure members can make timely appointments at § 2.2.6.H., but we recommend that DHCS also conduct regular direct testing of Contractor's provider networks and directories through mechanisms like secret shopper surveys, and that the plans be required to cooperate with those studies and respond to resulting recommendations.	
Ex. A Attachment III	§ 5.2, p. 167-195	As described in detail above, Medi-Cal beneficiaries continue to experience significant challenges accessing culturally competent and linguistically appropriate care.	DHCS must more closely monitor plan networks to ensure they can adequately deliver care to LEP beneficiaries, BIPOC beneficiaires, and LGBTQ+ beneficiaries, including by ensuring that plans routinely offer in-depth cultural competency and sensitivity training, and have robust processes in place for ensuring that they offer interpreter services when providers who speak a beneficiary's language are not available. The contract should make clear that when plans fail to ensure that beneficiaries have access to culturally competent and linguistically appropriate services, DHCS will require corrective action, up to and including sanctions.
Exhibit A, Attachment III	§ 5.2.1(A)(2)	Contractor must consider the requirements in W&I Code section 14182(b)(11) when assigning Members who are SPDs to a PCP. Additionally, Contractor must ensure that Members have the option of selecting an IHS, FQHC, or RHC, as their PCP, where available.	There should be clear language that duals who are moving to managed care Medi-Cal under CalAim should not be assigned a PCP in the Medi-Cal plan. This would interfere with a beneficiary's choice of primary

			care physician under Medicare rules
Exhibit A, Attachment III	§ 5.2.1(D)(2)(e)(iv), p. 187		Contractor shall provide necessary assistance for participation including, as appropriate, transportation to meetings (including appropriate transportation for persons with disabilities)
Exhibit A, Attachment III	§ 5.2.1(D)(3)(c)		Include language and sign language interpreters, and assistive devices and other accommodations needed by persons with disabilities.
Ex. A Attachment III	§ 5.2.7, p. 175-179 Out of Network Care	Does not include for Basic Prenatal Care as noted in listing in Section 2.3.1	Add right to out of network care for basic prenatal.
Exhibit A, Attachment III	§ 5.2.3(B)(2) p. 169-70	This section only requires commercial plans to contract with one FQHC / RHC / FBC. This misstates plans' obligation. FQHC, RHC, and FBC services are covered Medi-Cal benefits. Thus, plans must adequately contract with providers of these services to ensure that their members have access to them. In many counties, contracting with only one provider will not be sufficient to ensure network adequacy.	Rewrite this section as follows: If Contractor is not a local initiative health plan model, it must contract with a sufficient number of ~~include at least one~~ FQHCs, ~~one~~ RHCs, and ~~one~~ FBCs in the Network, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law to ensure that such services are available to members.
Exhibit A, Attachment III	§ 5.2.4(A), p. 171	Without a definition of "FTE" in this context, plans can and do count the same providers who may be participating in dozens of plan networks and in fact have limited availability to see plans in this particular network.	Define FTE and eliminate "double counting" of providers.
Exhibit A, Attachment III	§ 5.2.7, p. 175	Does not require plans to inform members that OON services are available, especially where the plan has an AAS in place.	Require plans to actively communicate, at least via their provider directories, where they have identified deficiencies in their networks and DHCS has approved an AAS, and inform members of their options to

			obtain transportation assistance or OON services.
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 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.	Add to section 5.2.11: The Contractor must be active in recruiting and retaining culturally 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	§ 5.3.4, p. 199	EPSDT services for children under 21 includes dental care, some of which is articulated in Section 4.3.14. This should be clearly cross referenced and aligned.	Add "dental screening and oral health assessment" to Section 5.3.4.A.3.
Exhibit A, Attachment III	§ 5.3.4.B, p. 199	Section 4.3.12 says that "Contractor must maintain a Medical Home and ensure the Care Coordination and case management of Members who obtain CHDP services through the local school districts or school sites." But the requirement or operationalization of a "Medical Home" is not described anywhere.	Add a Section in 5.3.4.B defining a Medical Home maintenance requirement for children under 21 and how DHCS will monitor compliance.
Ex. A, Attach. III	§ 5.3.6, p. 205	Language specifies requirement for MCP to cover prenatal but not postpartum care	Medi-Cal contract language must also include language that the MCP must provide postpartum care for all enrollees, and that such care must also meet the most current standards or guidelines of ACOG and CPSP.
Ex. A, Attach. III	§ 5.3.6, p. 205	Only general reference is made to CPSP. DHCS has never audited for CPSP compliance. The RFP needs to make the contractual expectations for CPSP clear so that bids can be focused accordingly. Starting with Assessments. CPSP's enhanced benefits package, including not only obstetrical but also psychosocial, nutrition,	<u>CPSP Assessments</u> Plans must conduct comprehensive perinatal risks and needs assessments at least once during each trimester, plus at least once as soon as possible

		and health education services, and related case coordination, was enacted into state law precisely because a pilot project had demonstrated that such services improved birth outcomes as well as reduced Medi-Cal costs. The contract must include CPSP's requirements for trimester and postpartum assessments, development and implementation of Individualized Care Plans, and documentation of whether follow up services were offered and received. See Welf. & Inst. C. §§ 14132(u), 14134.5(d) and generally; Title 22, Calif. Code of Regulations, §§ 51179, 51348.	during the 60-day postpartum period. Beginning April 1, 2022, the risks and needs assessment shall be updated by the fourth month following the end of the 60-day post-pregnancy period. The plan's assessments must include all of the risks and needs which are assessed by the CPSP trimester and postpartum tool developed by the California Department of Public Health
Ex. A, Attach. III	§ 5.3.6, p. 205	As noted, only general reference is made to CPSP and the plans have never been audited for CPSP compliance. The RFP needs to make the contractual expectations for CPSP clear so that bids can be focused accordingly.	<u>CPSP ICPs</u> Plans must prepare an individualized care plan for each pregnant plan member.. The ICP must be updated based on trimester and postpartum assessments and as otherwise needed. The ICP template must address all of the factors identified by the risks and needs assessments and shall be comparable to the ICP templated developed by CDPH for CPSP.
Ex. A, Attach. III	§ 5.3.6, p. 205	As noted, instead of a general reference to CPSP, the RFP needs to make the contractual expectations for CPSP clear so that bids can be focused accordingly.	<u>CPSP Services and Documentation</u> Plans must offer, or arrange to have offered and provided, to the plan member services included in the individualized care plan The plan must document in the member's patient record what services were offered under the individualized care plan for CPSP,

			whether such services were received, and if not, why not.
Ex. A, Attach. III	§ 5.3.6, p. 206	Language specifies that MCP "must ensure that pregnant Members at high risk of a poor pregnancy outcome are referred to appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives, Licensed Midwives, and Doulas…"	Medi-Cal contract must include a requirement that MCP give all pregnant enrollees, and not simply those at high risk of poor pregnancy outcomes, information about the services available to them while pregnant, including perinatologists, FBCs, CNMs, LMs, and doulas.
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	§ 5.3.7(B), p 207	The hospice provision states plans will cover all hospice; this section doesn't mention that most hospice for duals is covered by Medicare.	Any additional hospice wraparound services provided by Medi-Cal must be coordinated with Medicare providers.
Exhibit A, Attachment III	§ 5.3.7(C)	is the health assessment of 120 days short enough to account for those that might elect hospice or palliative care? Duals might choose palliative care provided by MCPs if they do not meet Medicare criteria of having life expectancy of less than 6 mos for covered hospice/palliative care and have declined curative treatment. Care coordination would be key for this population.	Revise 120 days palliative care assessments
Exhibit A,	§ 5.3.7(I)		Care coordination is key for duals who need Medi-Cal plan covered transportation (either NMT or

Attachment III			NEMT) to appts with Medicare providers. Education to members of this benefit and the Rx requirement for NEMT must be coordinated with the Medicare provider. A MCP develops a policy for prior auth for NMT as well, this would need to be coordinated with Medicare provider and cause delays in NMT
Exhibit A, Attachment III	§ 5.3.7(G)		This section should account for the ways duals receive LTC, which often is first paid for by Medicare and then Medi-Cal and minimize disruption to care.
Exhibit A, Attachment III	§ 5.4.3	Regarding A.	Add requirement for plans to collect and submit to DHCS authorization of as well as utilization of CBAS hours for participants assessed for CBAS. Require plans to also collect and submit to DHCS demographic data--including age, race, and language spoken--of participants authorized for CBAS and participants utilizing CBAS
Exhibit A, Attachment III	§ 5.4.3	Algorithms should promote, not hinder, health equity.	Add requirement for plans to share with DHCS the algorithms used determine the number of CBAS hours participants are authorized.
Exh. A, Attachment III	§ 5.5	With respect to behavioral health services, more details are needed. Under EPSDT, the behavioral health services required to be provided to children and youth under age 21 should be spelled out in greater detail. While the RFP selectively details plan requirements for particular services required under EPSDT (e.g. Behavioral Health Treatment, Exh A, Att III, p 203), other services - namely all the mental health and SUD services - are not detailed or not specifically addressed under EPSDT at all (Att III, p 208). Where these mental health and SUD services are detailed (Section 5.5 of Att III), there is no mention of EPSDT or children and youth at all.	Provide detailed and specific obligations by the plan to provide mental health and SUD services to children and youth under age 21, including any overlapping services with the MHP (e.g. psychotherapy).

Exhibit A, Attachment III	§ 5.5.2, p.221	The list of MHSUD services for which transportation services are available is incomplete, as SUD services provided by DMC and DMC-ODS plans are also eligible for covered transportation.	This section should clarify that MCPs remain responsible for covering the cost of transportation services to and from DMC and DMC-ODS services (as stated in the DMC-ODS waiver special terms and conditions and in APL 18-015). In the alternative, the paragraph should be modified to read as follows: "EMT, NEMT and NMT services pursuant to 22 CCR section 51323 required by Members to access Medi-Cal covered mental health services and substance use disorder services. These services include*, but are not limited to,* outpatient opioid detoxification, tobacco cessation, and AMSC services…"
Exhibit A, Attachment III	§ 5.6,	Counties participating in the DMC-ODS program must enter into an MOU with any MCP enrolling beneficiaries served by the DMC-ODS program. However, the attachment makes no reference to this MOU requirement.	We recommend adding a section as part of 5.6 regarding the MCPs' responsibility to enter into an MOU with counties participating in the DMC-ODS program.
Exhibit A, Attachment III	§ 5.6.1, p. 228		We recommend the addition of a paragraph that states that the MOU entered between MCPs and MHPs must include a statement to the effect that patients should continue accessing medically necessary services while a dispute resolution process is ongoing, pursuant to 9 CCR § 1850.525.
Exhibit B	§ 1.5.A.2, p. 4	Health plan performance on quality and equity benchmarks should be a central driver of quality improvement in rate development. The current language which simply "reserves the right" of DHCS to consider performance and quality is the status quo that DHCS has not invoked. DHCS should amend the rate development process and impose withholds for failure to meet an MPL of the 50th percentile for adult and children's preventive services, consistent with current policy in APL 19-017.	Rewrite Section 1.5 to amend the rate development process to be a driver of quality improvement and impose financial withholds for failure to meet an MPL of the 50th percentile for adult and children's preventive services as set forth in Exhibit A, Attachment III, Section 2.2.9.A.