December 16, 2019

Via Email: Jacey.cooper@dhcs.ca.gov
Attention: Jacey Cooper, Senior Advisor - Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899

Subject: CalAIM Feedback and Recommendations from the California Children's Trust

Dear Ms. Cooper:

The California Children's Trust (CCT) is pleased to submit comments in response to the California Advancing and Innovating Medi-Cal (CalAIM) initiative led by the Department of Health Care Services (DHCS). The CCT represents a broad statewide coalition of stakeholders committed to addressing the children's behavioral health crisis in California. Today our feedback covers the following topic areas: 1) changes to the definition of medical necessity; 2) the move toward full integration and its impact on children and youth; and 3) the state's long-term plan for foster youth. We plan to submit additional comments by December 23, 2019 regarding the payment reform proposals in CalAIM.

We applaud DHCS for its work in CalAIM to recognize population health management strategies as a critical tool to identify and provide early intervention services to members with emerging risk factors (including the social determinants of health) as soon as possible. There is immense opportunity within the CalAIM proposal, and we are particularly enthusiastic about the modernization of the definition of medical necessity as we move away from a pathology-driven system where children receive services far too long after their first sign of struggle. As a coalition representing a broad and diverse group of stakeholders, including the providers of behavioral health services for youth and families, we also look forward to the alleviation of unnecessarily onerous administrative burdens presented by the shift away from cost-based financial models and minute-to-minute billing, which we will elaborate on in our feedback on December 23.

The CCT is strongly aligned with the fundamental goal of CalAIM to improve access to and quality of services for Medi-Cal beneficiaries in California. In the spirit of that shared goal, we offer the following recommendations:

Population health management member assessments

CCT supports CalAIM's Population Health Management proposal to require health plans to conduct assessments for new members and for all members annually. We applaud CalAIM's requirement that these assessments gather Social Determinants of Health (SDOH), including

"access to basic needs such as education, food, clothing, household goods, etc.;" "housing and housing instability assessment;" and "use of community-based services and supports" (CalAIM Proposal, p. 26). **CCT recommends in particular that plans be required to gather data reflecting economic distress and a youth's potential exposure to trauma,** such as, but not limited to the following questions from the Whole Child Assessment: "On average, how difficult was it for your family to meet expenses for basic needs like food, clothing, and housing in the last year?" and "Do you feel your child is difficult to take care of?"

We also support the requirement that plans identify members with "emerging risk" factors and provide those members case management services, including ensuring a "family-centered approach by identification of [a] member's circle of support or caregivers;" and "developing relationships with local community organizations to implement social determinant interventions (e.g. housing supports, nutritional classes, etc.)" (CalAIM Proposal, pp. 29-30). **CCT believes it is critical that plans are required not only to identify members who should receive more thorough follow-up assessments, but also to ensure members actually receive those evaluations and any recommended follow-up interventions.**

CCT appreciates CalAIM's distinction between "plan-level risk assessments" and assessments "that are more appropriate to be delivered in the clinical setting, such as screenings conducted by providers during the initial health assessment visit" (CalAIM Proposal, p. 25). CCT therefore recommends that **if a plan level risk assessment reveals a youth's family is experiencing an unaddressed SDOH, the plan should be required to place that youth in its "Emerging Risk" category and provide case management services** to ensure: 1) the youth receives from a community-based provider a more thorough assessment that evaluates both possible exposure to trauma and other SDOH, such as the Whole Child Assessment and 2) the family receives all recommended follow up care, including early interventions for parents and other caregivers, such as evidenced-based infant-parent home visiting programs.

Medical necessity

The California Children's Trust supports CalAIM's approach to modifying existing eligibility criteria for outpatient and inpatient specialty mental health services in order to align with the intention of the EPSDT federal entitlement. In light of everything science and best practice tells us about behavioral health, and especially children's behavioral health, we must shift philosophy and mechanics of our current diagnosis-driven system to a new approach that is responsive to the level of impairment and reflects an understanding of the impact of trauma and social determinants of health on long-term health and mental health outcomes.

CCT strongly supports CalAIM's recognition that eligibility criteria should be driven not just by diagnosis, but also by "level of impairment or a set of factors across the biopsychosocial continuum" (CalAIM Proposal, p. 75). **We urge DHCS to clarify that level of impairment and/or biopsychosocial factors will drive not only the choice of delivery system, but also whether a member is eligible for services.** Providers in either delivery system who identify youth with emerging mental health conditions or exposure to trauma or other SDOH must be

reassured that they can be reimbursed for providing appropriate follow up assessments and interventions to address these factors before the youth's mental health challenges deteriorate into a diagnosable disorder.

Accordingly, CCT proposes the following:

1. Establish a condition-based eligibility category for managed care and specialty mental health services

The EPSDT framework is centered on the principle of early intervention, as evident in the requirement that states provide "early and periodic screening, diagnostic and treatment services," including all "necessary health care…to correct or ameliorate…mental illnesses and conditions" ((42 USC 1396d(r)(1)). Although this federal law entitles youth to care necessary to address a mental health "condition," California has limited this right to children with a mental health diagnosis. Moreover, in order to receive care from a Specialty Mental Health Services provider, that diagnosis must be one the listed SMHS covered diagnoses. These restrictions prevent providers from intervening early, when they have the opportunity to alleviate the effects of stressful circumstances or events that -- if left unaddressed -- are known to increase the likelihood that a child will develop mental health problems.

We know, for example, that Adverse Childhood Experiences (ACEs) correlate with developmental delays, behavior problems, and injuries.[1] The current diagnosis requirements, however, prevent providers from addressing these factors until the youth's mental health has deteriorated to the point of meeting criteria for a mental health disorder. This systemic flaw is particularly evident in the case of children in foster care; even though all foster youth qualify for Medi-Cal -- and have endured significant trauma, such that most need behavioral health interventions -- only about one-half of foster youth receive any Medi-Cal SMHS services.[2]

We applaud California's excellent first step in this direction by providing Medi-Cal coverage for trauma screens such as the Pediatric ACEs and Related Life Events Screener (PEARLS). However, in order to ensure that PEARLS screens will bring tangible benefits to California's youth, DHCS must also ensure providers will be reimbursed for providing follow up assessments and interventions to address the challenges identified by these screenings.

This investment in California's youth will not only alleviate or prevent mental health challenges, but also bring long term cost savings. A joint analysis by the National Academies of Sciences, Engineering and Medicine determined that every **$1 investment** in prevention and early intervention for mental health illness and addiction programs yields **$2 to $10 in savings** in health costs, criminal and juvenile justice costs, and low work productivity.

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[1] Burke NJ, Hellman JL, Scott BG, Weems CF, Carrion VG. The impact of adverse childhood experiences on an urban pediatric population. *Child Abuse Neglect.* 2011; 35:408-413. Jimenez ME, Wade R Jr, Lin Y, Morrow LM, Reichman NE. Adverse experiences in early childhood and kindergarten outcomes. *Pediatrics.* 2016; 137:e20151839. Marie-Mitchell A, Studer KR, O'Connor TG. How knowledge of adverse childhood experiences can help pediatricians prevent mental health problems. *Fam Syst Health.* 2016; 34:128-135.

[2] The California Children's Trust: Reimagining Child Well-Being, November 2018, p. 3.

2. CalAIM's Level of Care tool should establish a clear and standardized pathway from developmental and trauma screenings to further assessment and early intervention.

Currently, managed care plans are responsible for early and periodic screenings. The Social Security Act requires that states establish a periodicity schedule for each screening, and California currently requires that MCPs use Bright Futures.[3] Accordingly, primary care practitioners (PCPs) use standardized developmental and trauma screening tools to identify existing and emerging physical, developmental and psychosocial problems. National associations such as the American Academy of Pediatricians have developed best practice guidelines with timeframes, including but not limited to Brighter Futures. Additional tools, such as the Staying Healthy Assessment (SHA) and the PHQ-A are among those used to determine if further assessment is needed. The PEARLS will be used for developmental trauma screening by pediatricians. The Whole Child Assessment combines both the SHA and ACEs questions in a single questionnaire.

Standardized screening allows practitioners to identify risk factors and indicators of problems associated with future onset of mental health disorders. Early detection provides a critical opportunity to intervene early, before risk factors or symptoms reach a diagnostic threshold.

However, currently there is no standard pathway to ensure that screening results are used to intervene before risk factors and signs of distress become severe problems that interfere with a child's daily life and well-being. For example, although the CALOCUS[4] has been suggested as a Level of Care Assessment tool that might guide providers in assessing levels of impairment and identifying corresponding interventions, this instrument fails to capture nearly all risks of emerging mental health conditions, such as exposure to trauma, and other SDOH. **CCT therefore recommends that, regardless of which Level of Care tool the state adopts, DHCS add an "at risk" level of care that confirms the youth's eligibility for more thorough assessments and early intervention services.** Drug Medi-Cal managed care plans already use this approach when evaluating substance use conditions; the American Society of Addiction Medicine (ASAM) Level of Care tool, which is used by all Drug Medi-Cal ODS plans, includes a "0.5" level of care that identifies youth "at risk" of developing a substance use condition.[5]

We encourage DHCS to create a pathway to early intervention services for youth with signs of an emerging mental health condition or SDOH known to place the youth at risk for a mental health condition. CCT recommends that DHCS form an expert workgroup to develop criteria that qualify youth for a condition-based eligibility category, which entitles them to appropriate follow up assessments and interventions. We recommend that DHCS and the workgroup consider the following:

[3] EPSDT coverage guide, CMS, 2014.

[4] Child and Adolescent Level of Care Utilization System

[5] Individuals qualify for Level 0.5 if they have "problems and risk factors" that appear related to substance use, but who do not meet the diagnostic criteria for a substance use disorder, or for whom there is "not sufficient information to document a substance use disorder". If an individual meets the criteria, they are entitled to "early intervention services", such as individual, group or family counseling.

1) An "Intermediate Risk" Score on an ACEs screen, or referral pathway algorithm using the PEARLS, as was established in the CYW Adverse Childhood Experiences Questionnaire (CYW ACE-Q);
2) A list of ICD-10 T- and Z-codes reflecting exposure to trauma and other SDOH, such as but not limited to child abuse (covered in 16 T-codes), and codes for problems identified by an ACEs screen (e.g. Z59.4 Food insecurity; Z63.0 Domestic violence; Z62.819 History of abuse; Z63.72 FH alcohol/drug abuse; Z81.8 FH mental disorder; Z63.32 Imprisonment).

Finally, **CCT recommends that plans be required to gather data regarding youth who have been identified as at risk of developing a mental health condition and to monitor whether they receive appropriate follow up assessments and interventions. Plan reimbursement should be based in part on a plan's rates of success in ensuring these youth receive appropriate early interventions**.

3. Ensure a broad range of providers beyond primary care are trained and equipped to deliver trauma screening for children

In order to reach children who may not be brought to a pediatrician for a well-child visit or who may exhibit signs of distress only at child care, school or in other areas of life, **we encourage DHCS to expand the providers able to deliver EPSDT-covered trauma screening to early childhood providers such as day-care providers and pre-school and K-12 teachers.** Schools in particular represent one of the most effective opportunities for early detection and intervention at the first sign of struggle. Ensuring that the condition-based eligibility recommendations above are effective at triggering appropriate prevention and early intervention services is predicated on the opportunity to deliver screening, assessment and linkage services in early childcare settings and in schools.

Delivery system reform

CalAIM proposes significant delivery system reforms, which the California Children's Trust is enthusiastic about as it relates to children and youth having greater access to care and an emphasis on early intervention. As DHCS and its stakeholders design the details of this integrated system, we have several high-level recommendations on the structure and important considerations we feel must be included in the implementation phases.

1. There is a fundamental misalignment between the role and function of managed care plans and the intention of the EPSDT entitlement for children

California's managed care delivery system was designed around adult services delivery. With the expansion of Medi-Cal through the Affordable Care Act, it was important to ensure that all adults received access to care, and this model streamlined the delivery system. It also allowed for MCPs to do what they do best – serve those with mild to moderate behavioral health issues – and MHPs to serve the more seriously mentally ill as they have historically done.

The EPSDT eligibility criteria was not considered as MCOs added children and youth into their system. This has led to a lack of available services through MCOs, and as the recent auditors

report indicated, "Despite the importance of these services, the use—or utilization rate—of preventive services by California's children in Medi-Cal has been consistently below 50 percent and is ranked 40th in the country—nearly 10 percentage points below the national average. In addition, despite efforts by the Department of Health Care Services (DHCS)—the state agency tasked with overseeing Medi-Cal—the utilization rate in California has not improved since fiscal year 2013–14."[6]

Given this, if DHCS, through its stakeholder process, determines that MCPs will be the primary entity for care management service provision, we suggest the following structural changes to ensure that all children and youth receive access to care.

- **MCPs must have full access to the EPSDT benefit claiming codes**. Currently, many MCPs cannot utilize the necessary EPSDT claims codes for services outside of individual or group therapy. While the law may require that they provide the services, the mechanisms to claim for them must also be in place.

- **Ensure contracting with community-based organizations (CBOs) that best know and understand the unique landscape of their local community.** In addition to community-based connection and rootedness, any network adequacy requirements put in place for MCPs and MHPs will be most effectively achieved through the use of CBOs.

- **Rate structures must pay the cost of services *and* must take into account the wide range in acuity of need.** There is currently significant discrepancy between payment for Medi-Cal services through an MHP versus an MCP, even when providing the same services for a similar population, which has resulted in most CBOs choosing not to contract with MCP. There is often as much as a $100 an hour difference in what can be claimed for similar services. Add to this that MCPs do not allow billing for transportation, phone calls, or other EPSDT services often claimed through MHP contracts.

- **Clearly articulate, monitor and report on the standards that MCPs must meet in order to for MCPs to provide Enhance Care Management (ECM) in-house.** The proposal (p. 41) does not clearly articulate what this measurement will be, and without this, it is likely that MCPs will attempt to do all ECMs in-house, simply because of the administrative ease.

2. Mental Health Plans face structural and administrative challenges that must be addressed

The alternative of MHPs taking on a much larger number of children and youth to provide less intensive services will have its own challenges. MHPs would need to significantly expand their networks, and the coordination with the MCPs regarding healthcare and behavioral health would be critical, particularly with those children with complex healthcare and behavioral health needs. If the state opts to adopt this approach, we recommend that the following structural considerations:

[6] P. 1, California State Auditors Report, March 2019

- **DHCS must ensure that each MHP is providing/contracting for the full array of EPSDT services, and that access to these services is available based on federal network adequacy requirements.** Standardizing the array of available services across counties - including rural counties who may need to adopt regional solutions to meet the need - is a critical component of ensuring equitable access to care.

- Reduce the administrative burden related to contract providers. In order for the system to be more cost effective and streamlined, and the focus to be on the beneficiaries, DHCS and the MHPs must identify overzealous requirements for CBOs, specifically as it relates to site certification, staff credentialing, and clinical paperwork. CBOs represent a critical part of the behavioral health workforce in California, yet receive lower rates for services and more stringent and onerous administrative requirements than other service providers. **Standardization of administrative requirements must be addressed to ensure network adequacy and the highest quality of care and treatment for Medi-Cal beneficiaries.**

3. A "no wrong door" approach is a step in the right direction but still reflects a fundamentally fragmented system approach for children.

There is confusion throughout the system about whether a child in need of services should be referred to the managed care plan or the county mental health plan. While CalAIM has established the intention that all children and families would receive services through a "no wrong door" approach regardless of which system is ultimately responsible for their care, this does not address the fundamental fragmentation of multiple delivery systems. **The California Children's Trust recommends consideration of a single point of entry rather than "no wrong door,"** which is currently not addressed in the CalAIM proposal despite the state's focus on system integration.

4. Explore a new approach for children's behavioral health: Regional Children's Administrative Organizations

The most significant system reform in services for children and youth is the need to ensure that they receive timely access to services within the robust array that exists, as well as any additional services that are medically necessary. One approach, given both MCP and MHPs need to pay for all EPSDT eligible services, it to design a regional entity, such as an Administrative Services Organization (ASO) for all Medi-Cal-eligible children and youth. This is similar to the model adopted by New Jersey for their children's system of care, which could be piloted in California for foster youth (see below recommendations for the foster care workgroup proposed by DHCS) but would ideally be a system mechanism to better serve all children and youth.

An ASO model would allow children to be seen at a provider service organization, billed to the ASO, and the ASO would be responsible for identifying the payor and claiming for the service. Rejected claims would be reviewed by the ASO, and a determination made regarding next steps (e.g. consult with DHCS on MCP/MHP denial when a child meets EPSDT criteria). Washington state has developed a statewide model for Medicaid funding and distribution that California could use as a model for consideration.

Additionally, these regional entities could provide or contract for the Enhanced Care Management for children and youth. Given the expertise needed to navigate the complexities of children's systems, having these entities provide child-specific ECM would be of significant benefit to children and youth.

Long Term Plan For Foster Youth

The CCT appreciates DHCS' recognition that youth involved in the child welfare system deserve a specially tailored and coordinated system-level approach to ensure access to high quality behavioral health services. We offer the following recommendations to DHCS in its efforts to develop a long-term plan for successfully serving foster youth in California:

1. Ensure cross-sector representation on foster care workgroup and integration with existing efforts

In building a system that effectively serves foster youth, it will be critical that DHCS **include foster youth and resource parents with experience navigating the EPSDT service system in the workgroup. Further, to have an effective process, DHCS must engage CBOs that are providing services to foster youth, particularly those organizations that provide care for youth placed from multiple counties.** This will assist the department in understanding the "on the ground" complexities and roadblocks that exist in working to ensure equitable access to the full EPSDT range of services.

We recommend the inclusion of education stakeholders in the long-term plan for foster care workgroup. As we have frequently observed during state discussions on social services or safety net programs, representatives from the education system are not at the table. The educational needs of foster youth are critical to address, and education is one of the most important (and commonly excluded) partners in this effort. The education sector has not been well-included in the CalAIM process to date and this must be addressed in the foster care workgroup.

Finally, there must be conceptual and operational alignment between the DHCS proposed workgroup and the many other reform efforts underway and workgroups/councils tasked with addressing this issue. For example, the child welfare system is still emerging from the complex multi-year roll-out and implementation of Continuum of Care Reform (CCR) and is currently preparing for the Family First Prevention Services Act (FFPSA) changes soon to come. Without sufficient stakeholder input or effective process, there is legitimate concern that the DHCS-led exploration of this topic will not be closely integrated enough into the landscape of CCR and FFPSA. with current discussion that DSS is having on Continuum of Care Reform (CCR). **We recommend DHCS formally partner with the California Child Welfare Council Behavioral Health Committee to ensure coordination and alignment of recommendations and future policy change.**

2. Foster youth deserve presumptive eligibility for the array of Medi-Cal behavioral health services designed to promote permanency and to reduce isolation.

Youth involved in the child welfare system, or at risk of becoming involved in the child welfare system, should have automatic eligibility for the behavioral health services needed to increase stability, address behavioral challenges, and strengthen permanency and networks of support. The trauma of being separated from their family, in addition to the precipitating factor (abuse or neglect) requires at a minimum an initial assessment to determine the value of providing behavioral health services to address the trauma. Our current system not only makes this difficult to obtain, but due to foster youth often being placed in a different county than their parent, it is often even more difficult to access services across county lines. **Presumptive eligibility would ensure that a full assessment of youth's behavioral health needs would be completed and early intervention provided to alleviate symptoms related to trauma exposure.**

3. Broaden the array of services that system-involved youth (and youth at risk of system-involvement) receive and create a fundamental standard of service access and quality for youth

Foster youth need a comprehensive continuum of services, ranging from outpatient and community-based stabilization services to high-end permanency-focused crisis residential and Short Term Residential Therapeutic Program (STRTP) options. Unfortunately, California is experiencing a dramatic shortage of treatment options for youth with the most complex needs and extraordinary behaviors, as well as an insufficient investment in prevention and early intervention programs for youth at risk of entering the child welfare system. While there are many factors that contribute to this shortage, DHCS has a role to play in bringing MCPs and MHPs to the table to design a system that seamlessly brings together multiple child-serving systems to integrate mental health services into schools and provide unconditional and multi-tiered intensive treatment options for youth.

DHCS should work with stakeholders to identify a clear standard for the range of services that foster youth deserve and accountability mechanisms to ensure this service array exists regionally. The lack of a statewide standard is a barrier to establishing meaningful accountability metrics. This recommendation extends beyond the needs of only foster youth, but could be piloted in any system design effort focused on foster youth. **The foster youth workgroup established by DHCS should be tasked with developing this statewide standard, inclusive of access to services, intensity of services, and quality of services.**

4. Develop strong oversight and accountability mechanisms to promote equitable access and to reduce disparities across counties

DHCS can play a leadership role in developing a robust accountability infrastructure for children's behavioral health through CalAIM, with a focus on continuous quality improvement. This should take the form of standardized data collection, tracking, and performance outcomes tools across the state, so stakeholders can know what services youth are getting, where they are getting them, and what the outcomes are. The current DHCS Performance Outcomes System is not sufficient as it is currently used.

Managed Care Contracts do not have special provisions for meeting the complex care coordination and behavioral health needs of foster youth. **The DHCS workgroup should**

discuss and consider leveraging integration opportunities to create new accountability structures for MCPs and MHPs to better achieve equity and consistency in the service array for foster youth.

Further, DHCS must ensure that the data requested through MHPs and MCPs is the same as what county social services and CDSS are requesting, to avoid duplication for children and families and service providers.

5. Consider piloting a regional administrative services organization model for foster youth that could be applied to broader populations of children and youth if successful

The workgroup established by DHCS should consider a model of care similar to the ASO model outlined above that specifically serves foster youth. There are other models (Inland Empire) and in Washington, New Jersey, and Texas that have focused services specifically for foster youth.

Behavioral Health Payment Reform

The CCT will provide more detailed recommendations regarding behavioral health payment reform before the December 23, 2019 comment deadline. In summary, however, CCT enthusiastically supports CalAIM's proposed move from Certified Public Expenditure (CPE)-based funding to Intergovernmental Transfer (IGT)-based funding. We think it is critical that DHCS explore how the IGT mechanism can be used to leverage federal reimbursement on existing expenditures in other child-serving systems. Critical to addressing the youth mental health crisis is increased funding for mental health and social-emotional supports for children and families in their communities. This means a dramatic increase in the scope and nature of programs available in schools and other child-serving systems.

Further, the switch to IGTs can help the state streamline its currently burdensome billing and documentation requirements. For example, CalAIM could significantly alleviate unwieldy and unproductive administrative requirements by: 1) moving from minute-to-minute billing to bundled payment rates; and 2) requiring all counties to use a standardized set of documentation forms. In addition, provider rates must be sufficiently competitive to attract and retain qualified mental health workers, and to enable those staff to provide all medically necessary services. This is especially true in geographic areas with historically low Medi-Cal penetration rates. We stand ready to work closely with DHCS to develop rates that reflect the true value of the services delivered.

We also encourage DHCS to ensure that new value-based payment systems offer meaningful incentives to provide preventive, early intervention and support services. For example, we applaud DHCS's decision to introduce Medi-Cal-funded trauma screens, and as mentioned above, we encourage DHCS to create payment incentives that will ensure that youth with needs identified by those screens will receive appropriate follow-up care. We will elaborate on these recommendations related to payment reform by 12/23.

General recommendations and comments on CalAIM proposal:

1. Access to the EPSDT benefit must be prioritized across all delivery systems and across all the child-serving systems

Regardless of the ultimate structure of the overall Medi-Cal health and behavioral health systems across the state, it is essential that the state exercise oversight and ensure the accountability of delivery systems to guarantee children's access to the full EPSDT benefit. There is significant variability in the current system not only between MCPs and MHPs, but also across MHPs. Further, EPSDT has not been maximized or fully leveraged across the child-serving systems (e.g. child welfare and education), where significant local and state revenue is currently expended on children's behavioral health services without accessing federal financial participation through EPSDT. A focus on EPSDT -- eliminating barriers and standardizing access -- must be a key commitment in redesigning the system.

2. Establish a children's workgroup for the CalAIM process

Advocates and stakeholders have been recommending a specific workgroup or subcommittee focused on children as part of the CalAIM process since the beginning of the stakeholder process in October. The needs of children and the landscape of the children's systems of care in California are dramatically different than those of adults and the adult systems of care. Further, there are multiple child-serving systems that assume responsibility for the behavioral health needs of children, including the education, child welfare, probation and developmental services systems. Our education partners in particular have not been included in the CalAIM process to date, and yet are a core stakeholder in our collective effort to ensure children receive the services they deserve. Given that children's behavioral health and EPSDT specifically are so critical to the health and wellbeing of our communities, we respectfully request a forum that includes representatives across the child-serving systems be convened to address the implications of CalAIM on children and youth.

3. Oversight and accountability of MCPs and MHPs

Based on feedback from other states that have made the transition to managed care within behavioral health, it is critical that the state develop clear standards for monitoring the practices and outcomes of MCPs and MHPs. In spite of other states (e.g. New York) developing conceptually ideal systems, there remain significant issues with inconsistency of care, continued lack of coordination, and serious issues with claims denials that disrupt the care for all beneficiaries. DHCS will need to have methods for monitoring services and gathering data on access to services for which there are currently no integrated systems.

4. Transparency in, and development of, model state contracts with MCPs and MHPs

Just as DHCS has indicated their interest in stakeholder feedback and engagement, as the detailed elements of rolling out this new delivery system are developed, transparency in the process is critical. Once the larger system structures are put in place, the success of the overall system will be only as good as the contracting, authorization, and claiming processes that exist in the system. Developing consistency between the MCP and MHP contracts will be **essential.** For example, network adequacy standards are not consistent between MCPs and MHPs currently.

5. Ensure that MHSA funds are not used to back-fill gaps in an integrated system

With the flexibility that MCPs will have, and the continued unmet needs that exist in our current system, it will be essential that there be assurances that MHSA funding will not "fill the gaps" when an MCP/MHP does not take responsibility for a clearly needed service or In Lieu of Services. Ideally the access to more flexible services should free up space in full-service partnership programs for those most in need. This will need to be closely monitored through DHCS to observe any significant change in services funded by MHSA.

6. Parity with Commercial Plans

As DHCS takes on the monumental task of changing how Medi-Cal services are provided, it is also critical to ensure that commercials plans are also held responsible for providing adequate services to meet their beneficiaries needs. The larger system cannot be disregarded given the number of individuals that often move between them, and while it is not the purpose of CalAIM to be driving this, it is a critical discussion to be had at the state level across DMHC and DHCS.

Thank you for your consideration of these recommendations and comments, and for your work to improve our state's most important safety net for children and families. We look forward to continuing to stay engaged in the CalAIM process and ensure the final proposal reflects California's commitment to ensuring that young people are given everything they need to grow and thrive.

Sincerely,

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