



December 16, 2019

Secretary Mark Ghaly, MD
California Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, California 95814

Acting Director Richard Figueroa
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, California 95899

Submitted via email to CalAIM@dhcs.ca.gov

Re: Cal AIM Proposal

Dear Acting Director Figueroa and Secretary Ghaly,

Thank you for the opportunity to submit comments on DHCS' CalAIM proposals. The CalAIM project is an impressively ambitious reform proposal that has the potential to make meaningful improvements in the delivery and administration of care for many covered by Medi-Cal. It is our hope that this reform effort will also be able to improve the health care and health of all children and their families served by Medi-Cal.

Our individual organizations will be submitting their own detailed comments in response to specific CalAIM proposals. Collectively, we wanted to share these overarching comments and recommendations relating to children and CalAIM.

Early Childhood Prevention, Intervention and Supports are the ultimate strategy for managing high-need utilization. CalAIM tackles many important issues in access and care coordination for Medi-Cal's various high-risk populations. While this makes sense given these populations' complex needs, CalAIM does not appear to offer much in the way of Medi-Cal reform for the vast majority of beneficiaries who are not high-need users but who may instead be "at risk" and need timely preventive care to quickly identify and address emerging risks.

A core, yet missing, objective of CalAIM in addressing its high-need users should be prevention, interventions and supports early in their lives to mitigate the onset of conditions in the first place. Identifying emerging risks early in a child's life, followed up with appropriate and timely care and support services can set the child's life on a course of health and wellbeing, preventing or

mitigating conditions in adulthood. For example, health systems should proactively nurture healthy relationships and resilience of young children and their families, and identify and address developmental, social-emotional, behavioral and other related issues at the earliest stages, before they spiral into long-term, high-cost needs. A Population Health Management requirement alone is not a sufficient strategy for prioritizing prevention, nor broader longer-term cost savings.

Over the last year, DHCS and this Administration has laid out several important steps– a outreach campaign, adopting the child core set measures, plan guidance on EPSDT, and incentive payments for screenings. However, these will not be enough to shift the trajectory for Medi-Cal children’s care and outcomes. A fundamental reform of Medi-Cal is needed for children’s preventive care and should be a major objective of CalAIM. Below, we have outlined a few core components of such important reforms that should be included in CalAIM and in the re-procurement/contract process: capitation payment restructuring for primary care and full EPSDT utilization accountability; care coordination with communities; and promotion of health-related support services.

Financing: Capitation Payment Structures that Drive Full EPSDT Utilization

Improvements in care management occur when the financing is aligned with those intended objectives and changes. As a result, the most effective tool for directing managed care plans toward emphasizing prevention and full EPSDT utilization is tying those objectives to their capitation payments. In addition to CalAIM financial incentives for Enhanced Care Management, we recommend that DHCS should also restructure the managed care payments to reflect a value-based payment structure, with an emphasis on care coordination and prevention. For example, we submitted a suggested payment structure for Medi-Cal children prior to the release of CalAIM, which includes 1) a “minimum spend” requirement for preventive care under EPSDT (e.g. Bright Futures) with withholds; 2) supplemental payments for incentivizing care coordination and community partnerships; and 3) bonus payments for achieving specified measurable objectives. Given the reported low utilization of Medi-Cal children’s preventive care, an important first step would be to assess the extent to which the current capitation payment actuarially accounts for full EPSDT utilization.

Improving Accountability for EPSDT Behavioral Health Services

We are encouraged by the Department’s proposal to develop a standardized assessment tool to determine a child’s need for mental health services, but would note with concern that the CalAIM document continues to perpetuate by inference an incorrect description of the bifurcation of responsibilities between Medi-Cal managed care plans and county behavioral health plans as it pertains to children. The mild-to-moderate/moderate-to-severe bifurcation of responsibilities is one that applies to *adults*, not children. Federal EPSDT law and state realignment of EPSDT behavioral health responsibilities to counties require that counties provide behavioral health services to children for all of the most common behavioral health diagnoses, if services are necessary to “correct or ameliorate a defect,” regardless of level of severity. We would urge the state to provide clearer, more accurate information to both Medi-Cal managed care plans and county behavioral health plans in order to promote more accountability for care and better access for children. We would also urge enhanced oversight of plans to ensure compliance with federal law in this respect.

Child-Centered Health Homes: Promoting Care Coordination for At Risk Children

Promoting care coordination and supports for at risk children will need more than a health population management tool as proposed in CalAIM. CalAIM should also include a pediatric health home program for all Medi-Cal children, which includes at risk or “rising risk” children, not just the currently proposed populations of high-need users. This child/family-centered model

of care has embedded a sufficient care coordination infrastructure and skill to navigate screening, address social determinants of health, provide family education, coordinate with community partnerships, complete referrals, and provide follow-up. This approach resembles the current Health Homes Program (HHP) model, though a child-specific model would serve the child for a shorter duration and require lower average intensity of support compared to high-utilizers in the existing Health Homes program.

Similar to the current Health Homes Program, MCPs would partner by contract with “community-based care management entities” (CB-CMEs) to deliver specified functionalities such as screenings, family education, referral navigation outside the health sector, and conduct care planning and support functions using paraprofessional/peer models. For example, an MCP could partner with an established Help Me Grow or other practice-levels models that can demonstrate proficiency in the specified functionalities and can provide improvements in screening and referral rates, helping to leverage existing and successful child-centered case management and care coordination models. Both MCPs and participating child-centered health home providers would be accountable for care plan completion, follow up and referral rates.

Measuring Effective Care Coordination

Pivotal to promoting care coordination is measuring it. MCPs’ facility site reviews are not sufficient oversight of care coordination or case management services. First, DHCS should assess the extent to which MCPs are currently providing/covering care coordination for “at risk” and “rising risk” children. Second, we strongly urge DHCS to develop with stakeholders measures with which to track the extent to which appropriate and timely care coordination is occurring and improving, perhaps through proxies such as closed-loop referral rates. In addition, a quantified performance standard for care coordination should be established.

Clarify and Promote Coverage for Health-Related Support Services for Children

As CalAIM strives to integrate and address social determinants of health for Medi-Cal beneficiaries, we would recommend a focus and promotion of health-related support services that are particularly relevant for children. While the proposed ILOS proposed under CalAIM may have value for specific high-needs children, for the most part, support services contingent upon a cost effective criteria will not capture many of those services of particular value for children. Moreover, many health-related support services are likely covered under the EPSDT benefit but plans and providers might not be aware of their coverage under Medi-Cal. For that reason, we recommend that DHCS provide guidance to plan and providers about the types of health-related support services with community partners that could be included in the EPSDT benefit, such as dyadic care, parenting class and peer-to-peer support for young children’s caregivers; medical legal partnerships; community navigators, home visiting, and health education from community health workers. In addition, we would recommend encouraging MCPs to provide additional health-related support services for children through the re-procurement process, whereby plans that provide value-added services for children are given higher ratings.

Integrate Care Provided to Medi-Cal Children Outside of Clinical Settings

As CalAIM proposes to centralize and coordinate care for Medi-Cal beneficiaries through their MCPs, thoughtful consideration must be paid to the varying and child-specific non-clinical settings in which care is currently provided children, such as schools, regional centers, homes and early learning centers. Consolidation of care under MCPs should not disrupt these effective modes of delivery of care but instead support and integrate them for families. Moreover, Medicaid financing offers the opportunity to provide sustainable funding for many of these social and health-related support services being performed by schools and other local child-centered agencies. We recommend that the Department incorporate payment reform for child-serving

entities and local child-centered organizations and collaboratives, such as schools and early childhood systems, similar to the payment strategies that CalAIM intends to develop for county mental health departments. In addition, consider and cultivate ways to maximize revenue for care provided in local non-clinical settings, and make it clear to providers how to claim that revenue. California can learn from Medicaid models in Oregon and New York, that integrate financing and objectives across education, early intervention, and Medicaid.

Support Existing Care Management Models for Children with Medical Complexity

The Department proposes to provide an enhanced care management benefit, operated through Medi-Cal managed care plans, for children with medical complexity. While we are supportive of providing enhanced supports to children with complex medical needs, we would note that those benefits have typically been provided through the California Children's Services (CCS) Program. In fact, we would note that the CCS Program was established specifically to provide additional support to children with medical complexity, and care management is a central component of the program. These services are typically provided through county CCS programs and CCS-designated special care centers that have expertise in managing these particular populations. It is unclear to us how an enhanced care management benefit provided through managed care plans would fit with the CCS model, and we are concerned that the benefit would be at best duplicative and at worst serve to undermine the CCS Program.

Create an Ongoing Children's System of Care Workgroup/Forum

As you have heard from several stakeholders in the CalAIM public review process, children's systems of care are distinctly unique from adult systems of care and warrant particular attention paid to how the CalAIM proposals will affect them. We again recommend that a specific workgroup or forum be granted to assess and discuss the specific implications of the CalAIM proposals on children's systems of care. While DHCS intends to present its CalAIM package to the Medi-Cal Children's Health Advisory Panel in January, we would respectfully request an analysis of CalAIM and the underlying Medi-Cal payment structure and their impact specifically on children and their systems of care. We would value discussing this analysis in a forum in which all child-related stakeholders could participate.

We look forward to continuing to work with you on improving the healthy development and well-being of Medi-Cal's children.

Sincerely,

American Academy of Pediatrics-CA
California Children's Hospital Association
California Children's Trust
Children's Defense Fund-CA
Children's Specialty Care Coalition
Center for the Study of Social Policy
The Children's Partnership
United Ways of California