



July 1, 2021

Delivered via email: CSBRFP8@dhcs.ca.gov

RE: Draft Request For Proposal #20-10029, Medi-Cal Managed Care Plans

To Whom It May Concern:

Our organizations are writing in response to the Draft Request for Proposal (RFP) #20-10029 on Medi-Cal Managed Care Plans released for comment by the Department of Health Care Services. As organizations interested in the health and well-being of all children and youth enrolled in Medi-Cal, we appreciate the many ways in which the Department and this Administration has signaled its commitment to the well-being of children and to reducing health disparities among children of color, which can last a lifetime. In this regard, we support the Department's overall shift towards health equity and the emphasis on population health in Medi-Cal. However, we are concerned that the draft RFP and model contract as proposed do not reflect the necessary accountability strategies to effectively change course on current poor performance of Medi-Cal managed care plans as it relates to child health and does not establish criteria and requirements for plans to demonstrate continued progress in narrowing the equity gap. This is a pivotal moment for the Medi-Cal program to shift practices to more effectively serve the vulnerable children enrolled in Medi-Cal, and we encourage the Department to boldly

use this opportunity to make its stated commitment to improved outcomes for children and health equity a reality.

Evidence is overwhelming that early investments in child health pay lifelong dividends for children, their families and their communities. In a state where nearly half of all children are enrolled in Medi-Cal managed care, such evidence-based investments can be cost-effective and transformative. Yet, despite the potential payoff, Medi-Cal managed care plans have consistently fallen short where children are concerned. Data and studies over the past several years shows that Medi-Cal managed care plans have a poor track record of meeting the health needs of children, particularly children of color. **This RFP provides an opportunity for the state to rectify years of poor performance on care for children by making children a priority in every aspect of the bidding and contracting process.** We stand ready to offer our partnership and expertise to the Department as it develops the final versions of these documents.

We recommend that to address these long-standing performance problems in the Medi-Cal managed care program, the Department:

- (1) Select plans through the RFP process that have a demonstrated commitment to improving maternal and child health outcomes and an ability to serve children effectively;
- (2) Strengthen proposed Managed Care Plan (MCP) contracts as it relates to maternal and child health; and
- (3) Enforce its contractual requirements with MCPs in order to make these requirements meaningful to the experience of children and families.

This letter provides our specific recommendations in the first two of these three areas, in response to the Department's request for comment on its draft RFP and the MCP contract language embedded therein.

RFP Must Reward Plans with Demonstrated Track Record in Maternal & Child Health

Over the past several years, the Department has made a number of policy decisions that clearly prioritize maternal and pediatric care, with a particular focus on early childhood health. The extension of maternal postpartum coverage for 12 months and new dyadic care and doula benefits for Medi-Cal beneficiaries are just some examples of the Department's commitment to improve the Medi-Cal delivery system for children and families. We applaud the Department's efforts in this regard and believe that the next challenge will be to ensure that this same level of priority is embedded into the Medi-Cal managed care procurement process and contracts. Recent reports regarding MCPs' performance on children's Quality Performance Measures illustrate the significant gap between DHCS expectations and plan performance. To address this gap, we recommend that the RFP prioritize and reward historical plan performance and demonstrated commitment to positively impacting the lives of children and families. Specifically, in response to the draft "RFP Main" document, we recommend that the Department:

- **Assign points commensurate with the priority on children’s health.** Children are the only population specifically listed among the five “demonstrated abilities” that the Department lists on page 11 of the draft RFP. To make this concrete, we recommend that the Department weight the RFP scoring so that it specifically recognizes health plans that have a demonstrable track record of making child health a priority.
- **Score plans based on prior performance on commonly reported child health metrics and/or demonstrated commitment to investments in child health.** We recommend that DHCS consider prior plan performance either in California or in prior geographic service areas on specific metrics of improving children’s health outcomes. This could include:
 - Past plan performance on key quality metrics that the Administration has prioritized, such as well-child visits in first 15 months, developmental screenings, or depression-screenings and care plans.
 - A history of plan utilization of existing DHCS incentive programs, such as the extent to which the plan’s provider network availed itself of Prop 56 payments for developmental screenings and/or ACEs screenings.
 - MCP specific efforts to reduce health disparities and past compliance with EPSDT preventive care and social investments in children’s health, including care coordination.
- **Score plans based on their investments in maternal, perinatal, and infant health (Section R(3)(f)(1)).** We recommend that the Department require plans to describe how they will better provide comprehensive services for at-risk populations, including leveraging evidence-based home visiting and dyadic care programs that serve pregnant and parenting foster youth, pregnant and parenting families participating in both Medi-Cal and CalWORKs, and other families who could benefit.
- **Require plans to disclose past or pending performance problems related to child health (Section R(3)(f)(4)).** This could include sanctions, warning letters, or liquidated damages within California markets or in other states.

Medi-Cal Managed Care Contracts Must Require Plans to Do Better for Children

Consistent with the comments we provided to the Department in fall 2020, we recommend that the State strengthen its existing contract language in order to hold managed care plans accountable for ensuring that children receive critical, cost-effective preventive services, obtain needed care coordination, and ultimately achieve better health outcomes. Specifically, we recommend the following to the Department on the draft MCP contract:

- **Payment to MCPs should more explicitly tie reimbursement to performance.** (*Exhibit A, Section 1.2.5 and Exhibit B, Section 1.5 and 1.8*). The state must ensure value and accountability for the monthly payments paid to MCPs for the important responsibilities in the Medi-Cal managed care contracts. We recommend that the Department do this

by revising the rate development process to integrate investments in children into plan reimbursement. Examples of such an approach could include:

- An explicit care coordination payment, potentially adjusted by risk or health of the child population that reflects the need to ensure managed care plan responsibility for coordinating timely access to prescribed medical and non-medical services provided by county mental health plans, dental providers, Regional Centers, school districts, and other support agencies and organizations. Notably, MCP care coordination, including basic care coordination, has been lacking despite the current contractual care coordination requirement. By paying explicitly for this as a category of services, the Department will increase the likelihood that plans make these important investments.
 - A Medical Loss Ratio requirement applied specifically to the Medi-Cal child population capitation rate, that includes a “minimum spend” MCP child capitation requirement for pediatric primary care medical spending, and a formula that better reflects full EPSDT utilization (not historical *underutilization*). Any undistributed payments as a result of the minimum spend requirement would go into a children's health incentive pool.
 - A child health performance bonus incentive opportunity, which should be made available after demonstrating year over year performance improvement on select child health indicators such as Bright Futures metrics and referral rates to EPSDT services, increased utilization of mental and behavioral health services, reductions in racial/ethnic disparities, and/or investments in social service supports.
 - Requirements that MCPs pay child-serving providers in their network sufficient rates, which should be at least comparable to Medicare rates. This rate floor is a key tool to improving access to pediatric care.
- **Prioritize children by requiring plans to address child health specifically within their Population Health Management and Quality Improvement Plans** (*Exhibit A, Attachment III, Sections 2.2.9, 4.3.4, Section 4.3.5*). Given that the Department has identified children as one the critical “demonstrated priorities” in the RFP, we recommend requiring plans to develop population health management strategies that are specifically tailored to children: DHCS should require plans to develop a Child Quality Improvement Plan, which would improve care at each stage of a child’s life and could address long-standing issues of concern, such as health disparities, or preventive screenings. Finally, the contract language should reflect the Administration’s stated intention to hold health plans accountable to benchmarks on the Children’s Preventive Services Report measures and be updated to accurately reflect the current policy (in APL 19-017) that all plans are expected to perform *at least* at the upper half (or 50th

percentile) of plans nationwide for Managed Care Accountability Set (MCAS) measures, and specify the means by which plans will be held financially or otherwise accountable.

- **Clarify responsibility for coordination of health-related support services for children** (*Exhibit A, Attachment III, Sections 4.3.5, 4.3.6, 4.3.10, and 5.3.4*). We recommend that the contract include language that specifically requires the promotion of health-related support services that are particularly relevant for children. In particular we recommend that:
 - The contract more explicitly addresses how MCPs will demonstrate that they are providing Basic Case Management (including all wellness and preventive services and screenings) to all children and coordinating care for all services for children under 21, including coordinating access and follow up to behavioral health, dental care, and other services related to social determinants of health.
 - The contract outlines how MCPs should incorporate the new telehealth, dyadic care, doula benefits, and community health worker services into their responsibilities and their work with contracted clinics and providers through policies, procedures, and training.
 - The contract requires plans to ensure providers who serve children complete ACEs training and conduct ACEs screenings and referrals, in order to realize the state's goal of reducing ACEs by half in a generation.
 - The contract delineates how coordination with the CCS program should occur in Whole Child Model and non-Whole Child Model counties.
 - The contract provides examples of EPSDT case management services and supports. Many plans and providers may still lack awareness of the full benefits that can be covered via EPSDT. For that reason, we recommend that DHCS clarify in contracts the types of health-related support services with community partners that could be included in the EPSDT benefit and, thus, should be covered, such as parenting classes and peer-to-peer support for young children's caregivers; medical legal partnerships; community navigators, home visiting, and health education from community health workers and promotores.

- **Require plans to regularly report progress on reducing child and maternal health disparities** (*Exhibit A, Attachment III, Sections 4.3.3 and 2.2.7*). We recommend that DHCS require plans to publicly report their Population Needs Assessments (PNAs), identifying where the greatest inequities exist, and expanding the collection, public reporting, and analysis of standardized utilization and performance measure data to regularly include race, ethnicity, language, sexual orientation, gender identity, and disability status, along with more granular age breakouts in data for children under 18 (such as young children under 5, children 6-12, and teenagers). MCPs should be required to report how they will use this data to reduce child and maternal health disparities. In addition, plans should be required to engage community organizations in addition to local agencies in the development of their PNA and PNA-related strategies. DHCS should also require Quality Improvement and Health Equity Annual Reports to contain a specific children's component and to be publicly posted.

- **Strengthen community engagement and the representation of children and youth** (*Exhibit A, Attachment III, Sections 1.1.10, 2.2, and 5.2.11*). We appreciate the list of required MOUs with third-party entities and county programs to ensure care coordination for members outlined in the draft contract. Communities can and should help guide health equity goals and activities, so we recommend additional opportunities to bring in Medi-Cal members and other community stakeholders. For example, community engagement should be strengthened further through more representation of expectant parents and parents, caregivers, and youth populations in the membership of Community Advisory Committees and the addition of consumer participation and transparency for the new Quality Improvement and Health Equity Committee (QIHEC) requirement. Finally, early childhood organizations that address the holistic needs of children ages 0 to 5 are critical community partners in children’s health and should be named as key stakeholders with whom MCPs should establish formal agreements.
- **Clarify a diagnosis is not needed for children to receive physical or behavioral health services.** The RFP and contract should make clear a diagnosis is not required in order for a child to receive services, regardless of whether services are provided by a County Mental Health Plan or an MCP. The Department should amend the Medical Necessity Definition (*Exhibit A, Attachment I*) to reflect this and also reinforce in multiple places in *Exhibit A, Attachment III* including Section 5.3.4. Services for members less than 21 years of age.
- **Require plans to have robust outreach to and engagement with parents and caregivers of children and youth to ensure awareness of the vast array of services guaranteed under EPSDT** (*Exhibit A, Attachment III, Section 5.1.3*). The contract should require plans to identify enrollees who have not used the preventive health services they are entitled to facilitate outreach with a focus on targeted engagement that is culturally appropriate.

Address Gaps in the Draft Documents. Finally, we note that the draft is missing a number of critically important components, without which it is hard to fully evaluate the overall effort. In particular, we would note that the draft documents make little mention of CalAIM, making it difficult to understand how aspects of the Department’s highest priority initiative will be embedded into new contracts going forward. Similarly, the draft does not incorporate important proposals that are included in the Governor’s budget, such as the new access to dyadic services, doula care benefit, population health management service platform, and community health workers. Finally, the draft does not include detail on the scoring criteria that the Department will use to evaluate potential bidders. **Given these omissions, we request that the Department issue new drafts with these critical elements for public review and comment as well as the revised RFP that incorporates any stakeholder comments from this current comment period.**

Thank you for the opportunity to provide comments on the draft RFP and contract language. We urge you to adopt the above recommendations so that the Medi-Cal managed care program can be held accountable for ensuring that every enrolled child receives appropriate physical, behavioral, and oral health care at the right time in the right place. We welcome the opportunity to discuss these recommendations and stand ready to work with you to achieve our joint goals of improving care for children.

Sincerely,

American Academy of Pediatrics, California
California Children's Trust
California Children's Hospital Association
California Medical Association
Children Now
Children's Defense Fund-California
Children's Specialty Care Coalition
First 5 Association of California
First 5 California
National Center for Youth Law
The Children's Partnership
United Ways of California