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Submitted via email to CSBRFP8@dhcs.ca.gov

Subject line: **Draft Request For Proposal #20-10029, Medi-Cal Managed Care Plans**

Dear Director Lightbourne:

The California Alliance of Child and Family Services (Alliance), The Children's Partnership (TCP), and the California Children's Trust (CCT) are pleased to submit comments in response to the Draft Request For Proposal #20-10029, Medi-Cal Managed Care Plans led by the Department of Health Care Services (DHCS). Our organizations are committed to improving the lives of children and we submit these comments with a focus on the mental health and well being of children and youth in the Medi-Cal program.

We appreciate the ways in which the state has signaled its commitment to the mental health and well-being of vulnerable children, as evidenced in the governor's budget and approved Trailer Bill Language, both of which begin to respond to the youth mental health crisis gripping our state. In particular, the budget centers both schools (as the sites where most children can be reached) and MCPs (as the payors) in reimagining our youth mental health system. And given our state ranks 44th in the nation in access to behavioral health care among children in Medi-Cal—81% of whom are Black or brown—this is long overdue.

However, we are concerned that the incomplete 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 children's mental health and does not establish criteria and requirements for plans to demonstrate continued progress in narrowing the equity gap.

In addition, DHCS is still working on critical aspects of the RFP including Narrative Proposal Requirements, Evaluation and Selection, and Evaluation Questions. With these sections missing, an honorable review of the draft is not possible. Because of this and the fact that the draft does not mention important new budget and TBL proposals

related to the central role of schools in addressing youth mental health for our state's most vulnerable youth, we request that the Department issue new RFP drafts for public review in advance of issuing a final RFP.

Our comments are provided through the lens of youth mental health in Medi-Cal and center on the following themes:

- Access to mental health services
- Addressing disparities
- Child-specific population health management strategies
- Rates
- Provider class
- Connection to other Administration's priorities for children's behavioral health
- Accountability in delivering required care coordination services
- Community engagement and youth representation
- Accountability
- Additional stakeholder review of missing documents

Our detailed comments are outlined below:

Make clear a diagnosis is not needed for children to receive behavioral health services. We know that experiences of racism can be both subtle and systemic in our overall system of care for families and children. We believe that each family and child is the expert in their own experiences and should be able to determine whether their experiences rise to the level of needing support. The RFP and contract should make clear that a diagnosis is not required in order for a child to receive services. 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.

Require health plans to be held accountable for reducing mental and behavioral health disparities in outcomes and service utilization among children and youth. While we appreciate the language in the RFP that holds plans accountable for improving quality and reducing disparities, behavioral health and children need to be explicitly included in plan performance outcomes. Recent reports regarding MCPs' performance on children's Quality Performance Measures and the 2020 Preventive Services Report illustrate the significant gap between DHCS expectations and plan performance. The behavioral health benefit is largely unutilized by children and youth (as evidenced by a Commonwealth Fund report setting California at 48th in the nation in unmet children's mental health need). Plans should be required to demonstrate how they are informing their providers and beneficiaries of behavioral health benefits for children and sufficiently publicizing their behavioral health provider network in effective and accessible ways (including in Non-English languages and in physical locations for beneficiaries who lack online access). The RFP should require plans to increase preventive and treatment service utilization by children and historically marginalized groups such as BIPOC and LGBTQ+ (including rates of depression screenings and associated care plans), but also require plans to track, report, and meet outcomes

standards at population levels, delineated by age and race. These outcomes should explicitly include metrics specific to children and youth, such as suicide, other risk behaviors, and positive relationships with family and peers.

Population Health Management and Quality Improvement Plans Must Include Children’s Mental and Behavioral Health Outcomes and Strategies (*Exhibit A, Attachment III, Sections 2.2.9, 4.3.4, Section 4.3.5*). Given that the Department has identified children as one of the critical “demonstrated priorities” in the RFP, plans should be required to develop population health management strategies that are specifically tailored to children, including specific language in the requirements around children’s mental health. We recommend that DHCS 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 mental and behavioral health outcome disparities, or uptake and utilization rates of preventive screenings among providers. These Child Quality Improvement Plans should be explicit about the evidence-based and community-defined public health approaches to mental health prevention and early intervention that MCP’s will utilize to achieve child well-being across the age continuum, such as broad deployment of community health workers in schools. These plans should also include universal strategies and systemic interventions, such as universal Adverse Childhood Experiences screenings or classroom-based early childhood mental health consultations, which are not tied to a particular child’s needs or benefits but rather support a community of Medicaid-eligible children, their peers, their providers, and their caregivers as a unit whose community health and wellness necessarily improves the well-being of individual child beneficiaries.

There must be requirements that MCPs pay child-serving providers in their network sufficient rates and reflect the level of care associated with specific populations served under the contract. Rates should be comparable to (and shall never be less than) Medi-Cal Specialty Mental Health Services rates for commensurate services (e.g, individual and family therapy). It should be the intent of this RFP to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

Expand Eligible Provider Class for Reimbursement. DHCS should make it clear that clinical trainees under supervision should also be credentialed under MCPs just as they are for specialty mental health. Medi-Cal Update, Psychological Services, August 2016, Bulletin 491 allows for this. DHCS should also expand eligible providers to include non-clinical workers who are closest in proximity to children and families with least access to traditional services and are more reflective of member’s racial/ethnic, socioeconomic, cultural, and language backgrounds. Many of the health issues and care coordination California’s children and adolescents face (particularly mental health issues) cannot be addressed solely in clinical settings, and instead require a wraparound set of services and supports at home, school, and in the community -- all of which need to be adequately coordinated and reimbursed. These providers would include appropriately trained and culturally relevant Community Health Outreach Workers, Promotoras, Peer Counselors and Peer Support Specialists, Rehab Specialists, Health Advocates, and

the new Behavioral Health Coaches proposal in the Children and Youth Behavioral Health Initiative. MCPs will need culturally-appropriate training to support these service providers outside of the medical setting. DHCS should require MCPs to make non-clinical supports available in their network to beneficiaries. In addition, contracts should clarify reimbursement guidelines for schools and community-based organizations to provide telehealth services, via video and text for children and families who face barriers to accessing care in traditional settings. Even more fundamental to clarifying Medi-Cal claim procedures is to alert and educate providers, MCPs and beneficiaries that Medi-Cal covers services provided in these settings.

The RFP must include more detail on the recent Youth Behavioral Health Initiative including the role of schools and their relationship to MCPs. Schools are evolving into an essential part of the healthcare system, as evidenced in the governor's budget and approved Trailer Bill Language, both of which begin to respond to the youth mental health crisis gripping our state. In spite of this, the RFI has scant mention of schools (none whatsoever in the Main RFP document), there is no mention of the new role schools will play in partnership with MCPs and nothing in the RFP about contracting and who pays for what in providing school-based mental health services at the scale currently envisioned. This must be included in the final RFP if the state is to assess bidders appropriately.

The RFP references requirements for MCOs to have MOUs with LEAs for care coordination purposes for students with IEPs (Exhibit A, Att III Section 4.3.12 / Page 126 of 256 and Section 5.6.1 - page 227 of 256). Care Coordination is a covered benefit for MCO beneficiaries regardless of the IDEA status and the proposed contract language does not have adequate accountability measures to ensure compliance.

Finally, MCPs are required to have LEAs represented on their Community Advisory Committees and Governing Boards (which is good), but this requirement must extend to students and youth as they are the most impacted and also the most outspoken about the need to improve services to address their mental health and well being.

Clarify and Uphold Responsibility for Care Coordination for All Children in Medi-Cal (*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 and MCP accountability mechanisms that are particularly relevant for children's mental health as outlined below:

- *Clarify and specify existing MCP care coordination responsibilities, including defining standards for protocols for providers and child-serving systems such as schools, early care and education settings, and Regional Centers.*
- *Create effective care coordination MCP performance measures to reflect EPSDT requirements, including measurable and meaningful access to support services for social determinants of health. These performance measures, as with other*

preventive care performance measures, should be tied to MCP capitation payments.

- *Make care coordination a distinct category of service for purposes of Medi-Cal rate setting.*
- *Provide an explicit care coordination payment to ensure MCP compliance in coordinating timely access to prescribed medical and non-medical services provided by county mental and dental health plans, Regional Centers, school districts, and other support agencies.*
- *Provide care coordination infrastructure investments for all tiers and categories of care coordination/case management, including basic care coordination, not just investments in the newly proposed enhanced case management for only specified complex health conditions with high utilization or for “at risk” children and youth.*
- *Require MCPs to initiate EPSDT care coordination services immediately after a suspected illness, condition, or risk is detected during a required EPSDT screening, including from an SDOH or trauma screening (instead of waiting to engage after a child is already receiving treatment at either a carved-out or in-network provider).*
- *Require MCPs to Include the community health workforce in care coordination or partner with community based organizations who employ community health workers to ensure children and families are not just screened but actually access and utilize the health, mental health, and social services to which they are referred.*

Strengthen community engagement and youth representation (*Exhibit A, Attachment III, Sections 1.1.10, 2.2, and 5.2.11*). Community engagement should further be strengthened through more representation of child 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. Youth themselves as Medi-Cal members should be identified representatives in plan advisory committees and governing boards and other areas with member representation. They should not be token members, they should be compensated for their wisdom and time and their voices and recommendations should be reflected in action.

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 capitation withholds or 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*) and/or a child health performance bonus incentive opportunity.

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, DHCS is still working on critical aspects of the RFP including Narrative Proposal Requirements, Evaluation and Selection, and Evaluation Questions which have not yet been released. 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. We would also 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 population health management service platform, telemental health and managed care school mental health and other components of the Youth Behavioral Health Initiative. 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 for public review that incorporate stakeholder comments as well as these critical elements.**

Thank you for the opportunity to provide comments on the draft RFP and contract language. We hope the Department will seek additional stakeholder feedback on a more complete draft that reflects these and other stakeholder recommendations. Reprocurement represents the single most important opportunity to begin to truly reduce health disparities and improve mental health for millions of Californians who rely on Medi-Cal.

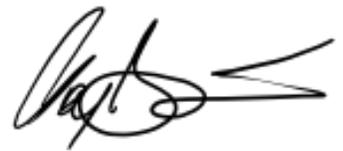
Sincerely,



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Services



Mayra E. Alvarez
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