September 16, 2019

To: DHCS CalAIM Staff

From: American Academy of Pediatricians – California, Breaking Barriers, California Children's Hospital Association, California Children's Trust, Center for the Study of Social Policy, Center for Youth Wellness, Children's Defense Fund—California, Children Now, Children's Specialty Care Coalition, First 5 Association, First 5 Center for Children's Policy, First 5 LA, San Diego State University Social Policy Institute, The Children's Partnership, United Ways of California

Re: Children's Health Proposals for inclusion in DHCS's CalAIM Proposal

We appreciate the opportunity to weigh in on the Department's upcoming CalAIM proposal. The organizations represented here encourage the Department to consider holistic approaches to caring for the specific needs of children and their families, and to fully achieve the responsibilities of the Medicaid Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit to proactively promote healthy growth and development, and to identify and address child health concerns as early as possible. Building on state budget proposals promoting screenings and the recently released All Plan Letter (APL) on EPSDT, which emphasizes the critical role of care management, we are proposing five interrelated practice improvement and modernization initiatives for California to ensure success for children. Our recommendations are grounded in the following problems we observe in California's current system of care for children and families:

- **Too many young children are not being adequately or appropriately served by Medi-Cal and the health care system.** Many Medi-Cal children are not receiving basic primary care or referrals to needed services. While there is a growing body of scientific

evidence affirming the importance of the earliest years for setting the foundations of lifelong health, learning and well-being, many families with young children are facing tremendous adversity. Research shows that providing families with information, services and supports positively impacts children in reaching their optimal health and development. 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. Because social emotional factors greatly contribute to children's health, it is critical that children are routed to timely and appropriate interventions so social-emotional problems do not adversely impact their functioning, development and school readiness.

- **California's children and adolescents are experiencing unprecedented, crisis levels of mental, behavioral, social-emotional and relational health issues.** According to the California Healthy Kids Survey, self-reported mental health needs have increased 61% since 2005. Hospitalizations for suicidal thoughts and attempts have gone up 104% over the past decade and intentional self-injury rates have doubled. Nationally, suicide is now one of the leading causes of death for children, outpacing cancer and car accidents. On average, there is a 10-year delay between the onset of children's mental health symptoms and any kind of intervention. Across all insurance types, more than 65% of children with a major depressive episode do not receive any help at all. Additionally, access rates as measured by the percentage of eligible children receiving even one service are declining, with less than 5% of the 6 million children in Medi-Cal receiving any service at all; only 3% are in ongoing care as measured by 5 or more services a year.

  Many of the health issues California's children and adolescents face **cannot be addressed solely in clinical settings, and instead require a wraparound set of services** and supports at home, school, and in the community. Improving health disparities and equity issues necessitates coupling pediatric care with social and emotional supports. Addressing the social determinants of health in communities and families is critical to ensuring their health and wellbeing. **It is imperative that Medi-Cal managed care health plans (MCPs), Mental Health Plans (MHPs), and their providers have the flexibility to incorporate a broad array of support services into care**. This is particularly apparent for those with multifaceted needs, but equally important when issues are diagnosed early. Some of the sources of trauma and behavioral concerns are more appropriately addressed at their source. For example, the current toxic immigration environment is wreaking havoc on children in immigrant families and medical-legal partnerships (MLPs) can go a long way to help; children in immigrant families, in particular, need a coordinated and collaborative set of services and supports.

- **California's continually low EPSDT screening and service rates suggest that many pediatric primary health care providers in the safety net need to modernize** infrastructure, workforce, and workflow to provide timely access to high-quality integrated care to young children. These demands are execerbated by the State's complex array of multiple and varying payers and accountability standards that providers must navigate in delivering the full range of EPSDT services to Medi-Cal children.

- **California ranks poorly in relation to other states when it comes to funding Medicaid**. For example, California ranks 28th in the country for the estimated percent of children with a serious emotional disturbance but 43rd for Medicaid spending per student for school-based physical and mental health services.

- **Just 32 percent of parents reported that their child had received a developmental screen in the past year**, according to a 2017 survey. This ranks California 43rd in the nation for children receiving developmental screens. According to a March 2019 report from the State Auditor, the Department of Health Care Services "has not been able to make demonstrable progress in the use of Bright Futures services, including developmental screenings." The greatest need for improved developmental screening is in communities of color. Treated early, children can recover from missed developmental milestones in some cases, attain needed skills, and improve their lifelong development.

- **DHCS has not provided sufficient oversight or enforcement to ensure that Medi-Cal managed care plans, County Mental Health Plans, and providers are providing the full range of services required under the EPSDT benefit**, based on several recent State Auditor reports on Medi-Cal, With 90% of Medi-Cal children participating in managed care, contracted managed care arrangements are the linchpin for effectuating the State's responsibility to ensure children receive legally mandated services. DHCS recently released an All Plan Letter related to EPSDT responsibilities, including the MCPs' requirement to coordinate referrals to and care between several critical entities. Currently, there is little oversight or indication that this referral coordination is occurring, and significant change is needed to ensure plans and their providers can support timely access to and the provision of EPSDT services for children, as required by federal law. DHCS must ensure that the Medi-Cal system is adequately financed to meet this mandate.

The following proposed recommendations address children's developmental and social-emotional health, and construct through Medi-Cal the system level and provider level infrastructure required to coordinate and support timely access to quality services associated with improved child well-being. Pivotal to these proposals is a foundation of solid program oversight, data monitoring and accountability from Medi-Cal, particularly in relation to its managed care contracts. DHCS has begun to take steps to improve upon its oversight and quality monitoring, much of which are works in progress, such as the new performance standards based on several Child Core Set measures, more frequent Health Disparities Reports, a design for MCPs' Population Needs Assessments (PNAs), and the plan for creating a regular Preventive Care Utilization Report. Implementation of these and other quality and accountability efforts are needed to lay the groundwork for restructuring initiatives. First and foremost, MCP/MHPs and their contracts must reflect a clear understanding and effective execution of the EPSDT responsibilities for any child-centered CalAIM proposal to be effective.

These proposals do *not require federal 1115 waiver authority* to implement but rather existing Medicaid financing and delivery authority would apply.

1. Establish a Statewide Pediatric Practice Improvement Network (PIN) to Accelerate EPSDT Practice Transformation and Modernize Infrastructure

California should launch a Statewide Pediatric Practice Improvement Network (PIN) to bolster provider practice infrastructure and workflow toward improving EPSDT screening, care

coordination, and outcomes, and to ensure promising county-level practices can be scaled throughout the Medi-Cal program. As an example of successful practice improvement efforts in California, CHOC Children's Hospital and Rady Children's Hospital Foundation partnered with LA Care and Pacific Business Group on Health to host a California Transformation Summit, sharing results from the past four years of several transformation practices, amounting to the largest quality improvement exchange in the state. To manage the proposed statewide Pediatric PIN, DHCS should select a qualified technical assistance provider and partner with any existing pediatric PIN efforts already underway. Oregon's Medicaid program had success in bolstering developmental screening and referral rates through a similar practice improvement network, which offered concrete technical assistance, created uniform referral forms, and offered quality improvement support.

The PIN could accompany a requirement to complete multiple Performance Improvement Plans (PIP) for specified pediatric or maternal measures, such as developmental or depression screenings, referral and linkage, and should not be limited to current HEDIS or External Accountability Set (EAS) metrics. MCPs should be required to engage in at least two child-focused PIPs to improve care for both younger children and school-aged children and address chronically low performance in delivering and coordinating care.

- One PIP requirement could be focused on early detection and primary prevention for the youngest children during the critical first three years, when early interventions can have the greatest impact. The aim of this PIP would be to increase the percent of young children receiving routine screenings, linkages, and referral, and decrease wait times for appropriate services for young children with or at risk of developmental or social/emotional delays, or other poor health outcomes. Of special concern is the coordination of services with Regional Centers and required referrals to appropriate community resources and other agencies.[1]
- Another PIP requirement for both MCPs and MHPs could focus on referral and follow-up care coordination for children receiving specialty mental health services and/or special education, which could help connect or leverage to Mental Health Services Act (MHSA)-funded services like Parent Child Interaction Therapy, Early Childhood Mental Health services, and County Mental Health Plans. One goal of this project would be to track referrals to and improve beneficiary wait times from a primary care referral to specialty mental health services and the initiation of those services for school-aged children and adolescents.

This PIN can also include exploration and investment in statewide tele-consult models that enable behavioral health providers to partner with primary care providers to appropriately provide specialty expertise and to do so in community settings. These models should build off best practice models used in other States.[2]

2. Establish a family-centered Child Population Health Model, which leverages lessons from current DHCS initiatives, such as Whole Person Care and Health Homes.
A Child Population Health Model would necessitate that child-centered health care practices and systems are embedded with sufficient care coordination infrastructure and skill to navigate screening, address social determinants of health, provide family education, complete referrals, and provide follow-up. This approach resembles the current Health Homes Program (HHP)

[1] All Plan Letter 19-010, pg 7. www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf
[2] Examples include the Massachusetts Child Psychiatry Access Program (MCPAP), a system of regional children's behavioral telehealth consultation teams designed to help primary care providers and their practices, or Project ECHO, which links expert multidisciplinary specialist teams at an academic "hub" with primary care clinicians in local communities - the "spokes" of the model.

model, though a child-specific model would serve the child for a shorter duration and require lower average intensity of support compared to high-utilizer adults enrolled in the existing Health Homes program. However, unlike Health Homes, this would be a population health strategy designed to serve all children in Medi-Cal, with an intensity of support tied to their assessed need, and should become the standard of care to codify how MCPs partner with and support child-health providers for care coordination and care management. Child Population Health Models should also include strategies to facilitate continuous care and smooth transitions from children's care to adult care systems, as they age into adulthood.

As previously mentioned, a foundational component of this care management functionality is enforcing MCPs' existing required care coordination responsibilities, but bolstering their capacity to do so with financial incentives and support. MCPs would be held accountable for helping children receive timely, family-centered care coordination services, and to access services and supports to address social need. This ensures that community-based partners who employ culturally-appropriate peer specialists, or community health workers can become part of the Medi-Cal provider system. Where possible and as appropriate, data should be accessible to all parties participating in the child's care plan. Models should ensure that pediatric providers receive confirmation that a child was successfully linked and served by an appropriate early identification and intervention service.

Similar to the Health Homes Program, plans would contract with "community-based care management entities" (CB-CMEs) to deliver screening, family education, referral navigation outside the health sector, and conduct care planning and support functions using paraprofessional/peer models. The current HHP framework is sufficiently flexible to allow for a variety of care management organizational types and models, accounting for differences in geographic and practice diversity. These may include IPAs, non-profit organizations, social service organizations, public health departments, or full delegation of care management to a medical group with the capacity to implement. In addition, an MCP could partner with an established Help Me Grow or other local entity, helping to leverage existing and successful case management and care coordination models. Currently, MCPs are providing limited care coordination to ensure children are successfully connected to timely services; this model will offer additional strategies for fulfilling their existing EPDST care coordination responsibilities and better triage children into appropriate and timely services.

As in the current HHP, the Child Population Health Model would include a paraprofessional/peer specialist role empowered to lead interdisciplinary care teams (ICTs) and to provide support inside or outside of the clinic for children with an identified developmental, social emotional or behavioral concern requiring coordination. Both MCPs and participating providers would be accountable for care plan completion, referral rates, monitoring, and referral rates. The paraprofessionals/ specialists in these models can connect children to resources to address social needs identified by screenings and to connect childre to concrete early intervention services outside of the scope of the MCP, such as MHSA-funded dyadic services like Parent Child Interact Therapy or Early Childhood Mental Health services in County Mental Health. The paraprofessional would also be responsible for involving additional community health workers, peer counselors, and family advocates on these teams, which are critical to providing enhanced administrative support and family support.

Participating Child Population Health Model organizations could elect to meet the program's community-based care management requirements via a practice-level intervention, such as a Healthy Steps or DULCE-like model or similar models for older children or adolescents, which can demonstrate improved screening and referral rates to early intervention services, including

between the health sector and schools. Such functionality standards should be outlined in the MCPs' contracts.

Supplemental funding for these child-focused models or initiatives should be provided to cover the supportive infrastructure needed to exchange data between the care management entity, the plan, provider, County Mental Health Plans, and CB-CME, and embed the required assessments and care plans into the Electronic Health Records and document that referrals are actually occurring.

3. Shift EPSDT Payment Models to Reward Linkages and Outcomes

Screening is distinct from referrals, so to incent practice change, payment must reward actual connections, and ideally, improved outcomes. Notably, Oregon's Medicaid program found that only a small percentage of children who received a developmental screening were successfully linked to services, leading to a focus on tracking referrals. Pay for value would reward screening and documented referrals to services for children with identified concerns, and help providers invest in mechanisms to incent and require follow-ups back to the referring provider to ensure the child receives recommended services. Given recent state audit data as well as other data indicating critical gaps in developmental screening, and an underutilization of mental health services compared to expected utilization, DHCS should drive performance improvement by setting standards and rewarding achievement. Examples include:

- *Performance on Bright Futures Screenings and Successful EPSDT Referrals*. Relevant performance metrics include Bright Futures screening rates at periodicity for maternal depression and autism, developmental screening and social-emotional screening, and accompanying successful referrals to appropriate providers, such as within County Mental Health, Regional Centers, school systems, and Autism providers.
- *Trauma Screening and Referrals:* A continued focus on trauma screening is warranted to ensure successful implementation of the recommendations from the AB 340 workgroup, and successful uptake of new Prop 56 incentive payments. In addition, it is imperative to ensure timely referrals for children with a trauma history to appropriate EPSDT-funded or community-based supports.
- *Valuing Family Experience*: DHCS payments to plans should include incentive metrics to assess and reward patient/family satisfaction with care, via Consumer Assessment of Health Care Providers and Systems (CAHPS) scores. California can gain valuable experience via early implementation of CAHPS, as this data will be required for submission to CMS as a required Child Health Core Measure in 2024.

Mechanisms for P4P or Enforcement

While we support the recent Prop 56 supplemental payment opportunities, they are insufficient as they exclude key populations, services, and health providers; for example, all P4P opportunities should be designed in a way to include FQHCs, given their critical role in the delivery system. For child behavioral health integration efforts to get off the ground, more support, partnership-building, training and infrastructure is needed to take advantage of the the Department's new Value-Based Payment programs. To ensure appropriate funding for the delivery and coordination of care for children, the state should focus on value in purchasing access to care for the preventive components of the EPSDT benefit (by way of managed care plans) through a three-part child health payment arrangement:

1. Full-utilization capitation payment for establishment of a child-centered medical home, that includes a "minimum spend" requirement on pediatric primary care medical spending, and a formula that better reflects full utilization (not historical *under*utilization);

2. A care coordination supplemental 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 services provided by county mental health plans, dental providers, Regional Centers, school districts, and other agencies; and
3. A performance bonus 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, reductions in racial/ethnic disparities, and/or investments in social service supports. To bolster improved child outcomes, Oregon's Medicaid program enables plans to earn up to 4.25% above capitation payments if they perform well on various measures, including developmental screening rates. These performance incentives could include value-based payments, an increase in membership via auto-assignment logic, or other mechanisms. With this funding, MCPs could be incentivized to invest in "value-added" support services to address social determinants of health.

DHCS should also explore withholding a percentage of payment to plans for non-compliance with established EPSDT data encounter submission and performance standards. And finally, any payment incentive program must accompany the release of annual EPSDT utilization reports that include accountability metrics and reporting on EPSDT screening, coordination/follow-up and treatment services, by age, by race/ethnicity, by plan and by geographic area. DHCS should report on MCP/MHP compliance with the most recent EPSDT APL, which confirms that MCPs are responsible for ensuring EPSDT members have timely access to all medically necessary EPSDT services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. DHCS will also have to develop, test and set standards for new performance measures such referal/follow up rates and their timeliness.

4. Support care provided to Medi-Cal children outside of clinical settings.
Additional federal funds may be available if the state is able to leverage activities currently being performed by schools and other local agencies and entities for services that are covered by Medicaid. We recommend that the Department consider and cultivate ways to maximize revenue for care provided in alternative settings, such as schools and the home, and make it clear to providers how to claim that revenue. Many activities currently undertaken by home visitors or at schools may be covered by Medicaid under EPSDT and thus should be leveraged to draw down additional federal funds. California can learn from Medicaid models in Oregon and New York, and ensure children are not just assessed, but that families are successfully connected to a vast array of health and social services to support and sustain healthy development. In addition, we recommend that the Department review select prevention and early intervention services funded under the Mental Health Services Act (MSHA), in case promising services such as PCIT could be financed by Medi-Cal, with modest regulatory changes and guidance. DHCS should systematically review and explore all available options to ensure that California is drawing down all Federal funds, and provide more guidance, greater claiming flexibility and training to support revenue maximization to bolster and sustain key services outside of the medical home, including County LGA/LEA capacity for MAA/TCM drawdowns. In addition, the Department should develop clear reimbursement guidelines for schools and community sites to provide telehealth services, via both video and store-and-forward, for children who face barriers to accessing care in traditional settings. Even more fundamental to clarifying Medi-Cal claim procedures is to clarify and educate providers, MCPs and beneficiaries that Medi-Cal covers services provided in these settings. Ensuring EPSDT

services are made available outside of clinical settings strengthens adherences to EPSDT requirements in order to best meet the needs of a child.

5. Behavioral Health Integration and Oversight
To ensure children with social-emotional or behavioral health needs receive timely support, efforts must be made to bolster accountability, quality, and transparency. As DHCS considers establishing system design pilots for behavioral health, DHCS should carefully consider challenges experienced in current and previous reform initiatives. First and foremost, DHCS must require greater accountability and transparency from both MCPs and MHPs to meet the federal entitlement to behavioral health under EPSDT. This can and should include efforts to:

- Improve care coordination and treatment by requiring data sharing so that each plan is aware of the mental health services its member receives from the other health plan.
- Address dispute resolution between plans to ensure that disputes between plans do not prevent enrollees from obtaining necessary mental health services.
- Provide data about mental health access, quality, spending, and interoperability in Medi-Cal, to ensure that DHCS and the Legislature can better oversee the performance of plans responsible for delivering mental health services to Medi-Cal beneficiaries.
- Require the MOUs between these entities to include referral and care coordination protocols, care coordination requirements for transportation services, and protocols to ensure enrollees receiving Drug Medi-Cal services have access to appropriate and coordinated services.; DHCS should review these MOUs annually.
- Codify continuity of care for mental health services when Medi-Cal beneficiaries move from one system to another.
- Enforce the care coordination obligation already in MCP contracts and require that care and support is provided during transitions between systems.

As DHCS explores making one organizational entity responsible for both physical and behavioral health needs of children, it should consider several options, including enhancing the role of either MHPs or MCPs, and establishing Accountable Care Organizations (ACOs) or other risk bearing entities focused on the unique needs of children. It is essential that DHCS initiates multiple models of reform to honor the diversity of existing safety net systems and communities, and to determine if these approaches would improve outcomes statewide. Examples may include carving in mental health services in rural counties where MHP administrative burdens and resources scarcity have challenged small MHPs to effectively serve children, or piloting models where MHPs adopt responsibility for the entire continuum of care for children with serious mental health issues, or the creation of integrated specialty plans for the seriously mentally ill (SMI) population that cover both physical and mental health. At a minimum, DHCS should provide additional technical support and clarification to county MHPs to ensure they are providing EPSDT mental health services as required under federal and state law.

We appreciate the opportunity to provide suggestions to support improved care and outcomes for Medi-Cal children, and to effectively change the trajectory of health outcomes for children. CalAIM can be a critical accelerator towards improving quality and value of Medi-Cal health care for children. We look forward to continuing an ongoing conversation with DHCS and California Health and Human Services about the ideas above within and beyond the context of the CalAIM proposal, including the upcoming managed care re-procurement process and contracting.

Cc:
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