Medi-Cal Managed Care Plan Procurement
Request for Information
ITUP Response Final
October 1, 2020

1. What MCP contract changes or actions do you recommend DHCS consider to address health disparities and inequities, as well as, identify and address social determinants of health?

DHCS and MCPs focus on paying for, coordinating, and providing medical care to Medi-Cal members. However, research shows that medical care prevents only 10 – 15 % of mortality in the United States. Other factors, that we call social determinants of health, greatly impact a person's health status. These include socioeconomic status, education level, exposure to toxic stress, environmental factors, and other social factors. DHCS and MCPs should consider including community engagement in every aspect of their business to have the best chance at improving a person's health, addressing their social determinants of health, reducing health disparities, and achieving health equity.
(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696)

To address a member's social determinants of health needs, DHCS should consider shifting its priorities from a system of sick care to well care. This includes: DHCS requiring and each MCP creating a strong population health plan that directs their quality improvement/reducing health disparities/hot-spotting/change management efforts; and, MCPs conducting regular and ongoing data analysis of each community the health plan serves. DHCS should consider asking all MCPs in a county to conduct a community needs assessment from a population health, epidemiological, environmental, and social determinants of health perspective, including key informant interviews with and surveys of community-based organizations and consumers. DHCS should consider requiring that, as part of the contract, each MCP, whether together as a county, or individually with each plan, regularly convene a community-based organization advisory committee, in addition to having a consumer advisory committee. As ITUP learns from our regional workgroups, these community-based organizations serve the same populations as MCPs, often have excellent insight into what works and does not work to improve the care and address the social determinants of health needs of Medi-Cal members, and can connect Medi-Cal members to services. These organizations engender a level of trust with communities that no one else has.

Another strategy DHCS should consider to address social determinants of health needs is to require each MCP's population health plan to include targeted environmental adaptations for the vulnerable neighborhoods they serve. Underserved communities could be identified through the community needs assessment mentioned above. Urban greening and re-forestation, for example, provide health benefits such as improved air quality water filtration and availability, and protects communities from excessive heat. All of these health benefits promote healthy communities, support well care over sick care, and reduce health disparities.

Here are a few examples and resources for learning more about using community engagement to reduce health disparities, effect quality improvement, and promote health equity:

Quality Improvement Initiative Example: DHCS and the CA Health and Human Services Agency have worked in the past with California Maternal Quality Care Collaborative (CMQCC) to set a state level target to reduce caesarean sections and utilized data to engage in change management with targeted hospitals that involved hospitals, doctors, nurses, and, in some cases, local employers. (https://www.cmqcc.org/qi-initiatives) CMQCC could describe their process to DHCS and to MCPs to share best practices on conducting meaningful and systemic quality improvement and change to meet a desired quality target.

DHCS should also consider lessons learned from the Whole Person Care pilots with regard to tracking all of the services that a Medi-Cal member uses—including both health care and social and community services. See Alameda County's Community Health Record as an example: http://accareconnect.org/ac-care-connect-chr/.

California Accountable Communities for Health Initiatives (CACHI) (https://cachi.org/) began as a partnership between the CA Health and Human Services Agency and California philanthropic foundations. Today, CACHI uses a combination of infrastructure and funding, wellness funds, collective action, community engagement, and prevention to connect the health care delivery system with the community to achieve whole-person health. Understanding their lessons learned could be helpful as DHCS considers how best to connect communities to the health care delivery system.

2. What MCP contract changes or actions do you recommend DHCS consider to increase MCP's community engagement?

To increase a managed care plan's engagement with a community, the MCP needs to first identify community-based organizations that serve their members and actively cultivate relationships with them. This can include an array of options: identify community-based organizations representative of their communities that address the social determinants of health and make them into an advisory committee to bring the community into the decision-making process; and, engage with community-based organizations as providers of services and contract with them to provide services, do home visits, and use promotores and other community health workers (similar to In Lieu of Services). Using promotores and other community health workers is a way to begin to make the delivery system reflective of the population and build upon trusted relationships; this is in evidence in our regional workgroup conversations.

3. What MCP contract changes or actions do you recommend DHCS consider for emergency preparedness and response for disasters?

The COVID-19 pandemic further exposed California's fragmented delivery system and severe health inequities. Now more than ever, these agreements and collaborations with local health departments need to be made meaningful and strengthened, starting with data-sharing agreements, to aid care coordination and to address a member's social determinants of health, at least during a declared emergency.

In our regional workgroups held across the state, communities continually cite a lack of formal coordination among the county's departments, the health care delivery system, and community groups. Most report that, six months into the pandemic, they are at least beginning to convene those three groups regularly to address the ongoing needs of their communities as the state of emergency continues. MCPs (and DHCS) should consider proactively working with the State Department of Public Health and local health departments to ensure that the delivery system, including MCPs, hospitals, clinics, other providers, community-based organizations, County Departments—Public Health, Health, Behavioral Health, Human Services—and schools are coordinated and included in the county's emergency preparedness plans. Those plans should include a process for immediate convening of the whole system (county departments, health care delivery system members, and community-based organizations) whenever a disaster occurs (e.g., pandemic, wildfires, earthquakes, heatwaves, or other disasters).

4. What MCP contract changes or actions do you recommend DHCS consider to achieve the other MCP goals listed?

Our regional workgroup conversations also show that meaningful data-sharing is needed among local entities, and especially between county behavioral health, health, and public health departments and MCPs. In addition to MOUs, DHCS should consider requiring plans and local governmental agencies to execute meaningful data-sharing agreements that allow data linkages to be made across departments, to ensure care coordination among systems.

5. What, if any, of the listed MCP goals provide significant challenges and what should be done to address those challenges?

DHCS's and the MCPs' greatest challenge is in connecting the core health delivery system to community-based organizations, schools, behavioral health, and public health to meet the needs of the whole-person, make people and the whole population healthier and to reduce health disparities. Please see our response to Question #1 with additional suggestions on how specifically to address these challenges.

Additionally, here are some state-run programs and offices that DHCS should consider meeting with and utilizing their resources in setting state-wide targets to address the social determinants of health and reduce health disparities:

Let's Get Healthy California Indicators and Progress: https://letsgethealthy.ca.gov/progress/

CalEnviroScreen: https://oehha.ca.gov/calenviroscreen

CDPH Office of Health Equity and Reducing Health Disparities Projects:
https://www.cdph.ca.gov/Programs/OHE/Pages/OfficeHealthEquity.aspx

Health in All Policies: https://sgc.ca.gov/programs/hiap/

6. What additional MCP goals should DHCS consider?

[No ITUP Response]

7. What additional changes or actions do you recommend DHCS consider for the planned *structural* updates to the MCP contract?

Since DHCS has stated 10 goal areas, DHCS should consider inserting sections for each of them into the contract and include specific language on how the MCPs can meet each goal, similar to how it proposes to include a section on Emergency Preparedness.

8. What additional changes or actions do you recommend DHCS consider for the planned *content* updates to the MCP contract?

Exhibit A, Attachment 4, Quality Improvement System—While DHCS requires health plans to conduct two quality improvement projects annually, quality improvement and reducing health disparities should be part of each MCP's normal course of business, focused on making systemic change. When strengthening the health disparities reduction language, DHCS should consider writing language that describes a process by which health plans should actively and routinely, as part of their normal course of doing business. This could include requiring them to: 1) scan their data (e.g., monthly, quarterly), even if that data is imperfect, for patterns across their county (also known as "hot-spotting"); 2) when a pattern that could indicate a health disparity exists is found, require the MCP to have a written process in place for how the health plan investigates that disparity, including interviewing community-based organizations, and, 3) create a written individualized, actionable systemic change management plan specific to improving quality and reducing that specific disparity. The change management process includes using data to identify a disparity, and then working with community members, Medi-Cal members, and local providers to make meaningful and systemic change to reduce the disparity.

Exhibit A, Attachment 6, Provider Network—Insure the Uninsured Project (ITUP) routinely hears from our regional workgroups how critically important it is for health plans to work

collaboratively with and contract with community-based organizations that serve people with Medi-Cal coverage. The CalAIM In Lieu of Services proposed benefit demonstrates that Medi-Cal can contract with non-traditional health delivery system providers to the benefit of Medi-Cal members. Based on our conversations with on-the-ground providers and community-based organizations, DHCS should consider expanding the types of organizations and services provided to include food security, home visits by promotores or community health workers, and schools, among others. We are happy to provide additional insights on how to best create these new contracting arrangements.

Exhibit A Attachment 8, Provider Compensation Arrangements—DHCS should consider encouraging health plans and providers to enter into compensation arrangements to prioritize prevention and better align fiscal incentives across all aspects of the delivery system (for example, MCPs, hospitals, clinics, other providers, and community-based organizations) to promote prevention and person-centered wellness. An example of this is Oregon's Coordinated Care Organization model: https://www.oregon.gov/oha/hsd/ohp/pages/coordinated-care-organizations.aspx

Exhibit A, Attachment 9, Access and Availability—In each of our regional workgroups, and from our statewide partners, ITUP hears that removing barriers to telehealth was critical to providing care during the COVID-19 pandemic. DHCS should consider clearly permitting the use of and paying for telehealth ongoing to expand access, with appropriate member privacy, quality of care, and culturally competent requirements to protect and ensure the highest quality of care for Medi-Cal members. Additionally, in our regional workgroups, community providers share that telehealth has significantly reduced their rates of no-shows to appointments. They have also pointed out that telehealth should be one of several tools in a provider's toolbox when providing care, meaning that care should not be entirely shifted to virtual care, but that it is valuable and should continue to be fully available after the state of emergency is lifted.

Exhibit A, Attachment 10, Scope of Services— Insure the Uninsured Project routinely hears from our regional workgroups how critically important it is for health plans to work collaboratively and contract with community-based organizations that serve people with Medi-Cal coverage. The CalAIM In Lieu of Services proposed benefit demonstrates that Medi-Cal can contract with non-traditional health delivery system providers to the benefit of Medi-Cal members. Based on our conversations with on-the-ground providers and community-based organizations, DHCS should consider expanding the types of organizations and services provided to include food security, home visits by promotores or community health workers, and schools, among others.

Exhibit A, Attachment 12, Local Health Department Collaboration—The COVID-19 pandemic exposed even further California's fragmented delivery system. In our regional workgroups, we continually encounter reports of a lack of coordination between county departments, MCPs, and community-based organizations. Now more than ever, DHCS should consider requiring

MCPs' agreements and collaborations with local health departments be made meaningful and strengthened, starting with data-sharing agreements to aid care coordination and to address a member's social determinants of health.