

CA ALLIANCE RECOMMENDATIONS REGARDING DRAFT COMPREHENSIVE QUALITY STRATEGY REPORT

The California Alliance of Child and Family Services (the CA Alliance) appreciates the opportunity to offer recommendations on the draft Comprehensive Quality Strategy Report (CQS Report.) The measures, targets, and accountability strategies that DHCS chooses to implement will play a critical role in ensuring that every youth receives the care they need to thrive. We have some overarching comments and recommendations, and we then make some specific recommendations by section/page number below.

To Increase Access to Early Intervention Behavioral Health Services, DHCS Should Measure PEARLS Screens and Well-Child Visits for Older Youth.

To ensure Medi-Cal Managed Care plans (MCPs) identify more youth with emerging mental health challenges, we would recommend that DHCS add PEARLS screens and well-care visits for older youth to the Managed Care Accountability Set (MCAS) and the Health Equity Measures Set. A 2019 report by the California Auditor found that access to preventive pediatric Medi-Cal services ranked 40th in the country, and that an annual average of 2.4 million children enrolled in Medi-Cal did not receive the required preventive services. The audit, moreover, found that plans were much more likely to provide the subset of preventive services that they were required to report to DHCS.¹ This report demonstrates both the need to greatly improve access to preventive care for youth and the importance of requiring plans to report their rates of delivering these services.

- **PEARLS screens**

DHCS has stated that the ACEs and PEARLS screens play a critical role in advancing California's goal of reducing health disparities stemming from childhood adversity and other Social Determinants of Health. In addition, because the PEARLS now can help identify youth who should be referred to their county Mental Health Plan (MHP) to receive supports to alleviate the effects of childhood trauma, this tool carries even greater potential to expand access to essential early intervention services. We therefore urge DHCS to incentivize plans to consistently offer this screen, as well as appropriate follow-up services.

- **Well-Care Visits for Older Youth**

We support DHCS's decision to include measures of well-care visits for youth who are 30 months and younger. In addition, however, we would encourage DHCS to also monitor well-care visits for older youth. Bright Futures, the schedule of preventive visits recommended by the American Academy of Pediatrics, includes annual visits for youth from ages three to 21, but none of these visits are included in the list of quality measures. Particularly in the midst of a pandemic, regular well-child visits for youth of all ages are essential to identify emerging physical and mental health challenges. This is especially true if pediatric offices are also incentivized to offer ACEs screens at these well-child visits.

¹ [Millions of Children in Medi-Cal are not Receiving Preventive Health Services](#), DHCS, March 2019.

DHCS Should Promptly Set and Enforce Targets for MHP Performance that are Based on the Rates of California’s Highest Performing MHPs.

We strongly agree with DHCS’s acknowledgement that California cannot accept 50% of the Minimum Performance Level (MPL) as our statewide goals, and that our ultimate goal is to set rates of 90% on key measures. Toward that end, we would recommend that DHCS promptly set targets for the youth Specialty Mental Health Services (SMHS) performance measures listed on the CQS Report, pp 152 to 158. These measures include: utilization rates, the percentages of youth who receive five or more SMHS, the time between inpatient discharge and step-down services, and the median amounts of several individual SMHS, such as In Home Behavioral Services and Therapeutic Behavioral Services. The report states that there is no research upon which to base targets for these measures; however, DHCS could use the rates of our highest performing MHPs to establish these targets. Indeed, DHCS uses a comparable approach to set the targets for the Cal Medi-Connect Program (for members who receive both Medi-Cal and Medicare.) (CQS Report, p. 162.)

This approach would be effective in part because SMHS penetration rates vary dramatically between counties. In FY 2018-2019, for example, Los Angeles achieved a SMHS youth utilization rate of 6.5%, while the rate in nearby Orange County was less than half that rate, at 3.2%, while the rate in Merced was just 2.5%. If DHCS helps every MHP match the success of our highest performing MHPs, it can significantly expand access to critical mental health services.

Rather Than Imposing Financial Penalties on Poorly Performing MHPs, DHCS Should Instead Focus on Technical Assistance, Support to Help MHPs Obtain Additional Funding, and Reduced Disparities Between CBO and County Provider Rates.

While we strongly support efforts to hold plans accountable for meeting performance targets, we believe that financial penalties often are counterproductive. This is particularly true for under-resourced counties. Research conducted by Young Minds Advocacy and presented to DHCS, for example, has shown that per-beneficiary mental health funding from the state to MHPs varies dramatically, and that the MHPs that receive disproportionately fewer funds also tend to perform less well on SMHS performance measures. Moreover, many of these poorly performing MHPs also face some of the highest child poverty rates in the state. For these counties, financial penalties will likely only exacerbate barriers to care.

Instead of imposing monetary fines, we urge DHCS to provide increased oversight, corrective action plans, public facing report cards, and technical assistance, as well as support in applying for additional funding. We were pleased to see that the Behavioral Health Continuum Infrastructure Program (BHCIP) offered planning grants to help counties prepare applications for BHCIP grants, and we encourage DHCS to expand that approach to other funding opportunities, especially for counties with the fewest resources.

As another alternative to imposing fines, DHCS should also require poor performing counties to reduce the disparity in the rates they pay staff with Community Based Organizations (CBOs) compared to their rates for county-employed staff. In many counties, CBO provider rates are significantly lower than county provider rates, and these low CBO rates have intensified staff shortages.

DHCS Should Ensure MHPs Correct Serious Failures Identified in EQRO Reports.

External Quality Review Organization (EQRO) reports have the potential to significantly enhance the quality of SMHS because they conduct in-depth reviews of both quantitative and qualitative measures. Yet when an EQRO report does uncover a severe barrier to care, it sometimes appears that little is done to ensure the problem is solved. For example, Fresno’s FY 18-19 EQRO Report found that youth who had been discharged from a hospital with a referral to one of the county’s Full-Service Partnership (FSP) programs faced waitlists of two to four months.² Yet the EQRO report for the following year did not report any decrease in those wait times, observing only that the MHP was “working to improve” referrals and case tracking and “looking at improving” staff recruitment and retention through a salary increase initiative.³ In this case, the EQRO system was woefully inadequate to correct a profoundly serious barrier to care for children in need of intensive supports. In the case of such severe gaps in care, stronger accountability measures are needed. In addition to the accountability strategies discussed above, DHCS could also consider requiring the county to enter into additional provider contracts in order to ensure that no youth are denied prompt access to care.

Below are some specific recommendations on additional sections of the report as noted:

Quality and Health Equity Improvement Strategy (pg. 45):

Strengths:

- A bold and ambitious set of transformational aims and projects that should they transpire close to stated intentions and plans ought to synergistically yield much needed improvements to health care access, delivery, equity and outcomes for California’s Medicaid/Medi-Cal populations.
- Population Health Management. Helpful specifications of performance metrics throughout, incl. in Addendum D by envisioned program types.
- Health Equity RoadMap. That this is foundational to CalAIM is simply excellent: inequities mean great harm is occurring to individuals, families and society. CalAIM identifies broad project areas (with some data shared that supports rationales for these), lists of participating perspectives that will be needed, lists of current projects and actionable areas to be worked on, and lists of questions of concern/interest for the co-design processes to come. It is a road map for sure (vs a detailed plan), yet with some details about what is underway, and envisioned nodes to be worked on.

Concerns:

- Conflicting aims: For example, there are stated aims to reduce documentation and paperwork burdens on clinical staff yet the proposal embraces an ambitious array of both existing and new metrics. Given much of the work on metrics remains to be completed, with multiple stakeholders at state and federal levels weighing in about distinct data needs, it is hard to see how the overall measurement burden on treatment staff will be reduced over the course of CalAIM implementation. Relatedly, but not specifically addressed, is the respondent burden on beneficiaries to supply information about themselves, which also will likely increase given the range/types of data envisioned as needed for service, quality and outcomes monitoring. This is just one example: the planning process might benefit from counterposing aims vis a

² [FY 18-19 Fresno EQRO Report at 49.](#)

³ FY 19-20 Fresno EQRO Report at 11.

vis each other to see where these might be in conflict (countervailing impacts), then adjusted and communicated accordingly.

- Rates and Payment Reform: Starting 2023, performance metrics will be considered when adjusting payment rates and member assignment. Participatory feedback loops, exact methodologies and algorithms remain TBD at this time. We strongly recommend that there could be more information widely shared and discussed about how current incentive projects are working out, at least some themes and lessons so far, if not data/results. Additionally, before DHCS implements the proposed changes beginning in 2023, CA needs to have a solid Health Information Exchange System and EHRs need to have capacity to integrate with HIE.
- Communications Plan: As we have seen with recent federal efforts to tackle broad yet detailed bundles of social programming, much gets lost in the effort to “sell” (and/or bring along) the public and elected decision-makers. This plan is foundationally incomplete without some characterization of intentions and planning efforts re: public health communications campaigns.
- Facilitative Discussions with Stakeholders: Our experience by and large at stakeholder forums has been that these are primarily structured around state personnel's presentations, usually with some brief Q&A along the way of or at end of the session. Not all questions are acknowledged nor addressed – and problem solving is not really a part of these meetings.
- Lastly, CalAIM is a complex, multi-faceted endeavor, involving many people, many resources with potentially profound and desirable transformative impacts on our systems. The plan does present synergies among initiatives that ought be facilitative of success over time – but (apart from acknowledging COVID), we do not see the other side of the planning coin – the “What Ifs” (politics, change in governance, economics, profound labor shortages, etc.) that could derail, undermine, or limit CalAIM success(es) and how these might be quickly identified, countered and problem-solved along the way.

Managed Care Assessment Evaluation and State Standards (pg. 82):

Page	Comments
7	Overview to Ch. 3 from the executive summary: Lastly, Section 3 of the CQS outlines significant changes at DHCS in terms of its quality management structure and managed care monitoring and oversight activities. Specifically, DHCS is centralizing and elevating core quality and health equity functions under its new Quality and Population Health Management (QPHM) Program. It will also align and standardize managed care policies, as possible, across delivery systems, and institute standard, proactive monitoring strategies (including user-friendly public dashboards) to support transparency and accountability.

	<p>RECOMMENDATION: Please consider reiterating this at the start of this chapter</p>
83 (3.1)	<p>Great guiding principles "improve transparency, accountability, and monitoring across its programs</p> <p>proactive monitoring structure.. with standardized data inputs, monitoring domains, and metrics processes and outputs = ensuring consistent and reasonable data collection methodology will be critical for provider compliance</p>
85 (3.2)	<p>standardize the QAPI across all programs to use similar methods and align them with DHCS priorities; references to standardized performance metrics and MPLs (I couldn't find a definition for MPL - would be helpful to spell out at least the first time) - RECOMMENDATION: We will want to know more about what these performance metrics & MPLs are, how they'll be measured, how much of a lift this will be for providers and counties, how much DHCS will work to leverage measures so we're not collecting and reporting on multiple ways of getting to the same/similar detail.</p> <p>This is promising (bottom of pg 85) DHCS has already started aligning metrics across programs to minimize provider administrative burden and maximize synergy of current measures.</p>
87	<p>PIPs and PIP Interventions - discusses what past practice has been. RECOMMENDATION: It would make sense to offer this information in the context of how DHCS is envisioning Performance Improvement moving forward, i.e., aligning metrics across programs and providing clear guidance on PI foci across all the MHPs, MCPs, etc. (aligning performance improvement goals across the state with some variation to reflect the unique needs and challenges of the counties... so maybe a statewide PI focus such as network adequacy and then a local focus)</p>
92 (3.3)	<p>External Quality Review (EQR) arrangements - table lists activities to be conducted 2022-2026.</p> <p>RECOMMENDATION/COMMENT: Where will DHCS identify activities to be conducted for the MHPs & MCPs</p>

	<p>related to mental health/substance use quality review / performance improvement?</p>
96	<p>Evidence-Based Clinical Guidelines - describes current practices to support EB clinical practice. RECOMMENDATION: It would be helpful to identify how this will be supported in future (and how it will support and align to quality monitoring across systems)</p>
97-99	<p>MCMC and MMPs MHPs, DMC-ODS & Dental MC - how DHCS sets requirements through contracts, review of policies & processes. RECOMMENDATION/COMMENT: Unclear if this will still be the process going forward. Our concern is that without clear guidance there is still a lot of opportunity for unnecessary variation across counties / plans, unless the state envisions their monitoring and oversight as the mechanism to control this.</p>
100	<p>Transition of Care Policy & Identification of Persons who need LTSS...</p> <p>Processes to identify persons who need LTSS - RECOMMENDATION: This puts a lot of responsibility on the initial health assessment to identify needed community resource coordination. There are other items that can trigger identification, e.g., SNF residents, but having "each MCM develop methods to identify enrollees who may benefit from complex case management services" is confusing. Why wouldn't the state set this via a standardized screening tool?</p>