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April 27, 2018

Jennifer Kent, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, California 95899

Sent via email to *publicinput@dhcs.ca.gov*

RE: Comments on 2018 DHCS Managed Care Quality Strategy Report

Dear Director Kent:

Thank you for the opportunity to submit comments on the Draft 2018 DHCS Managed Care Quality Strategy Report. The undersigned health advocacy organizations believe quality measurement and improvement is an essential component of the Medi-Cal program, particularly the recognition and reduction of health disparities.

Overarching Comments

Align data collection and quality improvement across managed care programs.

It is clear from the Draft Quality Strategy Report that DHCS managed care data and quality improvement is currently fragmented, leading to mixed outcomes for Medi-Cal members. While we understand that DHCS provides dental services, specialty mental health services, and substance use disorder treatment through separate managed care systems, one member may access care through four different delivery systems. Therefore, the health outcomes of the member are influenced by the quality of each system, in addition to their ability to work together to provide integrated, coordinated care. Furthermore, DHCS and stakeholders cannot evaluate the quality of care provided by the Medi-Cal program without looking holistically at the four delivery systems.

We recommend developing a quality strategy that merges the data from each of the delivery systems and includes performance improvement targets that focus on integration and care coordination, in addition to providing plan-specific data. As an example, people living with serious mental illness have their life expectancy shortened by 14 to 32 years, compared to the general American public. This is primarily due to co-occurring physical health conditions and substance use. However, because current DHCS data and quality strategies are not integrated, the state does not evaluate how to improve care and reduce disparities for this population through both physical and mental health interventions when people are accessing services through both a Medi-Cal Managed Care Health Plan (MCP) and a County Mental Health Plan (MHP).

This is particularly important for people of color, LGBTQ people, individuals with disabilities, and limited English proficient consumers, who experience barriers to access and disparities in each of the delivery systems. As mentioned in the Draft Quality Strategy Report, communities of color experience poorer health outcomes and less access to care than their counterparts. **The reduction of disparities should be woven throughout the strategy, not relegated to a separate section.**

- All quality measures should be stratified by demographic factors including county, primary language, race, ethnicity, sex, age, sexual orientation, gender identity, and disability status.
- Health disparities should be examined across the four delivery systems in order to address the poor health outcomes experienced by these demographic factors.
- DHCS should consult with stakeholders to develop disparities reduction goals and priorities and plans to reach these targets.

In this vein, it is important to produce timely data that gives a snapshot of where we are today, not one or two years ago. We understand that data sharing challenges exist, but believe these can be overcome through innovative use of technology, de-identification, and improved privacy agreements.

Improve demographic data collection.

We appreciate the acknowledgment that significant disparities exist in MCP performance for areas including prevalence of hypertension and postpartum visit rates. However, no other specific disparities appear to have been identified for the other three delivery systems, and the Draft Quality Strategy Report primarily relies on compliance monitoring such as reviewing Cultural Competence Plans and requiring implementation of CLAS standards. We recognize that it is too early to expect data from the DMC-ODS, but MHPs and DMC have functioned for decades. **Identification of health disparities and plans for reduction of these disparities should be an immediate priority of the strategy.**

Currently, demographic data collection is not sufficient to be able to do meaningful work to reduce disparities. There is a lack of uniformity in the way demographic data is collected across the state, plans, providers, and programs. At the state level, we are aware that there are inconsistencies between collection and reporting of data based on modality. For example, write-in data for race/ethnicity collected on the single streamlined paper application was never entered into the online system. Plans rely on beneficiary file data that they receive from DHCS, so it is critical that this information is correct and complete. At the county level, some counties use self-reported data and others eyeball demographic information.

Despite these clear challenges, no goal has been set for the collection of demographic data. Without clear targets and goals, there will be no change in this arena. **DHCS must lead a comprehensive strategy to require the collection of data on county, age, race, ethnicity, sex, gender identity, sexual orientation, primary language, and disability status.**

- DHCS should set year-over-year targets for demographic data collection and reporting. This is currently being done in the PRIME pilot program, which is a good example of what is possible.
- The targets set by DHCS should include the gold standard of self-reported demographic data. This is currently done by Covered California.
- DHCS should require counties, plans, and providers to adopt the latest Electronic Health Record (EHR) technology in order to improve the accuracy and consistency of data collection.

Include the consumer voice.

The Draft Quality Strategy Report provides little information on the use of member perception and experience surveys, which are a critical tool for evaluating quality, particularly for diverse communities. DHCS should require annual member surveys be administered by plans and that these surveys be translated into threshold languages. Currently, MHPs and DMC provide translated surveys, but MCPs do not. On the hand, MCPs administer consumer surveys through a random sample (but only every three years), while MHPs administer consumer surveys through a convenience sample. **DHCS must require better collection and reporting of translated member surveys consistently across programs.**

DHCS should hold a formal stakeholder process to align quality improvement and disparities reduction efforts across all programs. Consumers should be at the tables with DHCS, health plans and providers in the selection and adoption of quality improvement metrics and plans. Once again, the quality improvement strategy should recognize that an individual member may interact with multiple delivery systems. We want to know more about this person's experience and outcomes across the Medi-Cal program.

Specific Comments

2.3 Managed Care Delivery Systems in California – Drug Medi-Cal Organized Delivery System

While the background information for the program provided in this section is correct, the DMC-ODS services list omits several services included as part of the DMC-ODS waiver. Under the DMC-ODS approval letter, counties opting in to the program must provide at least one level of service of withdrawal management. In addition, counties have the option of including additional levels of withdrawal management services, partial hospitalization services, and additional Medication Assisted Treatment (MAT) services. We see no reason why optional services should be omitted from the list of services available for beneficiaries in DMC-ODS counties.

2.4 Managed Care Delivery Systems in California - Dental Managed Care

Dental managed care was initially implemented to test how oral health services delivered through a managed care model compared to delivery through fee-for service. Yet, the Draft Quality Strategy Report does not include details on how DHCS intends to compare the two systems. To adequately test how the managed care model compares to fee-for-service, the following data, at a minimum, should be collected and compared with the same measures in fee-for-service: utilization data across demographic factors and services, provider participation, beneficiary satisfaction, and provider satisfaction.

4.2 Evidence-Based Clinical Practice Guidelines – County Mental Health Plans

As noted in the draft report, each MHP is also required to implement mechanisms to monitor the safety and effectiveness of medication practices, at least annually. Yet, this section focused almost exclusively on the administration of psychotropic medication for children and youth in foster care. While we are supportive of that guidance, there is nothing addressing the needs of other populations of vulnerable children or adults. In addition, DHCS should include the medical necessity criteria for specialty mental health services, which is most clearly set forth in federal law as the EPSDT medical necessity standard. DHCS should work with stakeholders to address current barriers to meeting medical necessity criteria for enrollees of color, LGBTQ enrollees, enrollees with additional disabilities, and limited English proficient enrollees. The screening tools and guidelines currently utilized by counties are not adapted for these communities where health disparities exist. Adults may be determined ineligible for county mental health

services due to differences in how symptoms and concerns are communicated to providers, rather than an accurate assessment of need. This is particularly important in the provision of mental health services because diagnosis relies heavily on member-reported symptoms and conversation, rather than objective test results.

In addition, assessment and eligibility criteria do not currently account for trauma. While AB 340 (Arambula, 2017) requires DHCS to convene stakeholders to consider updating, amending, or developing tools and protocols for screening children for trauma, we recommend that DHCS conduct a similar process to identify tools and protocols for screening adults for trauma.

4.3 Evidence-Based Clinical Practice Guidelines – Drug Medi-Cal Organized Delivery System

We recommend consistently using the term "substance use disorder" in place of the term "addiction," which carries connotations of stigma and discrimination and may serve as a barrier for individuals with SUD to access necessary services. In addition, we urge DHCS to describe the complete medical necessity criteria used for DMC-ODS services, including the fact that the program uses the ASAM definition of medical necessity without overriding the federal EPSDT medical necessity criteria. Finally, it should be clear from the text that pursuant to the special terms and conditions of the DMC-ODS waiver, medical necessity may be determined by a Medical Director or by any Licensed Practitioner of the Healing Arts, which includes not only physicians and prescribers, but also Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT).

4.4 Evidence-Based Clinical Practices – Dental Managed Care

Provider Handbook
Dental managed care relies on the same model of care as is used in fee-for-service, which set forth in the Dental Program Provider Handbook. The Manual includes the limitations, exclusions and special documentation required for the delivery of services. Unfortunately, the requirements and standards set forth in the Provider Handbook have proven to be both a barrier to care and not based in evidenced-based care, but instead a response to provider fraud. The Little Hoover Commission included in its report a recommendation that Denti-Cal establish a dental advisory board responsible for establishing a Denti-Cal model of care that is based in evidence and improves the health of the population at a lower cost. We strongly urge the Department to take this step for both managed care and fee-for-service to improve the quality of care and services to all Medi-Cal recipients.

DMC Contracts Clinical Practice Guidelines
We appreciate that the Department has provided contractual clinical practice guidelines for children, intravenous sedation and anesthesia, and for pregnant women. We strongly recommend that clinical guidelines also be provided for the care of older adults who frequently have multiple chronic conditions that complicate oral health treatment as well as clinical

guidelines for delivering treatment in institutional settings including skilled nursing facilities and intermediate care facilities for the disabled (ICF-DD).

5.2 Continuous Quality Improvement – County Mental Health Plans

We are concerned that the current quality metrics and performance targets that are outlined in the Draft Quality Strategy Report are inadequate to present a picture of the quality of specialty mental health services. Penetration rates (having one or five encounters with the MHP) and approved expenditures are not quality measures and should not be included here. Time to step down is one measure, but far from sufficient to evaluate the quality of services. Further, the quality improvement work plans (QIWPs) and project improvement projects (PIPs) are individualized to each MHP (chosen by the MHP) and thus not comparable in any way across plans statewide or consistent among plans as quality measures that can be evaluated statewide. This results in largely disparate practices across the state. The Final Rule, the 1915(b) STCs, and current state law governing the Performance Outcomes System require DHCS to develop and publicly report quality measures. The Draft Quality Strategy Report should also include data on mental health disparities as required by AB 470 (Arambula, 2017).

The two stated QI goals and priorities of DHCS for SMHS are to (1) provide high-quality and accessible SMHS; and (2) improve coordination of care within DHCS' service delivery systems as well as other service systems the SMHS beneficiaries commonly access. Yet there are not currently quality measures of being collected statewide. Timely access, while critical, is not synonymous with quality care (only one narrow element), and all of the stated measures focus on access to a specific number of services or to the time to get into services. Even the focus on improved care coordination for children in child welfare sets a measurable goal of a number of services and the time it takes to receive the first service. Again, these are part of the state and federal timely access to care standards that are required for all managed care enrollees but do not focus on other important elements of quality of the services provided, such as the effectiveness of the service.

We appreciate that DHCS has identified the reduction of disparities in mental health as a focus area for MHPs. However, while DHCS details the limitations of current demographic data collection, no plan is outlined to improve collection of this critical data. We recommend that DHCS provide training and institute requirements for counties to improve demographic data collection. In addition, the information technology systems must be strengthened in order to allow for data to be accurately and consistently captured and utilized for performance improvement.

DHCS should continue to work with stakeholders through the POS process to develop robust quality measures for mental health. The Draft Quality Strategy Report states that there is a lack of nationally or locally agreed upon mental health quality measures and corresponding state or national benchmarks. However, CMS has recommended a set of behavioral health core measures, and significant research has been conducted in this area. In addition, CPEHN has communicated to DHCS that we are working with experts in the field to develop recommended

quality measures for the POS, through a project with the California Health Care Foundation. We urge the adoption of these measures once the project is completed in May. Finally, we note that the current proposal for improvement in care coordination pertains only to children in the child welfare system. We believe that it is important to also examine care coordination for other children and all adults, and that this work must integrate data from MCPs.

5.3 Continuous Quality Improvement – Drug Medi-Cal Organized Delivery System

We recommend adding information regarding data required to be collected by counties for purpose of the EQRO protocol. Pursuant to the DMC-ODS waiver terms, counties are required to include, at a minimum, the following data: number of days to first DMC-ODS service at appropriate level of care after referral; existence of a 24/7 telephone access line with prevalent non-English language(s); access to DMC-ODS services with translation services in the prevalent non-English language(s); number, percentage of denied, and time period of authorization requests approved or denied.

5.4 Continuous Quality Improvement – Dental Managed Care

Section 5.4 puts a heavy emphasis on improving the quality of care for children. While we agree that DMC should adequately serve children, it also has the responsibility of adequately serving the entire Medi-Cal population including adults – and specific sub-populations of adults including pregnant women, individuals with disabilities, older adults, and individuals residing in institutional settings. The Department should make clear that these populations are equally prioritized and the Department is evaluating the data to ensure that health disparities are being addressed. Additionally, the quality metrics and performance targets should be reviewed annually to ensure that the Department is adequately assessing the quality of care and access to services for all Medi-Cal populations.

6.2 External Independent Review – County Mental Health Plans

The current EQRO review is very difficult to use for quality improvement since each county report is produced separately and they cannot be easily compared to either other counties or across time. We recommend creating a more-consumer friendly and actionable format for the data.

The Draft Quality Strategy highlights only three quality measures, yet, as described earlier, all of these pertain to timeliness, which is only one narrow element of quality. Furthermore, while the report cites a key finding that MHPs improved reporting rates in tracking timeliness indicators (for first appointment and inpatient follow-up) and that large and medium-sized MHPs reduced their wait times significantly during the past three fiscal years, the report doesn’t note the fact that MHPs do not have uniform standards of timely access and many do not use the same methodology for determining access to appointments. The lack of a statewide uniform standard or methodology makes statewide comparability impossible and county specific data less useful. The report also fails to mention the very alarming fact that the average

first psychiatric appointment time exceeded 30 days for all except small MHPs and that the situation was significantly worse for children's first psychiatry appointment timeliness (FY 2016-17 EQRO Validation of Performance Measures Report, Figures 2-21 and 2-22). Finally, the report fails to note that a number of MHPs continue to not report at all on the basic timeliness measures of initial access, urgent appointments, inpatient follow up, and psychiatric appointments.

Despite the substantial concerns above that are not mentioned in the report, we nevertheless, appreciate the focus on timely access to services, which the EQR report demonstrates has continued to present significant barriers to care in the county mental health system. We believe the focus should shift from tracking reporting rates to DHCS using the EQRO data to rigorously enforcing the uniform timely access standards required by the Final Rule and adopted by the state law beginning July 2018.

In addition, the EQRO should evaluate additional quality and disparities issues, including mental health outcomes, language access, and consumer experience. The consumer experience data collected by the EQRO is largely based on focus groups, which do not present a robust picture of consumer satisfaction. We recommend utilizing a random sample methodology and ensuring representation of underserved racial groups through over-sampling. Outcomes measurements are largely lacking from the EQRO review. Upon procurement for the next EQRO contract, DHCS should convene stakeholders to determine outcomes measures that should be reviewed, in alignment with the POS.

6.4 External Independent Review – Dental Managed Care

We appreciate that the Department is working to secure a contractor to perform the EQRO function for Dental Managed Care. We urge the Department to specify the timeline for this review.

7.3 Transition of Care Policy – Drug Medi-Cal organized Delivery System

In its recent Medicaid Mental Health Parity and Addiction Equity Act Compliance Plan, DHCS made clear that it intended to adopt a continuity of care policy for SUD services, which we believe would extend to DMC-ODS counties and plans. The Transition of Care Policy Section in the Medi-Cal Managed Care Quality Strategy Report would be an excellent opportunity to provide clarity on DHCS's policy regarding continuity of care for SUD services in DMC-ODS counties.

8.2 Reducing Health Disparities – County Mental Health

We are pleased to read that DHCS will be conducting a review of the MHP Cultural Competence Plans (CCPs) this year. CCPs are required by law and must be reviewed and approved by DHCS. We believe that greater scrutiny of MHP CCPs and cultural and linguistic access would be beneficial. In addition, while CCPs are written by each county individually, it would bolster this

process to also have statewide strategies and priorities for the reduction of disparities. Finally, CCPs should clearly delineate specific disparities and plans to reduce or eliminate these, and DHCS should monitor MHP progress in each area.

In addition, CCPs should not be the only tool to reduce mental health disparities. The EQRO and DHCS triennial reviews should focus heavily on access and quality of services for communities of color and limited English proficient communities, especially when the penetration rate for these populations is decreasing. Again, specific disparities, goals for reduction, and strategies should be identified, and MHPs should be measured against annual progress in this area.

DHCS should report statewide and plan specific quality data by race, ethnicity, language, sexual orientation, gender identity, age, and disability. Much of this is required by AB 470 (Arambula, 2017), which requires the first report to be issued by December 31, 2017. AB 470 also requires stakeholders to be consulted to develop both the data elements and the strategies to reduce mental health disparities. We recommend that DHCS align the Quality Strategy with this work.

Finally, while not mentioned in this section, Section 1557 of the ACA and SB 223 (Atkins, 2017) both apply to MHPs. DHCS should note this in the Quality Strategy and should ensure that MHP contracts comply with the law.

8.3 Reducing Health Disparities – Drug Medi-Cal Organized Delivery System

Similarly to MHPs, we are pleased that DHCS will be ensuring the use of CLAS standards and compliance with Section 1557 of the ACA. However, there is much more that should be tracked and monitored to ensure that DMC-ODS counties are reducing mental health disparities. Once again, we recommend establishing disparities reduction goals and requiring plans to make annual improvements toward these goals.

8.4 Dental Managed Care – Reducing Health Disparities

We appreciate the Department's steps in reducing health disparities by collecting encounter data with regard to age, county, race, and ethnicity. We have multiple recommendations with regard to other identifiable areas that the Department should also be reviewing to address oral health disparities: 1) The Department should report out age data that includes age brackets and not just data for children and adults over age 21; 2) the Department should collect and review access to oral health by specific populations subsets (which could be identified by aid codes) including pregnant women, individuals with disabilities, older adults, and individuals residing in institutional settings (intermediate care facilities and skilled nursing facilities); 3) The Department should report out data by zip code. While county-level data is useful, zip code data is the only way to truly assess disparities that occur based on geographic location.

Conclusion

In addition to the detailed, specific comments provided, we recommend the following be included as part of the Department's Managed Care Quality Strategy:

- Align data collection and quality improvement across delivery systems, including Medi-Cal managed care plans, Denti-Cal, county mental health plans, and DMC-ODS.
- Weave health disparities reduction throughout Quality Strategy Report.
- Improve demographic data collection, including collection of data on county, age, race, ethnicity, sex, gender identity, sexual orientation, primary language, and disability status, across delivery systems.
- Include the consumer voice through a formal stakeholder process as well as better collection and reporting of translated member surveys.

We look forward to working with you to help implement these recommendations. If you have any questions regarding our comments, please contact Kiran Savage-Sangwan at ksavage@cpehn.org.

Sincerely,

California Pan-Ethnic Health Network
Health Access
Health Consumer Alliance *
Justice in Aging
Black Women for Wellness
Korean Community Center of the East Bay
Maternal Mental Health Now
Mixteco/Indígena Community Organizing Project
PALS for Health
South Asian Network

CC: Nathan Nau, Medi-Cal Quality & Monitoring Division

* The HCA is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the Western Center on Law and Poverty, and the National Health Law Program.