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Strengthening the Social and Emotional Health of California's Young Children: Medi-Cal Strategies and Options for Creating an Advanced Child Health Delivery System

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About DCR Initiatives

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Table of Contents

Preface

California's longstanding efforts to promote child development and kindergarten readiness are well-established and have paved the way for focusing greater attention on the vital role child health can play in realizing the full strength of these critical state investments. As a large and diverse state, California has unparalleled reach: Medi-Cal, the State's Medicaid program, covers five million children—more than the number of children covered in 23 other states combined. In addition, Medi-Cal covers prenatal care and pays for half the births in the State, and 64 percent of children under the age of five rely on Medi-Cal for their care. Of particular importance, two-thirds of children with Medi-Cal coverage are Black and Brown, notable as the nation contends with its long-neglected obligation to advance racial justice and health equity. Policy and practice innovations originating in California and progress achieved for its young children and families have the capacity to demonstrate ways to make meaningful, positive change for millions of others as well.

To take advantage of Medi-Cal's potential to drive improvements in the health and development of young children and the Newsom Administration's strong interest in early childhood, a group of funders—the David and Lucile Packard Foundation, J.B. and M.K. Pritzker Family Foundation, and Genentech Charitable Giving—commissioned a California-focused "Options Paper" to identify concrete strategies for leveraging Medi-Cal to strengthen the social and emotional development of young children through pediatric primary care. This work is an outgrowth of the Pediatrics Supporting Parents initiative and builds upon the accomplishments of its Medicaid and Children's Health Insurance Program (CHIP) State Implementation Work Group, in which California participated.

Core to the development of the California-focused strategies was a working group of four counties—Alameda, Fresno, Los Angeles, Ventura—represented by their First 5 County Commissions, and the integral participation of the First 5 Center for Children's Policy. These county organizations brought to the process a local perspective and a wealth of practical, on-the-ground experience with the early childhood systems and infrastructure. Their insights and ideas, along with input from state policymakers, providers, health plan representatives, and advocates, were key to the analysis of options and opportunities presented in this Options Paper.

The Options Paper presents Medi-Cal policies and financing mechanisms that are central to the support of an equitable, advanced child health delivery system—a model rooted in whole child, family-centered care that incorporates integrated care teams and community partners to provide the care that families with young children want and need. The underlying analysis identifies three major sets of strategies that could be adopted relatively quickly to 1) establish greater accountability for child health among Medi-Cal managed care plans; 2) realize the full potential of Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for California's children; and 3) elevate a focus on children among the managed care plans and the State Medicaid agency. It also outlines a number of longer-term strategies that the State will need to consider to achieve the goals of an equitable, advanced child health delivery system, a number of which will require substantial time and resources.

California's families, healthcare providers, community-based programs, and policymakers are reeling from the events of the past year. They continue to confront the COVID-19 pandemic and its economic fallout (see COVID-19's Impact on Californian Children & Families), the long-overdue societal reckoning with systemic racism and racial injustice that came to the forefront in 2020, the repercussions of destructive wildfires, the impact of federal immigration policies that split up families and discourages use of Medi-Cal and other health and social supports (see Consequences of Harsh Federal Immigration Policies Exacerbate Effects on the COVID-19 Pandemic), and more. These simultaneous critical developments elevate the urgency to find and implement equitable solutions and accelerate change. The strategies described throughout this Options Paper offer promising practices and policy options that can be promoted, adopted, and expanded to improve the lives of California's young children and their families.

COVID-19's Impact on Californian Children & Families

4.8 percent increase in Medi-Cal enrollment from February to August 2020[1]

16.4 percent unemployment rate—historic high—in May 2020[2]

13 percent uninsured non-elderly adults[3]

14.4 percent of households experiencing food scarcity[4]

18 percent children with no live teaching instruction due to school closures in Fall 2020[5]

40 percent reduction in routine children's vaccinations[6]

Consequences of Harsh Federal Immigration Policies Exacerbate Effects on the COVID-19 Pandemic

California is home to more than 10 million immigrants, with half of California's children having at least one immigrant parent.[7] While, historically, California has been supportive of immigrants when it comes to eligibility for public benefits, the severe federal policies and hostile rhetoric of the past four years have fueled fear and confusion among immigrants and their family members. Concerns about the dramatic changes in the implementation of public charge guidance and new obstacles for people who want to sponsor family members to join them in the United States have caused "chilling effects," steering many immigrants and their families away from seeking the health, nutrition, and other help they may need.[8] Such needs may be even more profound than before, due to the health and economic fallout from the COVID-19 pandemic.

Recently, the Urban Institute found that among adults in households with low incomes that include immigrants and children, nearly one-third (31.5 percent) reported forgoing assistance due to fear of "risking future green card status."[9] Even more worrisome is that serious misunderstandings are widespread and many adults in California immigrant families did not understand key aspects of the rule; for example, only 18.2 percent knew that children's enrollment in Medi-Cal would not be considered in their parents' public charge determinations.[10] There will likely be early action by the Biden Administration to reverse the damaging changes to the public charge policy; however, it will still be critical to address the residual impact of the "chilling effects" on coverage and re-build the trust lost in public benefits programs like Medi-Cal.[11]

Introduction

This paper presents a set of strategies and options that California can use to leverage Medi-Cal, the State's Medicaid program, to move toward an equitable, advanced health delivery system for its children. Close to five million children are enrolled in Medi-Cal, more than two-thirds of whom are Black and Brown children.[12] California's program alone covers more children than 23 other states combined.[13] Among children under the age of five, almost two-thirds are enrolled in Medi-Cal with an estimated $3 billion spent on their care, half of that representing State and local (e.g., county) dollars.[14,15] With the State's sweeping size and potential influence, the steps California takes at this pivotal moment can play a substantial role in transforming pediatric primary care for young children and their families in the months and years ahead.

California has a robust history of working to improve the lives of young children. With the support of its residents at the ballot box, it has used tobacco tax revenue to establish First 5 County Commissions to improve young children's health and development (see First 5 County Commissions). California also provides coverage to children regardless of immigration status, a critical decision in a State where 45 percent of children live in immigrant families.[16] Even so, a March 2019 report by the California State Auditor found that millions of children in Medi-Cal are not receiving preventive services to which they are entitled and concerns persist about the quality of care they receive and their access to services.

In recent years, the current Newsom Administration and State legislative leaders have taken steps to address some of these issues and to focus on young children's social and emotional development.[A] Initiatives include:

- **Supplemental Provider Payments for ACEs and Developmental Screenings.** Starting in January 2020, Medi-Cal providers have been able to receive supplemental payments—on top of the general reimbursement rate—for providing adverse childhood experiences (ACEs) screenings for child and adult Medi-Cal beneficiaries and developmental screenings for children enrolled in Medi-Cal. The additional payment is $29.00 per ACEs screening and $59.90 per developmental screening. While the supplemental payments are slated to expire in July 2021, the Administration's budget calls for extending them through July 2022 and others have recommended making the increases permanent.[17,18,19]
- **Family Therapy Guidance.** In September 2020, the Department of Health Care Services (DHCS) issued first-in-the-nation guidance permitting children enrolled in Medi-Cal to receive "dyadic" treatment (i.e., treatment of the child and parent/caregiver as a unit) without requiring the child to have a mental health diagnosis.[20] Children who have at least one of a robust list of specified risk factors may receive needed treatment services; children without a risk factor may receive up to five treatment sessions without a diagnosis.
- **Master Plan for Early Learning and Care.** Published in December 2020, the "Master Plan" prioritizes a child's first five years of life and highlights supporting their caregivers, families, and educators to ensure children are prepared for success. The Master Plan

[A] Among the State's current leaders are a significant number of nationally-recognized early childhood experts and advocates. Selected examples include California's first Surgeon General, Dr. Nadine Burke Harris, a pediatrician, national authority on the impact of early trauma and ACEs on long-term health, and Chair of the First 5 California Children and Families Commissions, as well as California's Health and Human Services (CHHS) Deputy Secretary for Early Childhood Development and Senior Advisor to Governor Newsom on early childhood development initiatives, Kris Perry, who was the former Executive Director of First 5 California and First 5 San Mateo.

presents key objectives and policy goals to focus on a child's early learning and care, including supporting positive health outcomes.[21]

- **Roadmap for Resilience.** Also published in December 2020, the "Roadmap" discusses solutions, models, and best practices to recognize and effectively address ACEs and toxic stress. In particular, the Roadmap identifies cross-sector strategies for addressing ACEs and toxic stress at the State level and prioritizing prevention, equity in outcomes, and enhanced coordination across healthcare, public health, social services, early childhood, education, and justice.[22]

First 5 County Commissions

Created in 1998 through a voter-approved initiative that relies on tobacco tax revenue (now often referred to as "Proposition 56 funds"), First 5 California is a unique public entity in each county that addresses the health and development of young children through age five.[B] Each county has a First 5 County Commission ("County First 5") that builds a system of local providers and programs. The County First 5s and their funded partners typically offer parenting resources and workshops, early literacy development, community supports and referrals for health, childcare, education, and access to developmental screenings, referrals, and treatment.[23] For Medi-Cal and Medi-Cal managed care plans, they are an important partner to consider in any effort to improve the health and well-being of young children.

These actions illustrate California's efforts to improve care for young children, and, while many issues still remain, there is interest in accelerating change in this direction.

[B] First 5 was established through the 1998 Proposition 10 (California Children and Families Act) ballot initiative which increased the cigarette surtax by 50 cents/pack and increased the tax on tobacco products by an equivalent amount with the revenue funding the County First 5s. Proposition 56 (Tobacco Tax Increase Initiative), a similar tobacco tax voter initiative, passed in 2016, reiterated support for the Proposition 10 funds for First 5 by increasing the excise tax by $2/pack (now at $2.87) and increasing the tax on tobacco products by an equivalent amount..

Key Characteristics of an Equitable, Advanced Child Health Delivery System for California

The strategies and options in this analysis are aimed at supporting an equitable, advanced delivery system for young children in California that features:

Whole Child Approach. The health of the "whole child" considers the child's physical health, mental health, the strength of the child's relationship with parents and caregivers, and the child's developmental process. Social and economic factors that affect health (e.g., access to safe and stable housing, food, early education opportunities, economic supports), as well as the extent to which they face systemic racism and inequity, immigration concerns, and exposure to ACEs (e.g., interpersonal violence, housing and food insecurity, separation or death of a caregiver). The focus of the whole child approach is on prevention, and includes universal screening to identify and connect children and their families to services—including preventive behavioral health services—to address concerns before major issues and challenges develop.

Family-Centered Care. A young child's nurturing, secure relationship with a parent or caregiver is essential to optimal health and development. Family-centered care validates and supports the strengths caregivers bring to this foundational relationship, and also provides anticipatory guidance to help parents understand and address each stage of their child's development. Since a parent's health and behaviors have a direct impact on a child's well-being, the pediatric care provider screens caregivers for depression, tobacco, or other substance use, as well as for economic and social needs.

Community-Driven Team Based Model. Integrated expanded care teams in the pediatric primary care setting include pediatric care providers who can attend to the child's physical and behavioral health, as well as practitioners who are best able to help families prepare for and navigate the well-child visit, and assist them in making connections to needed community resources. Such care teams may include community health workers, peer support specialists, doulas, and/or family navigators who share lived experience with families, including with systemic racism and discrimination. Through strong, intentional community partnerships, care team members can help link families to culturally competent supports and resources outside of the clinic, ensure that the family has been able to follow up on referrals, and offer cross-sector coordination when a child faces issues at the intersection of health, development, and early learning.

Tools for Promoting Change: Implementation Approaches

California policymakers have a number of Medi-Cal levers at their disposal to work toward an equitable, advanced child health system.

Medi-Cal Managed Care (MMC) Reprocurement. DHCS is in the midst of a major reprocurement for Medi-Cal managed care plans (MCPs), the first such effort in over a decade. The request for proposal (RFP) is expected to be released in 2021, and the reprocurement will impact millions of Medi-Cal beneficiaries—including the 41 percent of all Medi-Cal beneficiaries who are children—by modifying the terms under which Medi-Cal MCPs serve beneficiaries and, potentially, changing the mix of plans in the California market.[C,24,25] Health plans are slated to submit their bids by mid-2021, and DHCS will make its decisions on which plans will serve the California market in December 2021, for an effective contract date of 2024.

Federal Waivers. California's current Section 1115 waiver, Medi-Cal 2020 (formerly "Bridge to Reform") was expected to expire at the end of 2020.[D] DHCS received Centers for Medicare & Medicaid Services (CMS) approval for a 12-month delay in the expiration of the existing waiver in light of the COVID-19 pandemic, extending the Medi-Cal 2020 waiver to December 2021. In October 2019, DHCS proposed a framework for federal waiver authority under Section 1115 and Section 1915(b) to advance "broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal."[26] DHCS could consider incorporating pediatric initiatives in its 2021 CalAIM waiver development, as well as through future waivers.[27]

Additional State Policy Levers. DHCS has numerous other ways it can change how Medi-Cal serves children. These include securing changes in benefits and eligibility via a state plan amendment (SPA); issuing guidance (e.g., All Plan Letter, Policy and Procedure Letter) to providers, health plans, beneficiaries, and families; and modifying its own internal staffing and MCP oversight and enforcement approach.

[C] The current Medi-Cal contracts are effective as of 2017, but have not been reprocured as they are now, in recent decades. Unlike most other states, California does not engage in regular reprocurements, potentially leading to entrenched incumbent health plans that do not face competitive pressure to improve quality and explore innovation. Recognizing this issue, the California State Legislature has considered legislation, most recently SB 936, that would require DHCS to conduct Medi-Cal managed care reprocurements every five years.

[D] California Medi-Cal 2020 1115 demonstration was approved December 30, 2015–December 31, 2020. The State was preparing to submit CalAIM for a Section 1115 waiver demonstration that would have been active January 1, 2021–December 31, 2025. With the State's recent CMS approval to extend the current California Medi-Cal 2020 waiver given COVID-19 through December 31, 2021, the CalAIM Section 1115 waiver is expected to be effective January 1, 2022–December 31, 2026.

Short-Term Strategies (12 Months)

The strategies in this section can be initiated within approximately 12 months to support an equitable, advanced child health system. The first set of strategies leverages the competitive reprocurement of Medi-Cal MCPs currently underway to increase accountability for the quality of care provided to children; the second set calls for strengthening implementation of the federally-required Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit; and the third set elevates children's issues within MCPs and DHCS.

STRATEGY

1

Leverage Medi-Cal MCP reprocurement to strengthen accountability and quality

Nearly 90 percent of the five million children enrolled in Medi-Cal receive their physical healthcare and behavioral health services for mild-to-moderate conditions through Medi-Cal MCPs, making the State's reprocurement of these plans a powerful tool for driving change.[28] With some exceptions, Medi-Cal MCPs have not been focused to date on young children because they are relatively inexpensive to cover—even when at risk for significant health issues later in life—and investing in their care is unlikely to show a major short-term return on investment (ROI), even if it improves their well-being, generates a long-term ROI, or creates savings for other sectors such as education or the juvenile justice system. In the absence of incentives to do otherwise, plans gravitate toward focusing on populations with high current expenditures, such as adults with unmanaged chronic conditions.

DHCS has recognized the importance of addressing child health issues in the reprocurement now underway. It has listed child health as one of ten top priorities in reprocurement materials and advised stakeholders that the issue is "of the utmost importance to the agency."[29]

Options available to increase plan accountability for children in reprocurement include:

Use withholds or incentives to encourage MCPs to improve care for young children

In the past few years, DHCS has increased expectations that plans will improve the quality of care they provide to children, but significant gaps still remain. A January 2020 study reported that only one in four children enrolled in Medi-Cal received a developmental screening in the first three years of life, a rate well below the national average of 33 percent. Some of the quality issues for children (and other populations) may be in part because, until recently, the State required plans to meet a minimum performance level (MPL) set at only the 25th percentile of national Medicaid results. Now plans are expected to meet an MPL set at the 50th percentile; but, for selected measures, including developmental screening rates, plans still are not required to meet MPLs.[30,31,32,E] When plans fail to meet minimum performance standards, they are

[E] In light of COVID-19, DHCS waived the requirement that MCPs meet MPLs for hybrid measures—measures that rely on administrative and medical record data—for the 2020 reporting year and provided additional flexibility on reporting. See All Plan Letter 19-017, "Quality and Performance Improvement Adjustments Due to COVID-19. April 30, 2020." Retrieved from https://

expected to engage in rapid cycle improvement plans, additional performance improvement projects (PIPs), and corrective action plans. While current State law authorizes sanctions to be levied—such as financial penalties or loss of beneficiaries assigned to them under the State's auto-assignment algorithm—these options do not appear to have been effective in driving quality improvement. A study of Medi-Cal managed care quality trends from 2008 to 2018 found that "There was no significant change over time in the trend of scores on measures that fell below the MPL, suggesting that the requirement for an improvement plan was not effective in improving scores on these measures."[33] The study also found performance on several measures related to children showed no improvement or declined over time.[34]

In order to achieve meaningful improvements for children, DHCS could reinforce quality expectations by making MCPs financially accountable. California is one of a shrinking number of states that does not use a withhold or incentive arrangement in their MCP contract to reinforce the state's priorities; for example, 24 of 40 Medicaid managed care states report using withhold arrangements and 23 of 40 managed care states report using pay-for-performance incentives.[35] Under withhold arrangements, a portion of an MCP's capitation payment is withheld by DHCS unless and until the MCP meets performance targets.[F,36] Withhold arrangements are not intended to reward plans for meeting basic contractual obligations or providing beneficiaries with required benefits, but rather for meeting performance objectives.[37] Alternatively, DHCS could offer financial incentives to encourage MCPs to invest in pediatric populations. Under such arrangement, MCPs could earn funds above the capitation payment if they meet or exceed DHCS-identified quality and performance metrics linked to young children's social and emotional development. Federal regulations limit incentive arrangements to an additional five percent above the capitation payment.[38]

DHCS could use a withhold or incentive arrangement to encourage plans to meet quality targets based on metrics collected and tracked over time, including metrics stratified by race and ethnicity, with targets to close health disparities (see Identifying, Preventing, and Reducing Health Disparities). For example, DHCS could link a share of capitation payments—either by withholding funds or by offering an incentive payment—to MCPs for strong performance and improvement in providing children with developmental screenings, as measured by the rate of children receiving required developmental screenings in the first three years of life and well-child visits in the first 30 months of life. In the longer term, DHCS could ensure MCPs are meeting higher levels of performance and quality metrics focused on children's care and their experience with the advanced children's health delivery system. These include fundamental areas related to accessing developmental screenings and childhood immunizations, as well as successfully linking families to supports and services and proactively addressing relational health and social drivers of health that impact children's development including housing, food and nutrition, educational access, and school readiness.

Implementation Approach

MMC Reprocurement

www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-017QISupp.pdf.

[F] Federal regulations state that withholding a portion of a capitation rate for non-compliance with general operational requirements is a penalty, not a withhold arrangement.

State Example

Oregon's Medicaid health plans, Coordinated Care Organizations (CCOs), are required to annually report pediatric-specific quality metrics to the Oregon Health Authority and plans are financially rewarded (or penalized) based on their performance. Similar to California's MCPs, Oregon's CCOs must report CMS Child Core Set Measures, as well as report on Oregon-developed measures[39,40,41] Oregon is leading the nation in efforts to develop kindergarten readiness-related metrics, such as whether the CCOs are taking steps to ensure that children are physically ready to begin school (e.g., whether the child has had well-child visits and dental checkups) and have access to behavioral health services.

Establish a robust and timely child health dashboard that displays how well plans are doing, including progress on racial disparities

Over the years, California has expanded the data that are publicly available on plan performance in several key areas.[G] However, DHCS could go further in signaling its strong interest in tracking and monitoring how children are faring through creation of a pediatric-specific dashboard that provides more granular, plan-specific data. This dashboard could include information on the following:

- Number and distribution of children enrolled in Medi-Cal by MCP;
- Plan-specific data on performance outcomes for children on the CMS Child Core Set Measures, such as developmental screening rates;
- MCP-specific data on access to services, such as behavioral health services;
- Data stratified by race, ethnicity, and language to support analysis on and accountability for closing associated disparities; and
- Specific action steps that DHCS is taking to address any gaps in pediatric care.

Identifying, Preventing, and Reducing Health Disparities

DHCS collects minimal data from MCPs regarding race and ethnicity, and can go further in both the data MCPs are required to report and how often plans must submit the data to DHCS for review. As noted by the California Pan-Ethnic Health Network, improving the quality of data collection, stratified by race, ethnicity, language, and other socioeconomic factors is critical to identifying and addressing health disparities and inequities. DHCS should further stratify disaggregated data—based on the federal Office of Management and Budget standards—to best identify and target health disparities in smaller communities, including Asian, Native Hawaiian and Pacific Islander, and American Indian/Alaska Native populations, as well as link accurate data collection and submission to capitation withholds, incentive bonuses, and/or PIPs.[103]

The 2020 Preventive Services Report—that was developed in response to the March 2019 California State Auditor report's recommendation that DHCS expand its monitoring provides—a strong model of the type of information that should be made available.[42] However, the Preventive Services Report is intended to be prepared annually; the child health dashboard should be refreshed on a quarterly basis to identify emerging issues and trends. Along with highlighting that DHCS is carefully staying on top of how children are faring under Medi-Cal, such a dashboard would provide valuable information to policymakers, providers, children's advocates, and families seeking to understand the State's progress in establishing an equitable, advanced child health system and facilitate State and local action on issues and trends of concern sooner.

[G] DHCS has a large amount of publicly available MCP performance data, though they are fragmented across reporting data and available sources; examples include, the Medi-Cal Managed Care Accountability Set (MCAS) (formerly called the External Quality Review Technical Report), National Committee for Quality Assurance (NCQA) accreditation and ratings, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results.

Implementation Approach

CA State Policy

State Example

Louisiana Department of Health hosts a Medicaid Managed Care Quality Dashboard with tables that are easy to access and understand and detail each plan's performance on State-selected quality performance metrics, including Healthcare Effectiveness Data and Information Set (HEDIS) and CMS Child Core Set Measures.[43] For example, the Care for Children and Adolescents table reports on six performance metrics, including well-child visits in the first 15 months of life. A further breakdown is provided on the specific metric, noting the State's seven managed care organizations' performance in the most recent year (2019), as well as rate of change in reporting the metric since 2016.

Strengthen care coordination and facilitate connections to community resources for children (e.g., parenting supports, housing instability, food insecurity, ACEs)

Care coordination is critical to connecting young children and their families to comprehensive services and ensuring they are able to navigate the available services. With states, including California, increasingly relying on Medicaid managed care delivery systems, and when some or all of the EPSDT benefit is delivered through MCPs, those MCPs have overarching obligations to provide care coordination for child beneficiaries. California has reiterated multiple times to MCPs the plans' responsibility to provide care coordination for children through the EPSDT benefit—referenced to as "comprehensive medical case management" and "targeted case management." While requirements are featured in the current MCP contract and reinforced in an August 2019 statewide All Plan Letter and in the Medi-Cal Provider Manual, feedback on the ground indicates that there is still confusion on scope and expectations for MCPs related to care coordination, leaving families and their providers to sort through the complexities and navigate multiple systems.[44,45]

With the MCP reprocurement, DHCS has the opportunity to clarify and strengthen its expectations and oversight approach on care coordination for children. It can make clear that MCPs have a fundamental obligation to provide care coordination for all children and that care coordination extends beyond referral and linkage to healthcare services to encompass community resources such as parenting supports, housing, food and nutrition, and education. DHCS can also require submission of children's care coordination plan, partnerships with local agencies and community-based organizations that serve young children and are culturally appropriate, and regular reporting by MCPs on their performance against these plans; for example, the MCP contract can require or establish an expectation that plans must contract with organizations that provide referrals and referral outcomes related to care identified in preventive services. Through partnerships with local agencies and community-based organizations, MCPs can leverage trusted resources to ensure children and families are referred to appropriate services and supports.

Currently, the MCP contract articulates requirements on care coordination and case management in Exhibit A, Attachment 11.[46] The attachment addresses requirements by systems (e.g., California Children's Services, children with special healthcare needs, specialty mental health, local education agencies, early intervention) rather than from a whole child perspective. This contract attachment could be reoriented and revised to comprehensively outline the MCP requirements for children. In light of the State's CalAIM priority to implement an enhanced care management (ECM) benefit to provide intensive and comprehensive care management services, it is particularly important that the care coordination and case management requirements be reinforced to ensure a strong and solid foundation on which to overlay additional ECM requirements for MCPs.

Implementation Approach

MMC Reprocurement

State Examples

Thirty California counties sponsor Help Me Grow, which is a national early childhood systems model that is aimed at creating a more comprehensive system for early identification of developmental delays or concerns, referrals, and care coordination through a collaborative of public agencies, families, and providers.

- **First 5 Alameda** supports Help Me Grow, which partners with family navigators who assist families through home visits and access to care, as well as care coordinators who work with patients and providers to ensure families are linked to community services and providers are updated on referrals and follow-up appointments.[47]
- **First 5 San Mateo** has funded a countywide "Watch Me Grow" collaborative since 2007 to coordinate care across pediatric and mental health providers, early childhood services, home visiting services, and preschools to ensure strong care coordination systems for families and prepare young children for school.[48]

MCPs' Care Coordination Responsibilities

California's statewide All Plan Letter (#19-010) and Medi-Cal Provider Manual reiterate MCPs' responsibility to provide care coordination for children through the EPSDT benefit.[49,50] Specifically, the MCPs must ensure the following as it relates to their enrollees' care coordination:[51]

- Ensure each enrollee has:
  - An ongoing source of care appropriate to his or her needs;
  - A person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee; and
  - Been provided information on how to contact their designated person or entity.
- Coordinate the services the MCP furnishes to the enrollee:
  - Between settings of care (e.g., hospital, institutional stays);
  - Services received from any other health plan;
  - Services received through fee-for-service Medicaid; and
  - Services received from community and social support providers.
- Ensure each provider furnishing services to enrollees maintains/shares enrollee health records.
- Ensure enrollees' privacy is protected per federal regulation and law.
- Provide a "best effort" to conduct an initial screening of each new enrollee's needs within 90 days of the effective date of coverage and share with DHCS or any other health plan(s) serving the enrollee the results of assessment.

While this is helpful guidance to plans, California has the opportunity to strengthen and then memorialize these obligations in the managed care contract itself.

Incentivize or require use of community-driven team based care

To implement community-driven team based models through Medi-Cal to improve children's and families' health outcomes, the MCP contract could require the use of community health workers, peer support specialists, or other team based models of care. While DHCS is in the process of implementing Senate Bill 803, which requires the agency by July 2022 to create statewide requirements for counties to leverage peer support specialists—individuals who identify as having lived experience with recovery from mental illness, substance use disorder (SUD), or both—the State could consider expanding the criteria of peer support specialists to support in primary care and prevention areas.[52]

The MCP contract could also require or incentivize MCPs to include community health workers and other frontline public health workers as network providers in pediatric primary care; specify community health worker to member ratios; and, importantly, direct MCPs to ensure that such workers are compensated for the care they provide. In addition, DHCS could prepare and submit an SPA for CMS approval to directly cover community health workers. Such community health workers and other similar professionals may provide preventive services and receive Medicaid reimbursement if they are supervised by a licensed healthcare practitioner.[H,53]

It is important to note that the traditional medical model has its own limitations and a history of systemic racism, especially toward Black and Brown people. DHCS could encourage or require MCPs to support social capital building strategies that partner with the community

[H] States have the option to cover community health workers as part of the preventive services benefit, which allows for coverage of preventive services "recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law."

and leverage peer-to-peer support, often including patients and coordinators with similar backgrounds and lived experience to engender trust and mutual support. Examples of such strategies include:

- DULCE, a team based care model that integrates a community health worker, a legal partner, and an early childhood system representative to support infant development and proactively address a family's social and support needs.[l,54]
- Centering Pregnancy and Parenting, a patient-centered care model providing group prenatal visits for pregnant women.[55]
- Family Independent Initiative, a national organization supporting financial and social capital in low-income communities through direct cash assistance and fostering community through peer-to-peer support.[56]

Implementation Approaches

CA State Policy

MMC Reprocurement

State Examples

Michigan's Medicaid health plans are required to participate in a State-approved Community Collaboration project (e.g., community health improvement plans conducted by hospitals and local public health agencies) aimed at improving population health through the community-led initiative.[57] Health plans must also support community health worker interventions coordinated by local community-based organizations focused on addressing social drivers of health and promoting health prevention and education. Michigan's managed care contract requires a ratio of one community health worker to 5,000 enrollees, and it incentivizes health plans to contract with community-based organizations' community health workers by counting the contracted community health worker as a 1.25 full time employee (FTE) as opposed to one FTE. The community health workers at community-based organizations provide a range of services to Medicaid enrollees, including arranging for social services, scheduling and participating in office visits, and serving as a culturally sensitive and reliable advocate for enrollees.

Oregon was approved to permit community health workers under the supervision of a physician to receive Medicaid reimbursement, prior to the 2013 CMS guidance on preventive services state-option guidance. The State updated its policy into an SPA in July 2017 to cover services provided by community health workers, as well as peer wellness specialists and personal health navigators, who are supervised by a licensed healthcare professional and performing services within the scope of that licensed healthcare professional's practice, including physicians, certified nurse practitioners, physician assistants, dentists, dental hygienists (with an expanded permit), Ph.D. and PsyD psychologists, licensed clinical social workers, and licensed professional counselors.[58]

[l] DULCE—Developmental Understanding and Legal Collaboration for Everyone—is an approach being further developed by CSSP.

Case Study—New Mexico's Integration of Community Health Workers Into Medicaid

The University of New Mexico Health Sciences Center (UNMHSC) established the CHW LEADS program to reach populations with barriers to accessing care, including Black and Brown patients.[59] Patients are admitted to CHW LEADS (1) through managed care referral or (2) after screening positive for a social need at a participating primary care clinic or federally qualified health center (FQHC). Community health workers are embedded in practices and social services agencies, assisting with referrals, assessing risks and needs, and building relationships with patients. UNMHSC estimates that CHW LEADS has generated a 4:1 ROI by increasing use of primary care and lowering prescription drug costs, among other metrics. In 2018, health plans paid a capitated fee of $2.19–$5.75 per member per month (PMPM) for members participating in CHW LEADS, and paid an additional $321.00 PMPM for select high-risk members in the program. CHW LEADS coordinates the community health workers, in collaboration with the State and managed care plans.

STRATEGY

2 Strengthen and build on existing EPSDT policy

A cornerstone of federal Medicaid law is its guarantee of all medically necessary services for Medicaid-enrolled children and youth under the age of 21, or the EPSDT benefit (see EPSDT benefit graphic below). Historically, California has faced significant concern that children enrolled in Medi-Cal have not received EPSDT services to which they are entitled. The issue of EPSDT compliance has been the subject of litigation, a State Auditor's report (see California State Auditor's Report), and legislative action.[60] California is now working to address these concerns and can use the Medi-Cal reprocurement and related actions to leverage the federally guaranteed EPSDT benefit.

EPSDT Benefit[61,62,63]

Early and Periodic Screenings	Diagnostic Services	Treatment Services
• Regularly scheduled comprehensive health and developmental screenings • Comprehensive unclothed physical exams • Appropriate vision and hearing tests, immunizations, and laboratory tests • Dental screenings and referrals • Health education	• Medically necessary diagnostic services when a risk is identified, including follow-up testing, evaluation, and referrals	• Timely treatment services as determined by child health screenings (which includes treatment services medically necessary to correct or ameliorate defects and address physical and behavioral health conditions)

Reinforce compliance with existing EPSDT policies through strong MCP contract language and outreach and education to plans, providers, and families

In 2018, Senate Bill 1287 was enacted to clarify the medical necessity standard, and directed DHCS and its contractors to update guidance and associated materials related to medical necessity by July 2022.[64] DHCS' August 2019 All Plan Letter reinforced MCPs' federally required role and responsibilities in ensuring eligible children under the age of 21 receive the EPSDT benefit for all medically necessary services, including behavioral healthcare.[65] The 19-010 All Plan Letter superseded and clarified similar guidance issued in 2007 and 2018 to confirm that California MCPs must comply with federal and State law to provide EPSDT for all children under age 21 in accordance with the American Academy of Pediatrics' Bright Futures periodicity schedule.[66] Further, the guidance clarified that MCPs must cover any pediatric service that is "medically necessary," which is aligned with the federal EPSDT standard of "necessary health care, diagnostic services, treatment, and [other measures] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered under the State plan."

Although it is helpful that DHCS has issued guidance reiterating the federal requirements related to EPSDT, the history of issues indicates that more is needed. DHCS could memorialize these EPSDT requirements in the MCP contract, including requiring MCPs to educate providers and members about the benefit. It is important to accompany contract clarifications with an active effort to ensure that plans understand and follow the requirements and that they work with their network providers to ensure that all children enrolled in Medi-Cal receive the benefits to which they are entitled. For example, DHCS could facilitate a statewide webinar series aimed at MCPs on their EPSDT obligations in order to elevate the issue and

California State Auditor's Report

The California State Auditor conducted an audit in March 2019 that identified that over two million children enrolled in Medi-Cal did not receive preventive healthcare services, leaving California ranked 40th among states for children's preventive service utilization.[104] The State Auditor concluded that DHCS delegates much of its responsibilities for ensuring children receive preventive care to the MCPs, missing opportunities to best serve children enrolled in Medi-Cal. The State Auditor provided a number of recommendations for improvement to the California State Legislature and DHCS:

- Legislative Recommendations
  - Direct DHCS to modify its criteria for evaluating MCPs' alternative access standards requests to determine whether the resulting times and distances are reasonable to expect a Medi-Cal beneficiary to travel;
  - Require any MCP unable to meet those criteria to allow affected members to obtain health services outside the MCP's network;
  - Direct DHCS to require such MCPs to inform affected members that they may obtain those services outside the MCP's network;
  - Require MCPs to assist members in locating a suitable out-of-network provider; and
  - Direct DHCS to implement a pay-for-performance program targeted at ensuring MCPs are more consistently providing preventive services to children in Medi-Cal.
- DHCS Recommendations
  - Propose to State Legislature funding increases to recruit more providers in areas where they are needed the most;
  - Establish performance measures aligned with the American Academy of Pediatrics' Bright Futures services for all age groups and require MCPs to track and report the utilization rates on those measures;
  - Conduct audit procedures through its annual medical audits that address the delivery of preventive services to all eligible children for all MCPs;
  - Improve its processes for validating the accuracy of the directories that Medi-Cal beneficiaries use to access services;
  - Require MCPs to address the most significant findings cited in their required reports on issues related to cultural and linguistic needs; and
  - Monitor and identify effective incentive programs at the MCP level and share results with all MCPs.

address any outstanding questions, as well as for county organizations such as First 5 County Commissions and other stakeholders that could use the information to better track, monitor, and support MCP performance in their communities. By ensuring that EPSDT is clearly understood by Medi-Cal MCPs and their provider networks—in both physical and behavioral health networks—DHCS can help young children access important services to prevent serious emotional disturbance (SED), support families with children with developmental delays, and assist providers in receiving reimbursement for EPSDT services.

In addition, DHCS could consider partnering with advocacy organizations to develop and disseminate a "Know Your Rights" summary of EPSDT for advocates and families, prioritizing families that are more likely to experience barriers in accessing healthcare services, such as Black and Brown families, parents/caregivers who are formerly incarcerated, immigrants and families with mixed immigration status, families with children with special healthcare needs, residents of rural counties, and individuals with limited English proficiency. The EPSDT summary should be easily understood by families and include explicit, actionable information on how to use and access a child's EPSDT benefit (e.g., preventive health benefit, non-medical transportation, appointment scheduling assistance, interpretation services), and highlight that accessing the EPSDT benefit does not implicate any public charge concerns for either parents or children who are immigrants.

Implementation Approach

CA State Policy

State Examples

New Hampshire's Medicaid managed care contract includes clear, well-defined expectations of managed care organizations and providers regarding a child's EPSDT benefit, including contract language on medical necessity, prior authorization requirements, preventive care, and member outreach and engagement.[67]

California stakeholders including the First 5 Association of California, the National Health Law Program, and Children Now—submitted responses to DHCS' request for information in preparation of the MCP contract reprocurement and development of the RFP, which includes draft EPSDT contract language for consideration.[68]

Extend approach from 2020 DHCS family therapy guidance to support a broader preventive approach to behavioral health for young children

The 2020 DHCS family therapy guidance was an important step in recognizing pediatric preventive care, the importance of behavioral health, and the critical relationship in the child and parent/caregiver dyad. Through the guidance, DHCS removed the requirement of a formal mental health diagnosis for the child and enabled a child and their parent/caregiver to access evidence-based family therapy as long as the child or their parent/caregiver meets broadly defined risk factors. This approach could be extended to cover a broader array of preventive behavioral health and related services for children without requiring a diagnosis, an issue of particular importance to young children given that they often (appropriately) do not have a diagnosis even when at significant risk of developing such a condition due to stressors experienced by the family.

Federally Qualified Health Centers (FQHCs)

FQHCs are a critical source of care for children and families in California—over 18 million annual visits—primarily serving Black and Brown communities (64 percent of patients) and individuals enrolled in Medi-Cal (63 percent of patients).[105] Under current rules, FQHCs are limited to being reimbursed for only one type of service to the same Medi-Cal patient on the same day.[106] Essentially, FQHCs are providing both behavioral and physical healthcare services to the same patient on the same day, but only paid for one of the services. Allowing same-day billing for physical and behavioral healthcare services better meets the needs of children and families and supports adequate reimbursement for FQHCs.

This comprises removing the requirement of a formal mental health diagnosis and recognizing reimbursement for a range of services to create a behavioral health well-child visit for all children that would enable dyad-focused mental health promotion, screening, interventions, needs assessment, care coordination, and referrals for services. It could be achieved by adjusting service criteria and opening new billing codes formalized through DHCS guidance. Through these changes, DHCS can better ensure pediatric primary care providers and the care team are reimbursed for evidence-based dyadic models—provided to a young child and another family member, typically a parent or caregiver—such as DULCE and HealthySteps.

Along with making policy changes, it is important to provide plans and providers with resources to understand and implement the changes. California could accompany a new focus on preventive behavioral health services for young children with outreach and education for MCPs, providers, and beneficiaries' families, and to train providers in evidence-based models and approaches. Under federal regulations, states are responsible for informing MCPs and beneficiaries about new covered benefits, and MCPs are responsible for informing providers and beneficiaries; however, elevating awareness and effective implementation will be most successful when a range of organizations with deep local commitments and broad reach are involved, including First 5 County Commissions, provider organizations (e.g., California Chapter of the American Academy of Pediatrics), and family-centered organizations and advocacy groups.[69]

Implementation Approach

CA State Policy

State Example

San Francisco County laid the groundwork for preventive family therapy with the assistance of The California Children's Trust, HealthySteps ZERO TO THREE, Children's Health Center at Zuckerberg San Francisco General Hospital and Trauma Center, and the San Francisco Health Plan.[70] The consortium entered into a groundbreaking collaboration in Summer 2020, providing preventive dyadic treatment and services to children eligible for the Medi-Cal mild-to-moderate mental health benefit enrolled in MCPs. The program leverages Z-codes aligned with accepted CPT codes to serve as children's primary diagnosis and providers' reimbursement. Specifically, the pilot program leverages HealthySteps' dyadic behavioral health services that rarely require a medical diagnosis, but prefer Z-codes to enable reimbursement for preventive services impacting young children and their families. The pilot program noted example Z-codes such as inadequate housing (Z59.1), unemployment (Z56.0), illiteracy and/or low-literacy levels (Z55.0), and institutional upbringing (Z62.22).

Continue enhanced payments for ACEs and developmental screenings, and incorporate lessons learned from recent initiatives

California ranks 40th when it comes to screening children for preventive services, a first step in helping families identify and address issues during the critical early years of a child's life.[71] In January 2020, DHCS implemented additional enhanced payments for providers who conduct a developmental screening and/or a screening for ACEs (see Proposition 56 Supplemental Payments for Pediatric Primary Care Providers). To qualify for the supplemental payment for the ACEs screening, providers must undergo some training on ACEs. Dr. Nadine Burke Harris, California's first Surgeon General and renowned pediatric trauma expert has spearheaded the ACEs Aware initiative, which provides training grants and outreach to healthcare providers on how to prevent and mitigate childhood trauma and implement trauma-informed care in pediatric practices.

Currently, the supplemental screening payments are slated to end in July 2021 although the Newsom Administration has called for continuing them through July 1, 2022.[72] Given the persistent issues with children enrolled in Medi-Cal receiving developmental screenings and the expected effect of the COVID-19 pandemic on ACEs, California should consider making the supplemental payments permanent and also addressing some of the implementation issues that arose with the payments in 2020, such as:

- Ensuring providers understand how to refer patients with a positive developmental and/or ACEs screening to appropriate community-based resources;
- Closing the loop between primary care providers and community-based organizations via a referral system to ensure referral and follow-up appointments are scheduled and completed;
- Requiring and facilitating regular data collection and analysis on developmental and ACEs screenings—disaggregated and stratified by race, ethnicity, language—to identify health disparities and gaps in care; and
- Strengthening partnerships with DHCS and other stakeholders, including MCPs, providers, provider associations, First 5 County Commissions, and family/beneficiary organizations and advocates to develop and provide beneficiary and provider outreach and education.

Implementation Approach

CA State Policy

Proposition 56 Supplemental Payments for Pediatric Primary Care Providers

ACEs Aware Screening & Provider Training[73]

- **Payment.** $29.00 per ACEs screening for child and adult Medi-Cal patients.
- **Screening Approach.** Children (up to age 21) may receive an annual screening, while adults (up to age 64) may receive one per lifetime. PEARLS is the recommended screening tool for children and the ACE Questionnaire is recommended for adults.
- **Training.** DHCS has awarded dozens of grants for community organizations and public entities to conduct peer-to-peer learning, provider training, and outreach for the ACEs screening.

Developmental Screening[74]

- **Payment.** Providers receive $59.90 per developmental screening for Medi-Cal children.
- **Screening Approach.** Children (up to age 21) may receive a screening, per the American Academy of Pediatrics' Bright Futures periodicity schedule at months 9, 18, 24, and/or 30. Providers are encouraged to use validated screening tools approved by CMS.

Physician Services[75,76]

- **Supplemental Payment.** Medi-Cal providers receive an increased payment rate for 23 CPT codes that include well-child visits and pediatric specialty care. The supplemental payments are estimated to be a 140–240 percent increase on 2016 fee-for-service base rates for physician services.

Early Childhood Bundle: Risk-Based Provider Incentive Payment[77]

- **Payment**. Providers receive supplemental payments based on if the child enrolled in Medi-Cal is "non-at-risk" or "at-risk" for performance linked to five metrics:
  - Well child visit in first 15 months ($70.00; $150.00 for at-risk patient).
  - Well child visits in third through sixth years of life ($70.00; $150.00 for at-risk patient).
  - All childhood vaccines for children at age two ($25.00; $37.50 for at-risk patient).
  - Blood lead screening ($25.00; $37.50 for at-risk patient).
  - Dental fluoride varnish ($25.00; $37.50 for at-risk patient).
- **At-Risk Defined**. Children are defined as "at-risk" if they have been diagnosed with a SUD, a serious mental illness (SMI), or are experiencing homelessness or have inadequate housing, a set of criteria that primarily describes high-risk adults.

STRATEGY

3 Provide additional resources to DHCS and MCPs to focus on children

Given the number of young children receiving care through Medi-Cal and California's sizable investments in the program, DHCS should consider dedicating additional resources squarely focused on the needs and priorities of children.

Require each MCP to establish a key position as the point of accountability for Medi-Cal children and children's health initiatives

Signaling the importance of young children's health and well-being, DHCS could require MCPs to identify a key individual in a leadership position within the MCP who is accountable for the care provided to children and for children's health initiatives. This dedicated leader would be responsible for overseeing and/or coordinating pediatric care improvement initiatives, children's health quality strategy, EPSDT compliance and outreach to families, stakeholder engagement, addressing racial disparities in children's health, and innovative pediatric pilot programs. DHCS can encourage MCPs, when appointing this leader, to consider an individual with shared and lived experience in the county(s) they will be serving.

The key point of accountability at the MCP could also be required to establish and maintain partnerships with local early childhood organizations that can bring on-the-ground perspective and relationships to facilitate more meaningful and relevant involvement of children and their families with MCPs; identify provider outreach, education, and training needs and augment MCP provider education efforts; and coordinate with other local child-serving systems such as child care and education.

Implementation Approach

MMC Reprocurement

State Example

A range of states have required their MCPs to have a dedicated, senior leadership position for priority populations and initiatives. For example, **New Hampshire** in the face of the opioid epidemic decided to require Medicaid health plans to hire a SUD coordinator to coordinate services and treatment related to SUD, as well as provider relations, social drivers and community-based resources, and quality management. The coordinator must be a master's level Licensed Alcohol and Drug Counselor or Licensed Mental Health Professional with demonstrated experience in SUD treatment and recovery strategies.[78]

Establish a DHCS leadership position accountable for improving child health outcomes and equity and ensuring an effective State-level advisory committee on children's health

A DHCS leadership position with supporting staff, focused on children enrolled in Medi-Cal and their families and reporting to the Medi-Cal Director, could elevate and embed a core focus on priorities for children. Given the well-documented challenges with EPSDT implementation, this DHCS official could be responsible for overseeing EPSDT compliance, including collection of timely and actionable data, monitoring, and facilitating child health delivery system improvement. This DHCS leadership position could also regularly meet with the MCPs' points of accountability on Medi-Cal children and children's health, as well as co-lead a refreshed State-level advisory committee on improving children's health in Medi-Cal complete with leading decision makers and cross-sector coordination on child health and well-being.

DHCS currently has a number of separate stakeholder committees working at various stages and with various levels of focus on children's health promotion and prevention, including the Stakeholder Advisory Committee, the Behavioral Health Stakeholder Advisory Committee, the Medi-Cal Children's Health Advisory Panel, the California Children's Services Advisory Group, and the California Behavioral Health Planning Council (and six standing committees), among others.[79] To effectively advance a whole-child approach, it is important that a State-level advisory committee focused on children incorporate other key agencies such as the Department of Child Support Services, Department of Public Health, Department of Education, and Department of Justice that touch some of the most vulnerable Medi-Cal children and facilitate coordination and collaboration across early childhood initiatives, including between Medi-Cal and Title V. It is also critically important that the voices and perspectives of families are well-represented (see Importance of Family Engagement). At minimum, the advisory members could include representatives from the Department of Public Health, Surgeon General's office, Governor's office, provider associations, MCPs, child health advocates, and family representatives, with a priority on representation that includes those with lived and/or shared experience as Medi-Cal enrollees.

Implementation Approach

CA State Policy

State Example

Maine's Department of Health and Human Services developed the Chief Child Health Officer/Chief Pediatrician role, working out of the Commissioner of the Department of Health and Human Services' office as a dedicated individual focused statewide on children accessing the agency's services. This person also serves on Maine's Children's Cabinet, which has focused on two main priorities since January 2019: (1) All Maine children enter kindergarten prepared to succeed and (2) all Maine youth enter adulthood healthy, connected to the workforce and/or education, as well as serving on the Children's Cabinet Early Childhood Advisory Council; both Cabinets are led by the Governor's Office of Policy Innovation and the Future.[80,81]

Importance of Family Engagement

Parents and caregivers are critical in leading a child's care team with support from pediatric primary care providers, community health workers, family support specialists, community-based organizations, and other necessary providers and resources. Establishing these partnerships and ensuring that a child's care is family-centered with decision making led by parents/caregivers is important to ensuring the family's agency to make the best decisions for the child. Unfortunately, parents and caregivers often report barriers in accessing care and communicating with providers and their staff, with families noting they do not always feel heard by their pediatric primary providers or do not receive follow-up or referrals following a positive screening result. Family Voices, a leading parent and family engagement advocacy group active nationwide and in California, partnered with the Pediatrics Supporting Parents team to conduct focus groups of parents and caregivers in California. The focus group reported the following themes and challenges to Family Voices in accessing Medi-Cal services for children:

1. Families feel rushed during pediatric primary care visits, with little time to build a relationship with the provider and developmental screening questions often felt like a repetitive checklist.
2. The Medi-Cal system of care is fragmented, with the family carrying the burden of coordinating care across multiple providers and services.
3. Home visitors can be helpful and convenient for families, but there is concern that home visitors are judging a family's home and living circumstances, creating fear and distrust.

Facilitate effective uptake of new child and family-centered policies by supporting Medi-Cal MCPs and providers with information, training, and technical assistance, and by identifying available funding that can be leveraged to conduct such activities

Experience across the country—and in California—demonstrates that for new policies to gain broad acceptance and to be implemented rapidly and correctly, DHCS needs to play an active role in promoting and supporting the transition to a new way of functioning. In addition to communicating directly with plans and providers to alert them to policy changes and new opportunities (e.g., All Plan Letters, Policy and Procedure Letters) DHCS could use an array of strategies to strengthen understanding of why a new policy or procedure is important and how it can be smoothly incorporated into routine operations, including:

- Engage DHCS or external experts to deliver virtual or in-person trainings on how a particular policy can enhance the health and well-being of young children and their families, as well as the advantages that successful implementation holds for MCPs and providers;
- Deliver MCP and provider trainings on how to use recommended screening tools, submit claims using proper billing codes, and assemble supporting documentation to ensure payments are received;
- Dispatch DHCS staff or contract with experts to help providers modify clinic workflow and train staff on executing new procedures; and
- Encourage MCPs to forge partnerships with county-based non-profit organizations with expertise in early childhood and with the infrastructure already in place to help with referrals and ensure that links to community-based services are complete.

DHCS could make resources available to:

- Reward MCPs that meet performance standards indicating quality delivery of new services;
- Offer providers continuing medical education (CME) credits for participating in trainings; and
- Provide appropriate new questions for patient/customer satisfaction surveys, and reward MCPs and providers for achieving high ratings for implementing new policies and procedures.

Activities designed to provide information, outreach, training, and technical assistance to improve the delivery of the Medi-Cal program are generally eligible for Medicaid administrative matching funds, usually available at a 50 percent match rate.

Implementation Approach

CA State Policy

State Example

South Carolina developed the Quality through Technology and Innovation in Pediatrics (QTIP) initiative to provide technical assistance and peer-learning opportunities to pediatric providers with a focus on improving children's quality care measures and addressing pediatric behavioral health concerns.[82] The initiative is a partnership between the South Carolina Department of Health and Human Services and the South Carolina Chapter of the American Academy of Pediatrics, with Children's Health Insurance Program Reauthorization Act (CHIPRA) grant funds in 2010, and then supported with federal Medicaid matching funds following the grant's conclusion.

Long-Term Strategies (2–5 Years): Strengthen the Medi-Cal Child Health Delivery System

While the focus of this analysis is on short-term, actionable strategies available to California over the next several months to move toward an equitable, advanced child health delivery system, it is important to identify some of the more significant structural features of Medi-Cal that will warrant review in the longer term. Many of the ideas and recommendations outlined below have been discussed in California for years, reflecting their importance, as well as that they may require sweeping, longer-term changes in Medi-Cal's structure.

STRATEGY

1

Increase investment in the pediatric delivery system

California invests relatively little in pediatric primary care compared to other states, ranking 49th in the nation for Medicaid physician fee index for primary care.[83] In order to dramatically improve children's development and support families, California may need to invest more in pediatric and family-based care. Some states are beginning to establish requirements for insurers to spend a specified share of their capitation dollars on services and/or populations that otherwise would not be prioritized by health plans. For example, **Colorado**, **Delaware**, **Oregon**, and **Rhode Island** require a minimum percentage of medical spending to be dedicated to primary care from Medicaid plans; some also include plans serving the State Employees program, the Health Insurance Marketplace, and the commercial market.[84] The **Massachusetts** Legislature is considering a bill that would require all payors—including Medicaid and commercial payors—to increase primary care spending by 30 percent over three years.[85] California could consider a requirement that MCPs increase the share of their expenditures dedicated to pediatric primary and preventive care.[86] The Medi-Cal rate setting process would need to take such a requirement into account. If, as intended, primary and preventive care encounters increase over time, rates would continue to need to be adjusted to reflect reversal of underutilization of required primary and preventive care for children.

Implementation Approaches

MMC Reprocurement

CA State Policy

STRATEGY

2

Continue to address access issues for children through rate increases and other means

California faces persistent concerns about the extent to which children (and other populations) have access to appropriate care in Medi-Cal. The State may need to consider initiatives aimed directly at increasing funding to support children's access to care, which, as already noted, has been the subject of litigation on a number of occasions.

Some of the additional steps that California could take in the longer term includes:

Increase reimbursement rates

California could extend its current policy of offering enhanced payments for ACEs and developmental screening to a broader set of child health services, making it more appealing generally for pediatric providers to participate in Medi-Cal. This, in turn, would require the State to increase capitation payments to MCPs to cover the cost of the rate increases. To ensure that the dollars are used to pay pediatric providers more, the State would need to secure approval from CMS to direct plans to use the additional funds in this way, as it has granted numerous times before for other "directed payment" initiatives. A sizable provider rate increase will require California State Legislature authority and CMS approval.

Require MCPs to provide out-of-network access

Even without a rate increase, California could consider more aggressive oversight and enforcement of the network adequacy standard, though doing so without additional resources may provoke significant concern from plans. California already has established clear "timely access" standards in its Medi-Cal managed care contract for children, reflecting a California State law that requires MCPs to develop different standards for pediatric and adult primary care providers and specialists.[87] However, in the first year that the timely access standards were implemented, DHCS approved nearly 10,000 waivers (or "alternative access standard requests") allowing plans to disregard the standards. Of these waivers, 70 percent were for providers serving children.[88] In the future, California could require plans to offer out-of-network access to pediatric primary care providers—rather than approving waivers—and require plans to inform beneficiaries of the out-of-network options and assist in locating an appropriate provider.

Implementation Approaches

MMC Reprocurement

CA State Policy

STRATEGY

3 Develop a value-based payment model that reflects a pediatric-specific approach

California has reiterated in recent guidance and stakeholder materials that it is committed to continuing to move toward greater use of value-based payments, allowing the State to pay for outcomes and high-quality care rather than for the volume of services delivered by a provider. When making greater use of value-based payment, it is important to reflect that some "traditional" elements of value-based payment are not well-designed for children, especially those at-risk for, but not yet diagnosed with significant physical or mental health conditions.[J] With some notable exceptions, children are relatively healthy and inexpensive to serve and, therefore, traditional methods of structuring value-based payments around short-term shared savings work poorly for rewarding high-quality, family-based, equitable care.

DHCS could develop a value-based payment methodology that reflects the short and long-term benefit of high-quality, preventive care for children. For example, California could direct MCPs to offer an additional PMPM payment to pediatric practices that demonstrate they offer high-quality, family-based care rather than promising a share of savings for driving down expenditures on children. DHCS would need to determine how to identify high-quality, family-based care, which could be done by outcome measures or, in the early years, by identifying the key characteristics of effective pediatric providers. For example, this might include providers that offer integrated physical and behavioral healthcare with onsite staff; engage family specialists or other types of community health workers to offer developmental and parenting support; screen for and follow up on social and economic problems that adversely affect a child's health; address racial and ethnic disparities in access to care; and conduct and follow up on ACEs screenings.

A recent analysis out of **Massachusetts** outlines in detail how the State's Medicaid program could design a value-based payment approach to support advanced pediatric medical homes with many of these characteristics.[89]

Implementation Approaches

MMC Reprocurement

CA State Policy

Section 1115 Waiver

[J] California has established value-based payment initiatives that offer add-on payments to providers for key services associated with important quality metrics, including for an early childhood bundle of services (see Proposition 56 Supplemental Payments for Pediatric Primary Care Providers). Specifically, DHCS offers an add-on payment for each beneficiary that receives a particular service with those "not-at-risk" members receiving a basic add-on and "at-risk" members receiving an even larger increase. The definition of an "at-risk" member includes those with a diagnosed SUD, a SMI, or who are experiencing homelessness or have inadequate housing, a set of criteria that primarily describes high-risk adults. To make the criteria more inclusive of children, DHCS could add children with SED to the "at-risk" definition.

STRATEGY

4

Revisit the bifurcated behavioral health system

A number of leading foundations and experts have analyzed the Medi-Cal behavioral health system and concluded it is highly fragmented and difficult for beneficiaries to navigate. In California, MCPs are charged with covering behavioral health services for beneficiaries with "mild-to-moderate" conditions while county specialty mental health plans (SMHPs) are charged with addressing severe behavioral health conditions. Moreover, counties are responsible for financing much of the cost of the Medi-Cal behavioral health system while the State covers the non-federal share of other Medi-Cal costs, creating disparate financing for behavioral health versus other Medi-Cal benefits. This bifurcation and expectation that SMHPs will fund more serious care creates a disincentive for MCPs to fully embrace preventive behavioral health services under their mild-to-moderate benefit requirements, as well as creates an incentive for county SMHPs to classify children as only requiring services for mild-to-moderate conditions. For families with children, the current approach means that they must sort through whether their child should be served through their MCP versus a county SMHP, creating a daunting system that the California Children's Hospital Association describes as "unconscionable" and "byzantine."[90]

DHCS has established requirements for MCPs and SMHPs to coordinate care and enter into memorandums of understanding; however, ultimately, a family-focused child health system will require a more fundamental review of the inherently complex structure created by dividing up a child's physical and behavioral health needs. California has acknowledged this issue and indicated that as part of CalAIM it will design pilots to offer fully integrated care. It will be important that children and their families be included in such initiatives and in long-term efforts to revisit the bifurcated healthcare system.

Implementation Approaches

CA State Policy

Potentially Section 1115/1915(b) Waiver

STRATEGY

5

Strengthen coverage options for children and their families

All the options and recommendations outlined in this analysis rest on a foundation of coverage for California's children and families. To the extent that the State again experiences a decline in coverage for children—as occurred in the months before the COVID-19 pandemic hit—or, if new enrollment does not keep pace with need in light of the pandemic and related unemployment, it will be more difficult to improve care for children in California. Of particular concern is the drop in coverage that occurred prior to the pandemic among children who are part of immigrant families, reflecting greater fear and concern about using Medi-Cal in light of anti-immigrant policies adopted by the Trump Administration.[91] While California has taken a number of steps to address these issues and concerns, including by covering all children regardless of immigrant status, some additional steps are available to further strengthen the coverage foundation.

Implement continuous Medi-Cal coverage for up to five years for children

DHCS could promote continuity of coverage through five-year, continuous Medi-Cal coverage for children by pursuing a Section 1115 waiver. Children undergo an annual Medi-Cal redetermination to identify changes in circumstances (e.g., income eligibility, family size). Often, children are found ineligible due to slight income changes that place their family above the income eligibility limit for Medi-Cal, which currently ranges from 133 to 208 percent of the federal poverty level (FPL) based on the child's age.[92] Health insurance disruption can have significant consequences for children—especially young children in the crucial first three years of life—as they are less likely to receive care and services, resulting in missed preventive screenings (e.g., developmental, social and emotional) and well-child visits. California and 22 other states currently provide 12-month continuous eligibility for children enrolled in Medicaid, meaning that changes in circumstance that occur in that year will not impact the child's Medicaid eligibility or enrollment.[93]

Potentially, through Section 1115 waiver authority and funding, California has the opportunity to lead a national effort to pursue continuous Medicaid enrollment for children for five years before redetermination. Adoption of this policy would stabilize children's health insurance eligibility and access to care, removing a common source of parent/caregiver stress and barrier to access, as well as signal California's commitment to early childhood development.

Implementation Approach

Section 1115 Waiver

Pursue twelve months continuous Medi-Cal coverage for adults

When parents have health coverage, they are more likely to be able to address their own physical and behavioral health needs, including conditions that could interfere with strong attachments to their children.[94] California has a strong history of Medi-Cal coverage for adults, including taking up the opportunity to expand Medi-Cal to more adults under the Affordable Care Act, including parents and caregivers in families with low incomes. Another opportunity that DHCS could consider is seeking a Section 1115 waiver from the federal government to authorize twelve months of continuous eligibility for Medi-Cal enrollees, similar to what New York and Montana have both done. **Montana** provides continuous eligibility of Medicaid coverage for parents and caregivers and **New York** provides coverage for adults in the Affordable Care Act's Adult Group population, with both states extending twelve months.[95,96]

Providing twelve months of guaranteed Medi-Cal coverage for adults mitigates the well-documented issue of "churning" where low and moderate-income individuals move back and forth between eligibility for coverage programs as they experience changes such as gaining or losing employment, getting married or divorced, or other changes in circumstances. Enabling greater continuity of coverage through twelve months of continuous eligibility has a myriad of benefits for Medi-Cal enrollees—and given the evidence on the important relationship between parent and caregiver health on children's health, their children—as well as their healthcare system, and the State. Beneficiaries are able to develop stronger relationships with their providers and avoid disruptions in care and providers and health plans have an improved capacity for delivering preventive care, managing care, and effectuating quality improvement. Additionally, the State, providers, and health plans see reduced administrative costs with fewer transitions in coverage and less paperwork to process.

Implementation Approach

Section 1115 Waiver

Extend postpartum coverage for Medi-Cal eligible women

DHCS can strengthen care for young children's earliest years by ensuring that postpartum mothers have access to necessary care through extending postpartum coverage for Medi-Cal eligible women past the federally required 60 days to at least twelve months.[97] Studies have shown that children are more likely to access care in the critical first years of life when their parents are insured, in addition to the need for postpartum women to have health insurance to access treatment related to the child's health, such as maternal depression treatment and healthy family planning.[98] This policy is particularly impactful for Black pregnant women in California, who are four times more likely to die giving birth or in the aftermath of giving birth than any other racial/ethnic group in California.[99] This is notable, given that California has one of the lowest maternal mortality rates in the country at a near-record low of 7.3 deaths per 100,000 live births—compared to the United States' maternal mortality rate of 22 deaths per 100,000 live births.[100] Providing postpartum coverage for at least one year after birth without interruption or the need to switch Medi-Cal eligibility categories can help ensure postpartum women can access necessary, life-saving care.

Georgia has submitted for CMS review and approval a Section 1115 waiver that would extend Medicaid coverage past 60 days postpartum to 180 days (or six months) for women with incomes up to 225 percent FPL.[101]

Implementation Approach

Section 1115 Waiver

Abundant Birth Project in San Francisco County

San Francisco County is in the midst of a groundbreaking pilot program through a partnership with Expecting Justice, a collaboration between the California Department of Public Health and the San Francisco Department of Public Health, to improve maternal and infant health for Black and Pacific Islander people.[107] Together with the Preterm Birth Initiative at the University of California San Francisco, Expecting Justice has launched the Abundant Birth Project to provide income supplements of $1,000–$1,500 per month for 100 Black and Pacific Islander pregnant women in San Francisco through pregnancy and 60 days postpartum, in an effort to address the high preterm birth rates of Black and Pacific Islander infants. By providing unconditional cash aid to combat generations of discrimination and racism against Black and Pacific Islander women that impact their own health, pregnancies, and earning potential, as well as their infants' health outcomes and early development, Expecting Justice hopes to improve health inequities and empower women to make healthy decisions.

Conclusion

Though California-specific, any state could utilize the concepts in the Options Paper to identify opportunities to support young children who are enrolled in Medicaid and CHIP in advancing their social and emotional development through pediatric primary care. The research is clear that addressing social and emotional concerns at a young age, as well as supporting a child's parents, caregivers, and families, improves long-term well-being and health options. Given the rapidly surging COVID-19 pandemic and the likely longstanding after effects, supporting young children is more important than ever.

Appendices

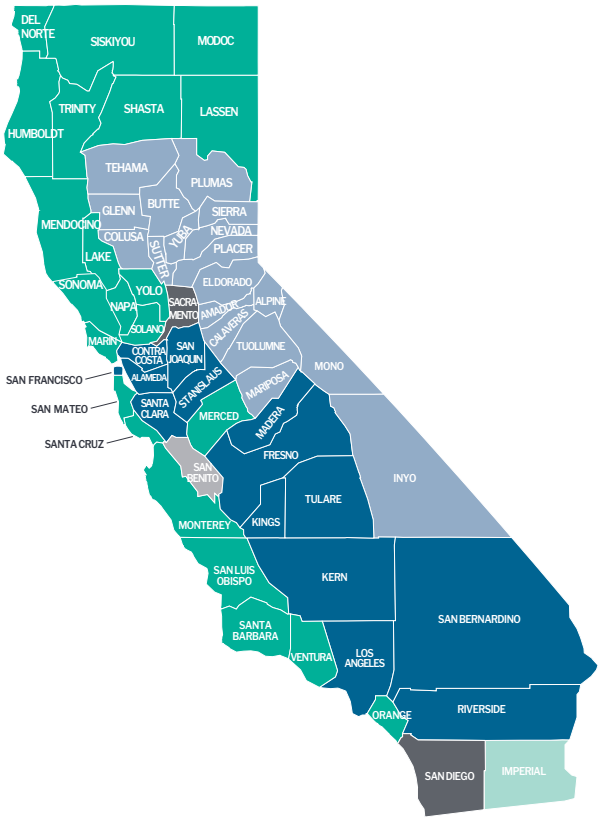
Appendix A: Pediatrics Supporting Parents California County Medi-Cal Implementation Work Group

In 2019, the David and Lucile Packard Foundation, the Pritzker Children's Initiative, and Genentech Charitable Giving engaged the Center for the Study of Social Policy (CSSP), Manatt Health, and Donna Cohen Ross, an independent consultant, to facilitate the **Pediatrics Support Parents (PSP) California County Medi-Cal Implementation Work Group**. Building on California's long commitment to early childhood and the National PSP Initiative, the Work Group's aim was to explore, test, and implement strategies through Medi-Cal to finance the promotion of social and emotional development through pediatric primary care.[102]

The PSP California County Medi-Cal Implementation Work Group brought together First 5 County Commissions from four counties—Almeda, Fresno, Los Angeles, and Ventura. The counties were selected with input from the First 5 Association in order to reflect geographic diversity, the presence of robust early childhood initiatives, and a variety of Medi-Cal managed care models. Throughout 2020, the counties received customized technical assistance and engaged in peer learning opportunities to identify and leverage Medi-Cal policy and financing opportunities to support pediatric practice changes aimed at fostering social and emotional development in their county. The PSP California Counties engaged with local child health leaders, Medi-Cal MCP representatives, and family advocates to improve engagement with Medi-Cal MCPs on pediatric-specific initiatives.

The valuable experiences and insights of the Work Group, the First 5 Association, and other key California stakeholders contributed to the development of the **California Options Paper** that identifies Medi-Cal strategies and implementation approaches available to California leaders and Medi-Cal officials to strengthen the social and emotional health of young children through pediatric primary care, and highlights bright spots in states and California counties. Recognizing the critical importance of partnership between First 5 County Commissions and Medi-Cal MCPs, the First 5 Association and PSP team developed a webinar series and tool kit to build the capacity of First 5 County Commissions and their partners to understand the opportunities within the Medi-Cal system and improve working relationships with their local Medi-Cal MCPs. With over half of children under age five in California insured through Medi-Cal, these resources can accelerate transformation of pediatric primary care to promote the social and emotional health of young children across California and impact millions of children and families statewide.

Appendix B: Medi-Cal Managed Care Models and Map



Two-Plan. DHCS contracts with a local initiative, county organized prepaid health plan and a commercial plan.

County Organized Health Systems (COHS). County Board of Supervisors may establish a commission to negotiate a COHS contract with DHCS, with all enrollees in the same plan.

Geographic Managed Care. DHCS contracts with several commercial plans.

Regional Model. DHCS contracts with two commercial plans in rural counties.

Imperial County. DHCS contracts with two commercial plans in Imperial County.

San Benito County. Beneficiaries may choose between a commercial plan or fee-for-service.

Sources: DHCS: Medi-Cal Managed Care Models; DHCS: Medi-Cal Managed Care Program Fact Sheet.

Appendix C: Summary of California Policy Options & Tools

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
Short Term Strategies (12 Months)			
1. Leverage Medi-Cal MCP reprocurement to strengthen accountability and quality			
Use withholds or incentives to encourage MCPs to improve care for young children	**Incentive & Withhold Arrangements** 42 CFR § 438.6 **Quality Strategy** • Social Security Act § 1932(c) • 42 CFR §§ 438.334, 438.340, 457.1200(c), 457.1240(e) **Performance Improvement Projects** 42 CFR §§ 438.240(d), 438.330, 457.1200(c), 457.1240(b)	**California Code** Welfare and Institutions Code § 14197.7 **DHCS** • Managed Care Accountability Set Measurement Year 2021 & Reporting Year 2022 (December 2020) • Comprehensive Quality Strategy – Draft Report for Public Comment (November 2019)	**California Pan-Ethnic Health Network** Medi-Cal Managed Care Plan RFI Response **North Carolina** Medicaid Managed Care Quality Strategy (starting on page 49) **Oregon** • Section 1115 Waiver Demonstration (starting on page 224) • Managed Care Contract (starting on page 98) • 2020 Incentive Measure Benchmarks

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
Establish a robust and timely child health dashboard that displays how well plans are doing, including progress on racial disparities	**Child Core Set Measures** Social Security Act § 1139A(a) **CMS** • 2021 Child Core Set Measures • Child Core Set Measures Resources Page	**DHCS** Preventive Services Report (December 2020)	**Louisiana** Medicaid Managed Care Quality Dashboard **HEDIS** • Measurement Year 2020 & 2021 Metrics • Measures & Technical Resources Page
Strengthen care coordination and facilitate connections to community resources for children (e.g., parenting supports, housing instability, food insecurity, ACEs)	**Care Coordination** • Social Security Act §§ 1905(a)(25), 1905(t) • 42 CFR §§ 438.2, 438.208, 400.203, 440.168, 457.1200(c), 457.1230(c) **CMS** SHO 21-001: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (January 2021)	**DHCS** • Medi-Cal Managed Boilerplate Contracts (Exhibit A, Attachment 11) • All Plan Letter 19-010 (August 2019) • Medi-Cal Provider Manual: EPSDT/ CHDP (September 2020) • CalAIM Proposal (January 2021) (starting on page 43)	**First 5 County Commissions** • First 5 Alameda Help Me Grow • First 5 San Mateo Help Me Grow **First 5 Center for Children's Policy** Flowchart: Navigating the Early Identification and Intervention Maze

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
Incentivize or require use of community-driven team based care	**Preventive Services** • Social Security Act §1905(a)(13)(A) • 42 CFR § 440.130(c) **Care Team Standards** • Social Security Act §1932(b)(5) • 42 CFR §§ 438.68, 438.206(b) 457.1200(c), 457.1218 **Funding for Training: State Plan Requirements** • Social Security Act §1902(a) (30)(A) • 42 CFR § 447.200-205 **Funding for Training: Rates of Federal Financial Participation Administration** • Social Security Act §1903(a)(7) • 42 CFR § 433.15(b)(7) **CMS** CIB Informational Bulletin: Update on Preventive Services Initiatives (November 2013)	**California State Law** SB 803: Peer Support Specialist Certification	**Indiana** SPA 18-005 **Michigan** Medicaid Managed Care Contract (starting on page 67) **New Mexico** • Medicaid Managed Care Contract (starting on page 371) • The Commonwealth Fund: University of New Mexico CHW LEADS **Oregon** • Medicaid Managed Care Contract (starting on page 205) • SPA 17-0006 **Programs** • DULCE • Centering Pregnancy and Parenting • Family Independent Initiative

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
2. Strengthen and build on existing EPSDT policy			
Reinforce compliance with existing EPSDT policies through strong MCP contract language and outreach and education to plans, providers, and families	**EPSDT** • Social Security Act §§ 1902(a)(43), 1905(r), 1905(a)(4)(B) • 42 CFR Subpart B § 441.50 – 62 **CMS** EPSDT Resource Page	**California State Law** SB 1287: Medi-Cal Medically Necessary Services **DHCS** All Plan Letter 19-010 (August 2019) **California State Auditor** Millions of Children in Medi-Cal are Not Receiving Preventive Health Services (March 2019)	**First 5 Association of California** Medi-Cal Managed Care Plan RFI Response **New Hampshire** Medicaid Managed Care Contract (starting on page 56) **American Academy of Pediatrics** Bright Futures Periodicity Schedule
Extend approach from 2020 DHCS family therapy guidance to support a broader preventive approach to behavioral health for young children	**EPSDT** • Social Security Act §§ 1902(a)(43), 1905(r), 1905(a)(4)(B) • 42 CFR Subpart B § 441.50 – 62 **Information Requirements** 42 CFR § 438.10 **CMS** EPSDT Resource Page	**DHCS** • Psychological Services Manual (September 2020) • Medi-Cal Update: Bulletin 552 (June 2020) • Medi-Cal Update: Bulletin 539 (August 2020)	**First 5 Center for Children's Policy** • Crosswalk of Medi-Cal Family Therapy Guidance and Dyadic Integrated Care Models in California • Blog: New Medi-Cal Policy Expands Access to Family Therapy for Young Children **San Francisco County** Report & Pilot Program: Babies Don't Go to the Doctor By Themselves **Programs** • DULCE • HealthySteps

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
Continue enhanced payments for ACEs and developmental screenings, and incorporate lessons learned from recent initiatives	**Directed Payments** 42 CFR §§ 438.6(c), 457.1200(c) **CMS** SMD 21-001: Additional Guidance on State Directed Payments in Medicaid Managed Care (January 2021)	**California State Law** AB 1004: Developmental Screening Services **Governor's 2021–2022 Budget** Proposed Budget Summary (January 2021) **DHCS** • SPA 19-0048 (November 2020) • SPA 19-0041 (November 2020) • SPA 19-0021 (August 2019) • All Plan Letter (20-014) (May 2020) • All Plan Letter (19-016) (December 2019) • Proposition 56: Developmental Screenings Policy (October 2019) • Proposition 56: Trauma Screenings (October 2019) **Office of Surgeon General** • Roadmap for Resilience: The California Surgeon General's Report on ACEs, Toxic Stress, and Health (December 2020) • ACEs Aware Resource Page	**California Medical Association** Proposition 56 Fund: What's New for FY 19-20 and Beyond **Children Now** Proposition 56 Funds Are a Critical Support for Children's Health in Medi-Cal

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
3. Provide additional resources to DHCS and MCPs to focus on children			
Require each MCP to establish a key position as the point of accountability for Medi-Cal children and children's health initiatives			**New Hampshire** Medicaid Managed Care Contract (starting on page 43) **New Jersey** Medicaid Managed Care Contract (see page 267)
Ensure a DHCS leadership position accountable for improving child health outcomes and equity and ensuring an effective State-level advisory committee on children's health		**DHCS** Stakeholder Engagement by Subject	**Maine** • Children's Cabinet • Children's Cabinet Early Childhood Advisory Council
Facilitate effective uptake of new child and family-centered policies by supporting Medi-Cal MCPs and providers with information, training, and technical assistance, and by identifying available funding that can be leveraged to conduct such activities		**California State Auditor** Millions of Children in Medi-Cal are Not Receiving Preventive Health Services (March 2019)	**South Carolina** Quality through Technology and Innovation in Pediatrics (QTIP) Program

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
Long-Term Strategies (2-5 Years)			
1. Increase investment in the pediatric delivery system			
Increase investment in the pediatric delivery system	**Directed Payments** 42 CFR §§ 438.6(c), 457.1200(c) **Enhanced Reimbursement** Social Security Act § 1902(a)(30) **CMS** SMD 21-001: Additional Guidance on State Directed Payments in Medicaid Managed Care (January 2021)	**California State Auditor** Millions of Children in Medi-Cal are Not Receiving Preventive Health Services (March 2019)	**Colorado** H.B. 19-1233: Payment System Reforms **Delaware** S.B. 116: Primary Care Reform Collaborative **Massachusetts** Bill H.4134: Improve Health Care by Investing in Value **New York** Final Report of the First 1,000 Days Preventive Pediatric Care Clinical Advisory Group (October 2019) **Oregon** S.B. 934: Payments for Primary Care **American Academy of Family Physicians** Primary Care Spend (September 2020) **Kaiser Family Foundation** Medicaid Physician Fee Index (2016)

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
2. Continue to address access issues for children through rate increases and other means			
Increase reimbursement rates	**Directed Payments** 42 CFR §§ 438.6(c), 457.1200(c) **Enhanced Reimbursement** Social Security Act § 1902(a)(30) **CMS** SMD 21-001: Additional Guidance on State Directed Payments in Medicaid Managed Care (January 2021)	**DHCS** Medi-Cal Rates	**Oregon** Medicaid Fee Schedule
Require MCPs to provide out-of-network access	**Network Adequacy Standards** 42 CFR § 438.68	**California State Law** AB 205: Medi-Cal Managed Care Plans **DHCS** Medi-Cal Managed Boilerplate Contracts (Exhibit A, Attachment 6) **California State Auditor** Millions of Children in Medi-Cal are Not Receiving Preventive Health Services (March 2019)	

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
3. Develop a value-based payment model that reflects a pediatric-specific approach			
Develop a value-based payment model that reflects a pediatric-specific approach	**Enhanced Reimbursement** Social Security Act §1902(a)(30) **Care Coordination & Management Standards** • Social Security Act §§1905(a)(25), 1905(t) • 42 CFR §§ 438.2, 438.208, 400.203, 440.168, 457.1200(c), 457.1230(c)) **Directed Payments** 42 CFR §§ 438.6(c), 457.1200(c) **CMS** • SMD 21-001: Additional Guidance on State Directed Payments in Medicaid Managed Care (January 2021) • CIB Informational Bulletin: Delivery System and Provider Payment Initiatives Under Medicaid Managed Care Contracts (November 2017)	**DHCS** All Plan Letter (20-014) (May 2020)	**Virginia** Medicaid Managed Care Contract (starting on page 274) **Massachusetts** Child and Adolescent Health Initiative: Recommendations for the MassHealth Section 1115 Waiver Renewal **New York** United Hospital Fund & Bailit: Value-Based Payment Models for Medicaid Child Health Services

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
4. Revisit the bifurcated behavioral health system			
Revisit the bifurcated behavioral health system		**California Code** Title 9 § 1810.370 **DHCS** • Medi-Cal Managed Boilerplate Contracts (Exhibit A, Attachment 11) • All Plan Letter (19-014) (November 2019) • All Plan Letter (18-015) (September 2018) • All Plan Letter (18-015) Attachment 2 (September 2018) • CalAIM Proposal (January 2021) (starting on page 77)	**California Health Care Foundation** • Medi-Cal and Behavioral Health Services (February 2019) • Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions (August 2016) **California Children's Hospital Association** Improving Behavioral Health Care for Children in California (December 2019)
5. Strengthen coverage options for children and their families			
Implement continuous Medi-Cal coverage for up to five years for children	**Section 1115 Waiver** • Social Security Act § 1115(a) • 42 CFR Subpart G § 431.400 – 428	**DHCS** Section 1115 Waiver Demonstration	**Massachusetts** Child and Adolescent Health Initiative: Recommendations for the MassHealth Section 1115 Waiver Renewal **Center for Children and Families** Covering all Children (February 2020)

Options	Tools		
	Federal Statute, Regulations, Resources	**California Statute, Regulations, Resources**	**Additional Implementation Resources & Examples**
Pursue twelve months continuous Medi-Cal coverage for adults	**Section 1115 Waiver** • Social Security Act § 1115(a) • 42 CFR Subpart G § 431.400 – 428 **CMS** SHO 13-003 & ACA 26: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014 (May 2013)	**DHCS** Section 1115 Waiver Demonstration	**Montana** Section 1115 Waiver Demonstration (starting on page 13) **New York** Section 1115 Waiver Demonstration (starting on page 26)
Extend postpartum coverage for Medi-Cal eligible women	**Section 1115 Waiver** • Social Security Act § 1115(a) • 42 CFR Subpart G § 431.400 – 428 **Postpartum Coverage** 42 CFR § 435.170 **Federal Bills (116th Congress)** • H.R. 4996: Helping MOMS Act of 2020 • H.R. 1897 & S. 916: MOMMA's Act • H.R. 2606 & S. 1343: MOMMIES Act • H.R. 2778 & S. 1481: Healthy Maternity and Obstetric Medicine Act	**DHCS** Section 1115 Waiver Demonstration **California Maternal Quality Care Collaborative** Pregnancy-Associated Mortality Review (Spring 2018)	**San Francisco County** Expecting Justice's Abundant Birth Project **Georgia** Section 1115 Waiver Application **Illinois** • Section 1115 Waiver Application • Section 1115 Waiver Demonstration (see page 3) **Center for Children and Families** Health Coverage for Parents and Caregivers Helps Children (March 2017)

Appendix D: Methodology

California-Specific Review. Manatt, Donna Cohen Ross, and CSSP conducted a "deep dive" analysis of California's Medicaid program, including review of State Medi-Cal law and regulations, DHCS policy and operational guidance (e.g., All Plan Letters, Policy and Procedure Letters, Medi-Cal Provider Manual), the Medi-Cal MCP contract and SMHP contract, Section 1115 waivers, MCPs' quality strategy reports, the Newsom Administration's early childhood specific initiatives (e.g., Master Plan for Early Learning and Care, ACEs Aware), and reports from State oversight bodies (e.g., Legislative Analyst's Office, California State Auditor). The team also conducted targeted analysis on State and county roles and responsibilities related to Medi-Cal, such as review of policy and program documents and analysis related to Medi-Cal administrative activities claiming, Medi-Cal mental health services for children, and First 5 County Commissions' authorization and strategic plans.

California County Work Group. Four California counties—Alameda, Fresno, Los Angeles, Ventura—were selected by PSP to participate in the PSP California County Medi-Cal Implementation Work Group, providing a deeper understanding of how leading counties engage with Medi-Cal and their MCPs. The counties were chosen for ongoing early childhood health programs or interest, reach of children enrolled in Medi-Cal, geographic and MCP model diversity, and presence of robust early childhood initiatives. The counties were represented by the County First 5s, who were also strongly encouraged to include pediatric care providers, Medi-Cal MCP leaders, representatives of evidence-based pediatric primary care interventions, parent leaders, advocates, and county health and social services officials as part of their team. Each county team identified goals to pursue supporting the county's youngest children enrolled in Medi-Cal and their families. The county teams participated in regular calls with the PSP Technical Assistance team to advance their identified goals leveraging Medi-Cal policy and financing opportunities and also engaged in peer-to-peer learning with other county teams through several webinars. Much of the insight gained from these four counties informed the development of this Options Paper, particularly how counties and First 5 County Commissions interface with MCPs and DHCS' potential role.

Key Informant Interviewees & Paper Reviewers. Manatt, Donna Cohen Ross, and CSSP interviewed key informants in Medi-Cal policy and pediatric primary care, including California and other states' early childhood and Medicaid leaders; First 5 County Commissions and First 5 Association leaders; early childhood experts and advocates; and pediatric providers. These interviews informed the key issues of focus in this Options Paper. Interview guides were often shared in advance and entailed 30–60 minute phone calls focused on the interviewees' observations and insights on leveraging Medi-Cal to impact California's children's social and emotional development. The PSP Technical Assistance team also sought review and feedback from these key informants on the framework, prioritized strategies, and working draft of this Options Paper to ensure that the strategies are impactful and actionable in California, recognizing policy, financial, and administrative considerations at-play.

Prior to publication, the PSP Technical Assistance team also briefed senior leaders from CHHS, DHCS (including Director William Lightbourne and Chief Deputy Director & State Medicaid Director Jacey Cooper), and the California Department of Education. The briefing provided an opportunity for DHCS leadership and other California State officials to hear about and comment on this Options Paper and for the group to discuss implementation opportunities, challenges, or concerns, and alignment with California priorities and considerations.

Key Informant Interviewees & Reviewers	
Name	**Title**
California State Officials & Leaders	
Kris Perry	Deputy Secretary for Early Childhood Development, California Health and Human Services Agency; Senior Advisor on Early Childhood Development Initiatives, Governor Newsom
First 5 Agencies	
Christina Altmayer	Vice President of Programs, First 5 Los Angeles
Sarah Crow	Managing Director, First 5 Center for Children's Policy
Sharon Elmensdorp	Program Manager of Help Me Grow, First 5 Ventura
Tara Ficek	Director of Health Systems, First 5 Los Angeles
Kim Goll	Executive Director, First 5 Orange County
Fabiola Gonzalez	Executive Director, First 5 Fresno
Elizabeth Majestic	Former Pritzker Foundation Fellow, First 5 Ventura
Charna Martin	Senior Policy Strategist, First 5 Los Angeles
Rachel Metz	Consultant, First 5 Alameda
Hannah Norman	Senior Program Officer, First 5 Fresno
Petra Puls	Executive Director, First 5 Ventura
Kristin Spanos	Executive Director, First 5 Alameda
California Advocates & Stakeholders	
Mayra Alvarez	President, The Children's Partnership
Lynne Ashbeck	Senior Vice President, Community Engagement and Population Wellness, Valley Children's Hospital
Alex Briscoe	Principal, California Children's Trust
Kristen Golden Testa	Director of the California Health Program, The Children's Partnership

Key Informant Interviewees & Reviewers	
Name	**Title**
Deb Kong	Program Officer, Children, Families, and Communities Program, The David & Lucile Packard Foundation
Kim Lewis	Managing Attorney, National Health Law Program
Mike Odeh	Director of Health, Children Now
Kiran Savage-Sangwan	Executive Director, California Pan-Ethnic Health Network
Jeff Sunshine	Deputy Director, Children, Families, and Communities Program, The David & Lucile Packard Foundation
Jennifer Tracey	Senior Director of Growth and Sustainability, HealthySteps, ZERO TO THREE
California Healthcare Providers	
Dr. Ken Epstein	Professor, University California of San Francisco
Dr. Dayna Long	Professor, University California of San Francisco
Dr. Ryan Padrez	Medical Director, The Primary School
Dr. Carmela Sosa	Medical Director, Valley Children's Primary Care
Other Leading State Officials & Leaders	
Gretchen Hammer	Founder, Public Leadership Consulting Group; Former Colorado Medicaid Director

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