March 22, 2019

To: California Department of Health Care Services

From: First 5 Association of California, California Children and Families Foundation, First 5 Los Angeles, Children Now, The Children's Partnership, California Children's Trust, Silicon Valley Community Foundation, Children's Institute of Los Angeles, American Academy of Pediatrics California, California Children's Hospital Association, Children's Specialty Care Coalition, Center for Youth Wellness

Re: Public Comment on Prop 56 Value-Based Payment, Developmental and Trauma screening proposals

The above-listed organizations jointly applaud the Administration's demonstrated commitment to improving the quality of health care for children through value-based payment measures and incentive payments for screenings. We support these proposals, and provide additional recommendations to ensure they best achieve their intended objectives.

Comments on Value-Based Payment Proposals

Our comments relate specifically to children and to the prenatal, early childhood, and behavioral health integration components of the VBP proposal, and we recommend three additional measures in these areas. Our comments on the specific measures are included in the attached comment grid.

We support the Department's interest in building quality into the payment structure for Medi-Cal providers. Value-based payment proposals have the potential to incentivize specific quality measures and improved health and wellness outcomes among children and expectant mothers. We appreciate the inclusion of well-child care in this VBP proposal, given that supplemental payment models often focus on the highest-cost, highest-utilizing populations and overlook the longer-term education and health outcomes and savings that come with early investments in young children. We know that too few children are receiving well-child visits and preventive services, and therefore incentives related to improving rates of well-child visits are well placed. We agree that the time to begin this work is now.

We recommend that the Department continue to refine and improve these efforts over time. While the proposed incentives are a valuable first step, we recommend **the Department immediately convene stakeholders to begin to consider future proposals for value-based payments that will additionally improve quality of care for children and expecting mothers**. For example, there is not currently a DHCS stakeholders forum or workgroup dedicated to the measurement and improvement of prenatal screening, prenatal care, or birth outcomes. We welcome the opportunity to work with the Department to identify additional VBP measures and strategies that focus on child and maternal health outcomes and improve accountability.

Federal rules require that all children enrolled in Medicaid receive blood lead screening tests at ages 12 months and 24 months. In addition, any child between ages 24 and 72 months with no record of a previous blood lead screening test must receive one. **DHCS should amend this measure to align with federal requirements**, providing payment when providers screen at 12 and 24 months, or between 24 and 72 months for a child not previously screened.

We recommend that DHCS **include metrics to reward pediatric practices for coordinating referrals to community-based providers, mental health providers and specialty care providers**. These aspects of care are not explicitly included in the measures, but are an essential part of a comprehensive VBP strategy. Providing an incentive for care coordination for patients with behavioral health concerns and ACEs, as proposed in the attached comment grid, could be part of that strategy. Recent data indicate that reimbursing practices for care coordination is a good investment. A CMS experiment that compensates doctors for care coordination for the sickest Medicare beneficiaries shows signs of both saving money and improving quality. We would urge the Department to explore using a similar approach for children, including measuring cost aversion and outcomes of evidence-based pediatric care coordination models.

We recommend that the Department **focus some of the proposed payments to support practice transformation,** including training to providers, and guidance and resources on forming ACEs and trauma-informed medical practices, in addition to provider incentive payments. This approach can support under-resourced practices that lack the workforce or systems capacity to successfully maximize incentive payments. Practice transformation efforts should be focused on areas with the greatest disparities in quality of care.

We **support the Department's inclusion of behavioral health measures,** but recommend that these be extended to children and youth, recognizing that nationally up to 30 percent of children under age 18 on Medicaid have a behavioral health condition, but only one-third of those children are identified and treated. Early identification and response are key, and some conditions can be prevented by improving the child's home environment.

We recommend that the **Department provide resources to support the newly proposed metrics**, which are not currently part of the External Accountability Set or regularly included in managed care organization quality incentive programs. These could include currently proposed metrics such as integrated behavioral health, and new critical metrics to assess services recommended by ACOG and the AAP, such as prenatal risk assessments and social emotional screening.

We recommend that the Department **clarify its plans for data collection and reporting** on the proposed metrics, and include the input of child health providers in the development of those plans. This is an opportunity to build the data reporting infrastructure for monitoring, and thereby encourage follow-up and referrals.

Further, we recommend the Department **provide clear guidance to managed care plans** on their roles and responsibilities to ensure compliance with existing responsibilities to outreach to providers and members about prenatal and well-child visits and recommended screenings, as additional ways to improve health outcomes for expecting mothers and children.

Finally, we recommend that the Department consider the long-term strategies for incentivizing providers to meet important health and wellbeing benchmarks, given that Prop 56 funding will decline over time.

Comments on Developmental Screening Incentive Payments

We applaud the Department's commitment to ensuring more young children are screened for developmental delays or concerns. Improving screening is one key step to fulfilling the requirements for Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Screening for risks to health and development in the context of well-child visits is at the core of the EPSDT purpose and design. Current best practice in pediatrics calls for screening for overall development, social-emotional mental health, and social determinants of health (SDOH). We applaud DHCS for adopting the American Academy of Pediatrics (AAP) Bright

Futures-recommended schedule for children's preventive services, which identifies a set of objective screening tools and periodicity.

We encourage the Department to consider additional steps to strengthen a system of early identification, referrals, linkage to appropriate services, and high-quality interventions that reach every community in California. This is an important step in identifying children with or at-risk for developmental delays or concerns. However, practice indicates that incentive payments alone do not significantly alter screening rates and referrals to appropriate services. Provider incentive payments, training, measurement, and quality improvement projects in combination have been shown to be effective in other states for improving rates of developmental screening.

Provider training and incentive payments

We recommend **that providers receive incentives for conducting full and complete screens** for developmental and behavioral delays using a standardized, validated screening tool at key intervals with the periodicity recommended by Bright Futures. Providers should receive incentive payments for each validated developmental screening tool they administer. In order to maximize productivity, we encourage the Department to include a broad definition of providers that could administer and interpret the results using a validated tool. The Department should further clarify that screening can occur in behavioral health settings by behavioral health providers in addition to primary care providers in addition to personnel within a primary care setting.

We recommend the Department **consider mechanisms to increase provider education about developmental screening**, which may enhance providers' compliance and integration of screening above and beyond the incentive payment. The Centers for Medicare and Medicaid Services has issued guidance on how Medicaid agencies can support provider trainings to increase provider awareness and ability to screen.[i] A number of states have demonstrated that Medicaid quality activities can accelerate improvements in developmental screening rates.

An additional incentive to increase the frequency of early developmental screening would be to eliminate the cost to providers of the screening tools themselves. Currently, providers must pay for licenses to use the most commonly used validated screening tools. First 5 has been exploring options that would amend the licensing structure for the most commonly used tools to help alleviate costs incurred at the site level. We welcome the opportunity to discuss with the Department what First 5 has learned so far with respect to these costs, strategies for workflow integration, and potential state-wide solutions.

Innovations at the State and Managed Care Plan level

Innovative practices at the state level can go beyond screening to improve referral rates to services. In addition to provider incentives, we recommend that DHCS **launch a Practice Improvement Program to increase the capacity of all managed care plans and providers to support early identification and intervention**. Practice transformation efforts led by the plans

should have an intentional equity lens focused on where screening rates are lagging, either in terms of geographic or racial disparities.

A number of states and counties can offer findings from their experiences with practice improvement collaboratives that have led to impressive statewide change. After adopting a screening quality metric, Oregon dramatically increased screening rates but did not experience an increase in children receiving timely services that addressed delays. Accordingly, Oregon funded a practice improvement network to bolster developmental screening, referrals of at-risk children, the number of children evaluated and deemed eligible for services, and communication and follow-up across systems. The projects included Medicaid plans and addressed provider barriers to service referral, including lack of awareness of services, lack of capacity of services, and parent engagement strategies. The network created concrete decision-support tools for providers, universal referral forms, parent education tools, and provided guidance to develop care coordination roles and internal processes. North Carolina has had similar experience with care networks and quality improvement approaches. Lessons learned from similar local level practice transformation projects funded by First 5s have shown that technical assistance to support electronic medical record modifications, care team transformation, paraprofessional role expansion, and workflow modification can dramatically improve screening and linkage rates for children.

Connecting to a larger system of early identification and referral

To ensure that California children receive the full EPSDT benefit and in recognition of the role that adversity plays in children's health, we recommend that the Department invest in Medi-Cal financing mechanisms to strengthen integrated care models and local systems of early identification, surveillance and referral. Integrated care models, like Healthy Steps, and locally-coordinated systems, like Help Me Grow, provide a critical access points of parent education and referral information to physicians; provide care coordination to ensure families are connected to the services they need; and close the feedback loop with physicians so they are made aware of referral outcomes. We encourage the Department to **convene stakeholders to discuss plans for building on existing efforts to create a scalable, sustainable early identification and referral system throughout the state.** This workgroup could also serve to clarify roles and responsibilities between the providers, health systems, the managed care organizations, County Mental Health and Public Health, and Regional Centers, and specify where each organization's care coordination responsibilities begin and align. This is imperative to ensure that screening leads to timely and effective intervention.

Data collection and reporting are also critical components of a strong system of identification and referral. California could be a pioneer in developing and refining a measure (or measures) of follow-up and care coordination for children's developmental needs, as timely and effective referrals are an essential component to making sure children are in fact getting care for what the screens identify. The establishment of such an accountability measure, or guidance around the existing allowable code for care coordination (99484: Care coordination performed by clinical staff for patients with behavioral health conditions), would significantly improve the

system of care. In the meantime, however, we recommend the Department clarify its plans for collecting and reporting developmental screening data. Providers should report the specific screening tool that was used, the outcome or score, and whether a referral was made as part of a reporting requirement to receive this incentive. The results of screens should be recorded, and used to help providers learn about the needs of the patient populations they serve and improve their practice. First 5s in a few counties have begun to implement data collection systems that work in pediatric care settings. We would welcome the opportunity to share this work with the Department.

Comments on Trauma Screening Incentive Payments

We applaud the Administration's interest in improving service referral and delivery to children experiencing adverse childhood experiences (ACEs). California's population of children and families experience high rates of adversity and trauma, including those related to current immigration policies. To strengthen the system and services that care for children who have experienced adversity and trauma, we recommend that the Department provide guidance and resources to help providers become trauma- and ACEs-informed. The Department, potentially working with the Surgeon General's office, could transform care delivery in communities by working with state and local agencies to develop, align, and issue guidance and expectations about best practices in ACEs screening and trauma-informed care.

ACEs screens should be used to inform referrals, practitioners' interactions with patients, and increase urgency for connecting families to services. Aligned with the approach outlined in the Governor's proposed budget released in January, the Department should engage with early childhood, ACEs and behavioral/mental health experts to learn from emerging evidence and make recommendations on how screening results can best inform practice and appropriate referral processes, and specify oversight mechanisms.

We recommend the Department seek to improve the system of referrals and care coordination for children who have experienced ACEs or trauma, and the collection and reporting of data to inform and improve the system of care. Our comments related to the importance of linking developmental screening to a larger system of integration and referral apply to ACEs screening, as well. Further, we encourage the Department to recognize the evolving nature of such screening tools, and the need for screening for social determinants of health and related home and community risks, in addition to ACEs, so that providers can act preventatively and mitigate adversity and trauma.

In summary, we support and appreciate the Department's efforts, and recommend as a first step that DHCS convene a group of stakeholders to discuss future VBP efforts and methods to improve the incentive payments proposals for developmental and trauma screening.

[i] See https://www.medicaid.gov/medicaid/finance/downloads/qa-training-registry-costs-071015.pdf

Submitted by:		Advocacy/Stakeholder Group:		

Comments to Draft Value Based Payment (VBP) Program Performance Measures					
#	Domain Category	Proposed Measure	Measure Payment Method	Support (Y/N)	Comments
1	Prenatal/Postnatal Care	Prenatal Pertussis ('Whooping Cough') Vaccine	Incentive payment to the provider for every pertussis vaccination for women between 27 and 36 weeks of pregnancy.	Yes	
2		Prenatal Care Visit	Incentive payment to the provider for ensuring that the woman comes in for her initial, first trimester prenatal visit.	Yes	We agree and suggest that these visit payments be linked to an assessment of the quality of care provided. In addition, we recommend that incentive payments be built into plan expenditures, so that total payment to providers are used in future rate setting.
3		Postpartum Care Visits	Incentive payment for completion of recommended postpartum care visits after a woman gives birth. Partial incentive payment if complete only one of the visits, full incentive payment for completing both visits.	Yes	We agree and suggest that these visit payments be linked to an assessment of the quality of care provided. In addition, we recommend that incentive payments be built into plan expenditures, so that total payment to providers are used in future rate setting.
4		Postpartum Depression Screening	Incentive payment for each screening for clinical depression using a standardized screening tool of postpartum women within 12 weeks after delivery.	Yes	We agree and suggest that the payment be tied to the full and complete use of a standardized, validated screening tool. DHCS should consider and plan for how screening data will be collected and reported; providers should be required to report screening results to receive these incentive payments. Bright Futures recommends that postpartum depression screening occur at the at the 1, 2, 4, and 6 month visit; the Department should clarify how often new mothers should be screened and that incentives can be attached to each screen recommended by Bright Futures within the first 12 weeks. Further, the Department should develop reporting mechanisms to define referral pathways and track referrals.
5		Postpartum Birth Control	Incentive payment to provider when the provide either a moderately or more effective form of birth control (birth control pills, shot, patch, ring, diaphragm, intrauterine device, implant or sterilization) for postpartum women between 3 and 60 days after delivery.		
6	Early Childhood	Well Child Visits in first 15 months of life (8 visits are recommended between birth and 15 months)	Incentive payment to a provider for successfully completing the last three well child visits out of eight total - 6th, 7th and 8th visits.	Yes	We agree and suggest that these visit payments be linked to an assessment of the quality of care provided. We recommend consideration of the two week visit as one to incentivize, given evidence that suggests children who attend that visit are more likely to attend subsequent visits. In addition, we recommend that incentive payments be built into plan expenditures, so that total payment to providers are used in future rate setting.
7		Well Child Visits in 3rd – 6th years of life	Incentive payment to provider for successfully completing all four well child visits during the 3rd – 6th years of life. Full incentive payment for all four visits, partial incentive payments if complete some but not all.	Yes	We agree and suggest that these visit payments be linked to an assessment of the quality of care provided. In addition, we recommend that incentive payments be built into plan expenditures, so that total payment to providers are used in future rate setting.

Comments to Draft Value Based Payment (VBP) Program Performance Measures					
#	Domain Category	Proposed Measure	Measure Payment Method	Support (Y/N)	Comments
8		All childhood vaccines for 2 year olds	For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given (e.g., the last dose of the diphtheria, tetanus and pertussis four vaccine series; the last dose of the three vaccine polio series; the 2nd flu vaccine, etc.).	Yes	
9		Blood Lead Screening	Incentive payment to a provider for completing a blood lead screening in children up to two years of age.	Yes	Federal rules require that all children enrolled in Medicaid receive blood lead screening tests at ages 12 months and 24 months. In addition, any child between ages 24 and 72 months with no record of a previous blood lead screening test must receive one. DHCS should amend this measure to align with federal requirements, providing payment when providers screen at 12 and 24 months, or between 24 and 72 months for a child not previously screened.
10		Dental Fluoride Varnish	Incentive payment to provider if provides oral fluoride varnish application for children 6 months to 5 years.	Yes	
11	Chronic Disease Management	Controlling High Blood Pressure	Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years being seen by the provider for their diagnosis of high blood pressure.		
12		Diabetes Care	Incentive payment to provider for each event of diabetes (HbA1c) testing that shows better than poor control (a result of less than 9%) for members 18 to 75 years with a diagnosis of diabetes.		
13		Control of Persistent Asthma	Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of persistent asthma who has more controller medications prescribed than those for the treatment of acute asthma.		
14		Tobacco Use Screening	Incentive payment to provider for tobacco use screening provided to members 18 years and older.		
15		Adult Influenza ('Flu') Vaccine	Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older for individuals with a chronic disease diagnosis (e.g., high blood pressure, atherosclerotic coronary artery disease, stroke, chronic obstructive pulmonary disease, asthma, chronic kidney disease, chronic liver disease, diabetes and dementia).		
16	Behavioral Health Integration	Screening for Clinical Depression	Incentive payment for provider for conducting screening for clinical depression (with a standardized screening tool) for beneficiaries 12 years and older		
17		Management of Depression Medication	Incentive payment for provider if beneficiary 18 years and old with a diagnosis of major depression and treated with an anti-depressant medication has remained on the anti-depressant medication for at least 12 weeks.		
18		Screening for Unhealthy Alcohol Use	Incentive payment for provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older		

Comments to Draft Value Based Payment (VBP) Program Performance Measures					
#	Domain Category	Proposed Measure	Measure Payment Method	Support (Y/N)	Comments
19		Co-location of primary care and behavioral health services	Health plan to attest to co-location of the provider and the direct payments to those providers. Payment per visit at the provider level.	Yes	We recommend that the Department consider this incentive payment as applying to enhanced pediatric settings, where multiple service providers ensure families receive the wide range of services they require to maintain a healthy, stable home.
20	Other Measure	Prenatal Screening	We recommend the Department consider providing a provider incentive for prenatal health and behavioral assessment, which can identify critical risk factors like past history of preterm birth.		
21		Low Birth Weight	We recommend the Department consider a provider incentive for low birth weight (reward for higher weight), consistant with the existing CMS Core Adult Measure. This reflects the prenatal provider's critical role in birth outcomes vs. effective prenatal care.		
		Social Emotional Screening	We recommend the Department consider a provider incentive for social emotional health screening, which would improve the pathway to county mental health/MHSA referrals.		
22		Care coordination	We recommend the Department consider provider incentives for care coordination performed for children who have been identified with behavioral health conditions or other developmental concerns, to manage the referral to behavioral health or regional centers, and support the pathway to county mental health services (CPT 99484).		
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Prenatal/Postnatal Care

Prenatal Pertussis ('Whooping Cough') Vaccine	Yes	
Prenatal Care Visit	Yes	We agree and suggest that these visit payments be tied to an assessment of the quality of care provided. [some language to that effect here]
Postpartum Care Visits	Yes	We agree and suggest that these visit payments be tied to an assessment of the quality of care provided. [some language to that effect here]
Postpartum Depression Screening	Yes	We agree and suggest that the payment be tied to the full and complete use of a standardized, validated screening tool.
Postpartum Birth Control		

Early Childhood

Well Child Visits in first 15 months of life (8 visits are recommended between birth and 15 months)	Yes	We agree and suggest that these visit payments be tied to an assessment of the quality of care provided. [some language to that effect here]
Well Child Visits in 3rd – 6th years of life	Yes	We agree and suggest that these visit payments be tied to an assessment of the quality of care provided. [some language to that effect here]
All childhood vaccines for 2 year olds	Yes	[no comment]
Blood Lead Screening	Yes	[no comment]
Dental Fluoride Varnish	Yes	[no comment]

Behavioral Health Integration

Screening for Clinical Depression		
Management of Depression Medication		
Screening for Unhealthy Alcohol Use		
Co-location of primary care and behavioral health services	Yes	We recommend that the Department consider this incentive payment as applying to enhanced pediatric settings, where multiple service providers ensure families receive the wide range of services they require to maintain a healthy, stable home.

Other Measures

Prenatal Screening		We recommend the Department consider providing a provider incentive for prenatal health and behavioral assessment

Social Emotional Screening	We recommend the Department consider a provider incentive for social emotional health screening, which would improve the pathway to county mental health/MHSA referrals.
Care coordination	We recommend the Department consider provider incentives for care coordination performed for patients with behavioral health conditions, to manage the referral to behavioral health or regionl centers.