February 27, 2017

Jennifer Kent
Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

SUBJECT: California Department of Health Care Services' Medi-Cal Managed Care Network Adequacy Proposal

Via e-mail: Jennifer.Kent@dhcs.ca.gov

Dear Director Kent:

The California Hospital Association, the California Association of Public Hospitals and Health Systems, Private Essential Access Community Hospitals, Inc., the California Children's Hospital Association and the District Hospital Leadership Forum are pleased to provide comments to the California Department of Health Care Services (DHCS) on its Medicaid Managed Care Final Rule: Network Adequacy Policy Proposal, released for public comment on February 2. The document outlines proposed network standards that harmonize California regulations with network adequacy provisions outlined in the Medicaid managed care and Children's Health Insurance Program (CHIP) managed care final rule.

Ensuring access for the Medi-Cal population is particularly important given its expansion under the Affordable Care Act (ACA), which has resulted in over 3.7 million new enrollees, and the growth of Medi-Cal managed care throughout the state and across populations. Medi-Cal — the largest Medicaid program in the nation — now serves over 13.6 million Californians, including approximately one-half of the state's children. Nearly one in three Californians depends on the Medi-Cal program for all of their health care needs. Additionally, California became the first state in the nation to establish its own state-based marketplace, Covered California, under the ACA. Over 1.4 million individuals have obtained health coverage though Covered California, a population that is anticipated to churn between the Medi-Cal program due to income fluctuations throughout the year.

Enrollment in California's Medi-Cal managed care delivery system has increased from 55 to 80 percent over the past five years. The lessons learned over that period highlight the need to ensure sufficient access and capacity in the broader delivery system and to maintain the health care safety net that is critical to serving all Californians.

As such, we are pleased to provide comments on DHCS' proposal, informed by our members' experience of providing health care services to the growing Medi-Cal population, and in a time of much uncertainty. We urge DHCS to consider our recommendations on: 1) time and distance and timely access standards, 2) additional considerations for certain populations, 3) alternative access standards, 4) ensuring adequate payments to support access to care, and 5) stakeholder engagement.

I. Time and Distance and Timely Access Standards

The final rule direct states to establish network adequacy standards in Medicaid and CHIP managed care for key types of providers, while leaving states flexibility to set the actual standards. Under the final rule, states are required to assess and certify the adequacy of a health plan's provider network at least annually and when there is a substantial change to the program design (e.g., new population, benefits, service area, etc.); develop and implement time and distance standards for primary and specialty care, behavioral health, OB/GYN, pediatric dental, hospital and pharmacy providers if covered under the managed care contract; and develop and implement network adequacy standards for managed long-term services and support programs that include criteria for providers who travel to the enrollee to provide services.

Despite the many challenges, we generally support the use of time and distance and timely access standards for provider networks, but encourage DHCS to allow for more narrowed requirements that would address the unique medical needs of children and adults with complex and chronic medical conditions. These complex patients often need more immediate and frequent access to certain specialty providers than is accommodated by a uniform time and distance standard. Additional recommendations are:

Specialists

Page 16 of the Department's proposal sets forth a list of "DHCS Core Specialists" to whom the time and distance standards would apply, and acknowledges a variety of reasons as to why not every type of adult or pediatric specialist is included. However, this discussion does not clarify whether the proposed time and distance standards are intended to apply to California Children's Services (CCS)-approved specialty providers who fall under one of the specialty types in the DHCS core providers list. We do not believe that the time and distance standards proposed for compliance with the federal managed care rule are appropriate for CCS-approved providers, due to the regional nature of the program and the importance of ensuring CCS-eligible children are seen by providers with the appropriate expertise in treating their CCS conditions. As such, we request that the Department explicitly exclude CCS-approved specialty providers from the time and distance standards in its final proposal.

In addition, neither the list nor the discussion explains whether DHCS intends for the new standards to apply to pediatric and adult specialists separately, such that plans must contract with enough pediatric specialists of each type to meet the time and distance standards for child enrollees without having to send them to adult specialists. We ask that this be clarified in the final proposal to ensure children who need specialty care outside of the CCS program have meaningful access to pediatric specialists in each of these core specialties.

Mental Health Services

We are pleased that the final rule required states to establish network adequacy standards in Medicaid and CHIP managed care for mental health providers. DHCS proposes to align mental health network adequacy requirements with standards for timely access for managed care plans (MCPs) and to apply the requirement to both adult and pediatric populations. We strongly recommend that DHCS adopt provider network adequacy standards for mental health providers that distinguish between adult and pediatric providers — a critically important distinction given the different regulatory frameworks required to serve child and adolescent patients with behavioral health needs. This distinction would better identify shortages and reduce reliance on out-of-network authorizations for care. The behavioral health needs of adults and children are

significantly different, and MHP (mental health plan) provider networks should be evaluated based on the needs of all populations they are contracted to serve.

We request that DHCS clarify whether proposed network adequacy standards also apply to outpatient services, as it has clarified under the substance use disorder network adequacy standards. As the final rule requires that all services covered under the state plan be available and accessible to beneficiaries of managed care organizations (MCOs), prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs) in a timely manner, we request that DHCS clarify whether these standards apply to long-term care services and residential treatment settings for behavioral health, such as institutions for mental diseases, mental health rehabilitation centers and residential treatment centers.

We request that DHCS further refine its proposal to ensure consistency of requirements pertaining to mental health providers, as it is our understanding that more prescriptive existing requirements are delineated in Title 9, the 1915(b) Medi-Cal Specialty Mental Health Services Waiver and in the corresponding MHP contract boilerplate language, including requirements for urgent care.

Lastly, on page 20 DHCS references Attachment F, a map of the California counties by mental health region. We request that DHCS articulate the relevancy of Attachment F, as its significance is unclear.

Substance Use Disorder Services
We are pleased that the final rule required states to establish network adequacy standards in Medicaid and CHIP managed care for substance use disorder (SUD) providers. DHCS' proposal categorizes these services as Drug Medi-Cal – Organized Delivery System (DMC-ODS) waiver services, and it is our understanding that these standards would also apply to non-DMC-ODS pilot counties. As such, we request that DHCS clarify in its final proposal that these standards also apply to non-pilot counties. In addition, DHCS notes in its proposal that SUD treatment services have been separated into outpatient and specialty categories. The proposal, however, only separates SUD treatment services into outpatient and opioid treatment programs. We request that DHCS clarify whether other specialty categories apply.

II. Additional Considerations for Certain Populations

In determining sufficient network adequacy, additional consideration must be given to certain patient populations — such as individuals living and working in rural communities and individuals in need of post-acute care services — particularly in a state as large and diverse as California. We urge DHCS to carefully consider the following examples of the current challenges in California with respect to time and distance requirements for network adequacy, and consider additional oversight and review to further refine standards over time.

Rural Hospitals
Health plans mistakenly apply mileage formulas to demonstrate that rural patients can travel out of their communities to urban or regional providers. The reality, however, is that these formulaic approaches often ignore the realities of rural travel, such as traffic conditions, mountain roads or harsh weather conditions.

Requiring rural patients to leave their communities for basic health care services can have long-term consequences. California's rural hospitals often are the primary — and only — source of care in their communities. They provide essential health, emergency and long-term care services to the 17 percent of California residents who live in rural areas. Rural hospitals also anchor other services in their communities, such as home health, ambulance service, hospice and post-acute care.

Because of the continued access challenges occurring in rural areas — challenges that DHCS acknowledges in its *Medi-Cal Managed Care Quality Strategy Comprehensive Review*, released for public comment in October 2016 — we urge the Department to ensure rural hospitals are included in health plan networks. Their exclusion renders it impossible for rural hospitals to maintain emergency services with only underfunded Medi-Cal and Medicare patients. Similarly, excluding rural hospitals from Medi-Cal managed care plan networks disrupts the fragile and interdependent rural health care delivery system, making it even more difficult to provide primary and preventative health care.

Post-Acute Care Services

Following a hospitalization for injury or illness, many patients require continued medical and rehabilitative care either at home or in a specialized facility. Timely access to the most appropriate level of post-acute care is an important factor in a patient's ability to achieve and maintain optimal medical and functional outcomes. The post-acute care continuum includes inpatient programs such as inpatient rehabilitation facilities, long-term acute care hospitals and skilled-nursing facilities, as well as home and community-based services such as home health care, hospice and outpatient services. Medi-Cal managed care plan networks should include an adequate number and range of providers at each level of care.

Many hospitals face significant difficulty securing appropriate post-hospital care for patients who no longer require acute care but may have specialized needs. When post-acute care services are not available in the Medi-Cal managed care plan's provider network, patients and hospitals are disadvantaged. As a result, these individuals may remain in hospital beds beyond the time required to treat their medical condition, often for extended periods — weeks, months or even years. Often, the challenges of access are masked because the hospital continues to provide care when the next level of care is not available. Retaining patients unnecessarily in acute care hospitals is not only an inefficient and costly use of resources, but also compromises patient outcomes. Medi-Cal managed care plans should be incentivized to ensure that they provide a full range of post-acute care services in their provider networks.

III. Alternative Access Standards

The final rule provides for exceptions to network adequacy standards in special situations. DHCS indicates in its proposal that it will develop an alternative access standards process for application by MCPs, MHPs, Drug Medi-Cal Organized Delivery System (DMC-ODS), and dental managed care (DMC) plans. Alternative access standards will only be approved in circumstances where the applying entity has exhausted all other reasonable options to obtain providers to meet either time and distance or timely access standards. Standards other than time and distance will be considered when the provider travels to the beneficiary and/or a community-based setting to deliver services. Other modalities, such as telemedicine and pharmacy mail order, will be considered for purposes of meeting requirements when reviewing these applications. In addition, seasonal impacts (e.g. winter road conditions) to time and distance standards will be considered when necessary. We urge DHCS to publicly display on its website

approved alternative access standards, as this information should be readily available to patients and providers.

In addition, DHCS' proposal notes that modalities such as telemedicine and pharmacy mail order will be considered **only** for purposes of meeting requirements when reviewing applications for alternative access standards. We strongly urge DHCS to consider alternative care delivery modalities that recognize patient access to health care is no longer defined by the traditional face-to-face office visit, without requiring providers to apply for an alternative access standard or demonstrate that all other options have been exhausted. In recent years, California's hospitals have worked diligently to find new, more patient-centered and efficient ways to provide services that meet the needs of a growing patient population. As hospitals develop and deploy new care models and modalities, it has become clear that traditional notions of access no longer sufficiently capture the growing range of ways that patients are receiving care and support from the health care system. The traditional markers of access to a physician or mid-level provider need to be expanded upon to appreciate the value of team-based care models that employ a diverse array of ancillary staff, like community health workers, care managers and nurses. Ideally, Medi-Cal members should have access to a comprehensive care team — not just a provider. The notion that care is provided via a one-on-one, face-to-face visit must evolve to recognize the growing importance of alternative modalities such as group visits for chronic disease management support, telephone visits, patient portals such as eConsult, telemedicine and texting. These innovative models of care require that we develop and test new measures of access that can evolve over time and keep pace with care delivery innovations. DHCS should support this work as part of its effort to ensure access to care for Medi-Cal members. The managed care rule calls out this type of access as something that must be considered; we urge DHCS to permit plans to meet the main access requirements through evidence of these types of services without applying for a special exception.

IV. Stakeholder Engagement

We acknowledge that DHCS will need to update its contracts with and policy letters to MCPs, MHPs and DMC-ODS health plans to incorporate many of these proposed requirements. In the past, DHCS has engaged its Medi-Cal Managed Care Advisory Group on Medi-Cal managed care issues related to MCP requirements, including the review of draft policy letters; we request that DHCS also utilize this group to review any draft policy letters that apply to MHPs and DMC-ODS health plans. As many of the final rule requirements are newer to the MHPs and DMC-ODS plans, we hope that DHCS can accommodate this request as it promotes transparency and ensures that the broader stakeholder community has a common and accurate understanding of these requirements' application to the entire Medi-Cal managed care delivery system.

V. Ensuring Adequate Payments to Support Access to Care

We appreciate DHCS' stated commitment to ensuring network adequacy for the Medi-Cal population, and urge DHCS to acknowledge the role hospitals play in providing 24-hour access to high-quality care. Stand-by capacity, as well as hospital contributions to the teaching and education of our health care professionals, must be fully reflected in provider payments. The cost of providing health care service is not linear. Providing health care services to our most vulnerable beneficiaries involves a complex delivery system in the midst of great transformation. DHCS must ensure that payment rates adequately address the changing nature of health care delivery, and support those changes by recognizing the costs and burdens associated with asking providers to do more with less. Inadequate reimbursement will further deteriorate our fragile safety net. We urge DHCS to ensure that capitation rates adequately support provider reimbursement levels that will promote network adequacy and timely patient access to care.

We appreciate the opportunity to comment on DHCS' proposal and welcome the opportunity to meet to further discuss our recommendations.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage
California Hospital Association

Ann-Louise Kuhns
President and CEO
California Children's Hospital Association

Erica Murray
President and CEO
California Association of Public Hospitals
and Health Systems

Catherine Douglas
President and CEO
PEACH, Inc.

Sherreta Lane
Vice President, Finance Policy
District Hospital Leadership Forum