September 29, 2016

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 Quality Strategy

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 draft Medi-Cal Managed Care Quality Strategy, released September 20. The Medi-Cal program has grown significantly under the Affordable Care Act (ACA), with managed care enrollment increasing from approximately 6 million people in December 2013 to 10.5 million people in September 2016, according to DHCS managed care enrollment reports. Given that approximately one-third of all Californians now depends on the Medi-Cal program for all of their health care needs, DHCS’ ability to both assure the quality of care for the services provided to Medi-Cal members and the proper oversight of its managed care plans is as critical now as it has ever been.

We commend DHCS for its commitment to improve the health of all Californians; enhance quality, including the patient care experience, in all of its programs, and reduce its per capita health care program costs. We welcome the opportunity to provide comments in the spirit of strengthening the draft and ensuring that Medi-Cal members are assured timely access to high-quality health care services. We are pleased to provide comments on the importance of coordinating quality strategies across managed care plans, access standards, quality measurement, monitoring and compliance and delivery system reforms.

I. Coordinating Quality Strategies Across Managed Care Plans

While we recognize that the quality strategy that DHCS has put forth pertains to Medi-Cal managed care organizations (MCOs), we also want to recognize that there are other managed care or managed-care-like plans in California serving the same beneficiaries as the Medi-Cal plans, such as county mental health plans, and soon the Drug Medi-Cal plans. In this report, DHCS does address the ways in which MCOs are coordinating with the other plans, which is critical for the public to understand. In addition, we would like to better understand how the quality strategies are coordinated and consistent across these various programs in service of providing seamless care to Medi-Cal beneficiaries, and to comply with new requirements under the Medicaid managed care final rule.
II. Access Standards

Though the draft acknowledges that standards for access to care include availability of services, assurances of adequate capacity and services, care coordination and continuity of care, and coverage and authorization of services as required by 42 CFR §438.206 – §438.210, we encourage DHCS to allow for more narrow 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. Currently, network adequacy standards fall short in ensuring truly adequate networks. For example, California has long had an issue with specialist access in the Medi-Cal program. Regulatory requirements do not include ratios for enrollees-per-specialist, or time or distance standards for specialists. While some appointment wait time standards are in place, they have proved difficult to monitor and enforce effectively.

In determining sufficient network adequacy, additional consideration must be given for certain patient populations — such as individuals living and working in rural communities, individuals with behavioral health needs and individuals in need of post-acute care services — particularly in a state as large and diverse as California. We encourage DHCS to carefully consider the following examples of the current challenges in California with time and distance requirements for network adequacy and consider additional oversight and review to further refine standards over time. In addition, it will be important to ensure that time and distance standards for pediatric specialty care support, and do not undercut, existing California Children’s Services standards.

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.

Excluding rural hospitals in health plan networks makes 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.

Behavioral Health
Medi-Cal managed care plans should be required to demonstrate sufficient capacity of behavioral health providers who treat children, in addition to adults, for psychiatric illnesses and substance abuse disorders. This is a critically important distinction because of 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 managed care plan provider networks should be evaluated based on the needs of all populations they are contracted to serve. We also recommend that DHCS outline in the draft its mechanism for measuring mental health parity compliance.
**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 (IRFs), long-term acute care hospitals (LTCHs) and skilled-nursing facilities (SNFs), as well as home and community-based services such as home health care, hospice care 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 and may have specialized needs. When the 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, patients may remain in hospital beds beyond the time required to treat their medical condition, often for extended periods — weeks, months or even years. Retaining patients unnecessarily in acute care hospitals is not only an inefficient and costly use of resources, but also compromises patient outcomes.

### III. Quality Measurement

In assessing which measures should be reported by Medi-Cal managed care plans, we encourage DHCS to give preference to measures that are appropriate for the patient population and that reduce the reporting burden on plans and providers, for instance by using measures already reported to CMS through other state and national programs. Providers are familiar with these measures, and in many cases are already collecting data. This alignment is essential in minimizing reporting burden and reducing costs.

### IV. Monitoring and Compliance

We appreciate that DHCS has outlined its corrective action plan (CAP) process and has indicated specific actions for low performing plans. While DHCS has historically posted the compliance audits and CAPs on its website at [www.dhcs.ca.gov/services/Pages/MedRevAuditsCAP.aspx](http://www.dhcs.ca.gov/services/Pages/MedRevAuditsCAP.aspx), it is not clear whether DHCS has updated its website to include specific, recent actions. We request that DHCS update its website accordingly, and post to its website the advance warning letters issued to MCPs that do not meet CAP criteria for the current reporting year, but that are at risk of triggering a CAP in the next reporting year. This information should be publicly available to patients and providers in a timely fashion.

### V. Delivery System Reforms

We request that DHCS include in the list of delivery system reforms in Section 4 the Whole Person Care and Public Hospital Redesign and Incentives in Medi-Cal programs approved under the current Medi-Cal 20202 waiver, and have suggested language below.

**Whole Person Care**
California’s 1115 Medicaid waiver extension, Medi-Cal 2020, provides an opportunity for counties and certain other entities to apply to become Whole Person Care (WPC) pilots, focused on the coordination of health, behavioral health and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. WPC pilots will provide support a county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority, to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been
identified as high users of multiple systems and continue to have poor health outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC pilot entities will identify target populations, share data between systems, coordinate care in real time and evaluate individual and population progress — all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes. Eighteen counties have applied for the first round of funding, and final pilot sites will be selected in October.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
PRIME directs designated public hospitals and associated health systems, along with district and municipal hospitals (collectively referred to as “PRIME Entities”) to use evidence-based quality improvement methods to achieve ambitious, year-over-year performance targets. All federal funding for this program is contingent on meeting these targets. The PRIME program is considered the successor to the 2010 Bridge to Reform waiver’s Delivery System Reform Incentive Program (DSRIP), a pay-for-performance program that improved care delivery to prepare California’s designated public hospitals for an influx of newly covered patients through the implementation of the ACA.

Efforts within DSRIP included expanding primary care capacity, enrolling individuals into medical homes, and reducing hospital infections. PRIME builds on the DSRIP’s success, with a greater focus on clinical outcomes and improved health for patients.

Organized in three domains, and with minimum project requirements for all PRIME entities, PRIME includes projects that focus on redesign of ambulatory care, care of high-risk populations and high-cost resource utilization.

In addition to the projects and metrics mentioned earlier under Patient Safety, PRIME also includes specific efforts aligned with other of the DHCS Managed Care Quality Strategy priorities. Several of the projects in Domain 1: Outpatient Delivery System Transformation and Prevention and in Domain 2: Targeted High-Risk or High-Cost Populations focus on improvements in the provision of comprehensive coordinated chronic care management. Targeted metrics include Controlling Blood Pressure, Diabetes Poor Control and Depression Remission at 12 Months. Project 1.5: Million Hearts® Initiative specifically focuses on reducing the morbidity and mortality associated with cardiovascular disease. The Million Hearts project, along with several others, will engage providers in focused efforts to increase tobacco assessment and counseling for all their patients. Project 2.6: Chronic Non-Malignant Pain Management will directly help leverage DHCS’ efforts in reducing preventable deaths due to opioid overdoses, through improvements on such metrics as Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy.

PRIME also supports the Medi-Cal Managed Care Strategy goal of reducing health disparities by requiring the collection of detailed race, ethnicity and language data, as well as gender identity and sexual orientation information, and to use those data to reduce disparities in targeted primary care metrics such as Controlling Blood Pressure and Colorectal Cancer Screening.

Through PRIME, DHCS is also establishing new innovative standards for health care performance measurement that will support improvements in the health of Medi-Cal beneficiaries and beyond. Measures such as (Specialty Care) Referral Reply Turnaround Rate will drive systems towards the use of eConsult, a platform for primary/specialty care collaborative care that greatly enhances highly needed access to specialty expertise. The Multi-Modal Therapy for Chronic Non-Malignant Pain metric will help to improve treatment success in this population while decreasing opioid prescriptions. This groundbreaking work helps support quality improvement measurement as technology, needs and diseases evolve.
PRIME is also preparing California’s designated public hospitals and associated health systems to move towards sustainable delivery system reform through the increasing use of alternative payment models, which endanger the quantity and quality of services provided to Medi-Cal managed care enrollees that are assigned to public health care systems for their care. In an effort to demonstrate that PRIME improvements can be sustained beyond Medi-Cal 2020, the waiver requires that, by January 2018, 50 percent of the state’s Medi-Cal managed care beneficiaries who are assigned to a designated public hospital system receive all or a portion of their care under a contracted alternative payment model. By January 2019, the goal will increase to 55 percent, and by the end of the waiver renewal period in 2020, it will increase to 60 percent. In both years four and five of the waiver, 5 percent of the statewide yearly allocated pool amount for all designated public hospitals will depend on meeting these goals. All of the projects, metrics and related transformative changes taking place under PRIME support the national movement in health care as well as DHCS’ goal to move Medi-Cal beneficiaries’ care from episodic, siloed, volume-based care to the coordinated, longitudinal, population and value-based care under the risk-based alternative payment models required by PRIME.

We appreciate the opportunity to comment on the draft, and welcome the opportunity to meet to further discuss our recommendations. We prepared comments quickly to meet DHCS’ compressed timeframe. Should we identify other areas of concern, we will submit our comments to DHCS in an expeditious manner.

Sincerely,

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