February 28, 2017

Jennifer Kent, Director
Department of Health Care Services
P.O. Box 997413, MS 8100
Sacramento, CA 95899

SUBJECT: Comments on the Department of Managed healthcare Services' Proposed Network Adequacy Standards for Medi-Cal Managed Care

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

Dear Director Kent:

The Children's Specialty Care Coalition (CSCC) and California Children's Hospital Association (CCHA) appreciate the opportunity to provide feedback on the Department of Health Care Services' (DHCS) *Medicaid Managed Care Final Rule: Network Adequacy Policy Proposal*, and help ensure California's most vulnerable children and youth have timely access to the care they need from appropriately qualified providers.

CSCC represents nearly 2,000 pediatric subspecialty physicians, whose mission is to ensure children with complex health care needs have access to timely and high quality medical care, and that pediatric specialists are able to thrive in California's health care environment. CCHA advocates on behalf of the State's eight, private, freestanding children's hospitals to advance the well-being of children, promote access to high quality pediatric health care, and ensure the long-term viability of children's hospitals.

How is the proposed rule meant to apply to CCS-approved providers?
Table 4 on page 16 of the proposal sets forth a list of "DHCS Core Specialists" to whom the network adequacy standards would apply. While the discussion about specialists on page 16 acknowledges a variety of reasons why it does not make sense to establish time and distance standards for every type of adult or pediatric specialist, it does not clarify whether or not the proposed standards are intended to apply to CCS-approved specialty providers or other pediatric subspecialists who may fit with the broad specialty types referenced in the table.

We do not believe that the proposed time and distance standards should be applied to CCS-approved providers, given that the majority of these providers tend to be based regionally in tertiary children's hospitals and designated special care centers. The regionalized nature of pediatric specialty care reflects the volume of pediatric patients in the state, and the fact that Medi-Cal rates are not sufficient to recruit and retain pediatric subspecialists in every community in the state. This is particularly true for certain pediatric specialties such as endocrinology, neurology, and gastroenterology, for which there are often nationwide shortages. Despite these realities, it is still critical that children with complex healthcare needs obtain care from experienced providers with appropriate pediatric-specific expertise. As such, we respectfully request that the Department explicitly exclude CCS-paneled providers from the time and distance standards in its final proposal.

Will the standards be deemed met if a plan directs a pediatric patient to an adult provider?
In addition, it is not clear from looking at Table 4 - "DHCS Core Specialists", whether or not the Department intends for these 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 their 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.

We would also encourage the Department to clarify what constitutes an alternative access standard, and seek assurances that a referral to an adult provider will not be considered as an alternative for pediatric specialty care referrals. Research continues to highlight the distinct characteristics of pediatric specialty care and its association with better outcomes, higher quality and reduced costs. Access to adult specialists is not an acceptable alternative. However, CCHA and CSCC are supportive of appropriately reimbursed telehealth as a viable alternative access standard, when an in-person visit is not needed.

Will the standards adequately address the realities of travel times in rural mountain and dense urban communities?
For each time and distance standard, we are seeking clarification on which standard must be met, the metric that is the greater or the lesser of the two. For example, for a patient in a large county where the standard is 15 miles or 30 minutes, would the network adequacy standard be deemed met if it takes the patient longer than 30 minutes to see a provider who is 15 miles or less from their home? Road conditions, seasonal weather, and traffic congestion can significantly impact travel time in some communities and make it virtually impossible for enrollees to cover distances in the time periods listed in the proposed regulation. As such, we request that the Department clarify that these standards will only be deemed met if a patient can access contracting providers within the time *and* distance included in the standard.

We applaud the Department's efforts to improve its access monitoring program.
Lastly, we strongly support the work the Department is doing to improve the quality of the provider network data it collects from managed care plans, as described on page 26 of the proposal. Many of the monitoring methods and network data relied on by the Department in the past has been erroneous or otherwise painted an incomplete picture about the availability of providers within plan networks. Robust plan-level data is critical to ensuring that contracting providers have enough appointment availability to support plan enrollees, and these efforts are of utmost importance for Medi-Cal beneficiaries.

Thank you for the opportunity to provide comment on the DHCS Network Adequacy Proposal. We look forward to engaging in further discussions with the Department and other stakeholders, to ensure that children have timely access to quality pediatric specialty care.

Sincerely,

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