californiahealth+ advocates
ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

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State of California Health and Human Services Agency
Department of Health Care Services
Submitted electronically to dhcsmcqmdnau@dhcs.ca.gov

RE: Medicaid Managed Care Final Rule: Network Adequacy Policy Proposal

To Whom it May Concern:
CaliforniaHealth+ Advocates (Advocates) is committed to advancing the mission of California's 1,150 not-for-profit community clinics and health centers (CCHCs) that provide comprehensive, quality health care services to 6.2 million Californians, and employ more than 33,600 Californians.

CCHCs provide healthcare services to California's most vulnerable populations with 76% of CCHC's patients at or below 200% of the Federal Poverty Level (FPL); more than 50% identifying as Hispanic; and nearly 40% identifying a language other than English. One in seven Californians are served by CCHCs, including more than 3.5 million Medi-Cal beneficiaries served through nearly 12 million Medi-Cal encounters. On behalf of California's network of CCHCs, Advocates appreciates the opportunity to work with the Department on improving network adequacy in Medi-Cal managed care.

Since expanded coverage under health care reform began on January 1, 2014, CCHCs have experienced significant challenges in obtaining timely access to care for their patients enrolled in Medi-Cal Managed Care Plans. This is especially true in rural areas that recently underwent the rural managed care expansion - in these remote and underserved areas, provider shortages or network inadequacies endemic to Medi-Cal are greatly exacerbated. We hope that a more thoughtful construct of network adequacy requirements coupled with enhanced monitoring, oversight, and accountability will ensure reliable access to a full spectrum of medically necessary care.

A primary cause of the network adequacy issues experienced in Medi-Cal managed care is due to California's health care workforce shortage. At current utilization, California will need an estimated 8,243 additional primary care physicians by 2030 (Pettersone, Cai, Moore, & Bazemonre, 2013). California's ratio of primary care physicians participating in Medi-Cal is approximately half of the federal recommendation. It has become clear to health centers across California that we cannot deliver on the promise of healthcare access if we do not have a robust workforce capable of providing the timely, culturally competent, high quality care our patients deserve. The Governor and Legislature began to address the crisis last year with a three year, $100 million investment in primary care workforce programs, but unfortunately the funding was zeroed out in this year's budget proposal and the state is nowhere closer to meeting our state's access needs. If the one-time $100 million investment is not restored in the final 2017-2018 budget, there will be a limit to the success of any new network adequacy standards, and the access crisis will continue at the expense of our most vulnerable communities' health.

As Medi-Cal managed care plans are responsible for ensuring that care is available to enrollees, we believe that it is in their interest to invest heavily in the creation and recruitment of this workforce. It is

our hope that strengthened network adequacy requirements coupled with increased enforcement will galvanize Medi-Cal plans into action, partnering with Advocates and other stakeholders to build the workforce we will need for the future. Coordinated, definitive action is needed to create meaningful increases in primary care capacity in California's medically underserved communities.

We appreciate the opportunity to provide comment on this policy proposal that so clearly demonstrates the need for increased investment in our state's health care provider infrastructure. We look forward to partnering with the Department and managed care plans to create innovative solutions to these clear and persistent network adequacy issues.

Comments

Primary Care

CCHCs are comfortable with DHCS' proposal to maintain the current standards as they relate to primary care, including OB/GYN primary care. We note that the document does not address accessibility of primary care to patients who are dependent upon public transit, or require ADA accessibility at the primary care site. In fact, the document does not appear to address public transit, which is a primary transportation mode for Medi-Cal enrollees. For this population, we would certainly hope that the time and distance travel times also take into account the time and distance a beneficiary must travel via public transportation. **We ask that DHCS clarify whether the time and distance standards address the need to ensure that primary care is accessible by public transit and require the inclusion of providers who can guarantee ADA accessibility within Medi-Cal managed care networks**.

Specialty Care

Types of specialists subject to time and distance standards:

California's CCHCs provide extensive referral coordination for their patients, and therefore have a strong understanding of the difficulty that Medi-Cal patients encounter when trying to access specialty care. Advocates has polled health centers about the types of specialty services that Medi-Cal patients often have difficulty accessing in a timely manner, and found that the list included in DHCS' policy proposal is nearly comprehensive. In addition to the specialist types listed in the document, CCHCs named radiology, rheumatology, urology, and transgender services as critical, regularly accessed services that are difficult to access in-network currently and must be monitored closely. CCHCs also note that HIV specialist services must be broken out and monitored separately to ensure ease of access to HIV services for the HIV positive population. While we believe HIV specialist services are, in fact, primary care services for persons with HIV, the recognition of limited HIV specialist availability and limited need among the full spectrum of Medi-Cal beneficiaries makes it appropriate for HIV specialist services to be measured like specialty services. **We ask that DHCS add radiology, rheumatology, urology, transgender services, and HIV specialists to the list of specialists subject to time and distance standards.**

Types of specialists subject to timely access standards:

According to this document, specialty care timely access standards remain the same as they are currently: 15 business days to appointment from request. However, current timely access standards apply to all specialists. The DHCS proposal reads as though the standard would be revised so that timely access standards apply only to the specialist provider types listed in the document. This is a critical distinction, as Medi-Cal beneficiaries deserve timely access to care, regardless of what type of care they need.

We understand that there truly are some specialty types where there are simply not enough specialists willing to contract at any cost, to meet time and distance requirements. For these specialists, whether in network or out of network, it remains critical to the health of Medi-Cal enrollees to ensure that timely access standards are met. **We ask that DHCS clarify that all specialist types should be available to a beneficiary within 15 days from their appointment request, not just the types listed in the proposal.**

Addressing physical barriers to access:
To address the transportation barriers and provider shortages across Medi-Cal networks, CCHCs continue to explore new and unique ways to leverage telehealth, especially for specialty access. As telehealth continues to expand and play a role in specialty access, it's critical that we understand how time and distance standards are applied to telehealth services. **We ask that DHCS clarify guidelines around how telehealth services are measured and accounted for in the network adequacy methodology, and, if necessary, encourage plans to invest in additional telehealth infrastructure in areas where availability of providers is such that they are unable to meet network adequacy requirements.**

Ensuring alignment of hospital and specialist contracts:
Because plans have hospital contracts for the use of facilities that are separate from their specialty contracts, it's critical that DHCS ensure alignment between in-network specialists who provide hospital services and the hospitals who are in the same network. There is at least one current example in the state where a health plan has a contract with a single hospital and has a network of surgeons that technically meet the network adequacy requirements. But, in fact, none of those surgeons actually have admitting privileges at the single hospital under contract with the plan, which means that surgical services are not readily available to enrollees, because facility and specialty privileges are not aligned. **We ask that DHCS require plans to report and verify that their hospital contracts and specialists' hospital privileges are aligned, at least for specialist types that frequently provide services within a hospital.**

Mental Health
Mental health time and distance standards currently require plans to provide "reasonable access." Under the DHCS proposal, mental health time and distance standards will mirror the new specialty care time and distance standards, and require no more than 10 business days from request to appointment. Advocates would argue, however, that mental health care services should be offered at parity with physical health services. **Mild to moderate mental health care should therefore meet the primary care time and distance and timely access standards, while specialty mental health services for the seriously mentally ill should be available at the time and distance standards required of other specialty care.**

CCHCs note that timely access for behavioral health care is largely nonexistent, and the gap is widening. While many CCHCs are working to grow their own behavioral health capacity, the workforce shortage coupled with FQHC billable provider limitations has stifled our ability to meet the behavioral health needs of our patients. Last year, the legislature passed AB 1863 (Wood), which allows FQHCs to utilize Marriage and Family Therapists (MFTs) to provide behavioral health services to Medi-Cal patients. Once implemented, this law would vastly expand the behavioral health workforce available to serve Medi-Cal patients, strengthening our ability to meet behavioral health access requirements. Unfortunately, the Governor's 2017-2018 proposed budget delays the implementation AB 1863 from January 2017, to July 1, 2018. As such, MFTs will not be able to bill for services within an FQHC for 18 months, forcing high-needs patients to wait even longer for behavioral health services. This is not a harmless processing delay, it will have real-world impacts on patients and providers alike, leaving an enormous gap in Medi-

Cal behavioral health services until that time. **To better serve Medi-Cal patients and to allow plans to meet these enhanced network adequacy standards for critical behavioral health services, Advocates strongly recommends DHCS move forward with allowing FQHCs to bill for MFT services as soon as possible.**

Pediatric Dental

In 2015, through 2.5 million oral health visits, approximately 860,000dental patients were served in California's FQHCs, but for too many California's oral health access is not a reality. Advocates encourages DHCS to do more to ensure that the pediatric dental standards are met and that dental care is accessible for the Medi-Cal population. As was made clear in the Little Hoover Commission Report "Fixing Denti-Cal," the pediatric dental system in California is suffering and overburdened, with care inappropriately hard to access. To overcome the challenges facing the dental health care delivery system, the Little Hoover Commission (LHC) recommends DHCS should:

- Simplify the Denti-Cal provider enrollment forms and put them online in 2017
- Overhaul the process of treatment authorization requests
- Implement a customer-focused program to improve relationships with its providers
- Purge outdated regulations
- Create an evidence-based advisory group for the Denti-Cal Program
- Increase teledentistry and the Virtual Dental Home model
- Expand concepts of Washington State's Access to Baby and Child Dentistry Program and Alameda County's Healthy Kids, Healthy Teeth Program to more regions in California
- Steer more Denti-Cal patients into Federally Qualified Health Centers with capacity to see them
- Recruit more pediatricians to provide preventative dental check-ups during Well-Child visits.

Advocates strongly encourages DHCS to adopt the policy recommendations in the Little Hoover Report "Fixing Denti-Cal," and increase monitoring and enforcement until pediatric dental standards can be met in all counties across the state.

Monitoring

In this report, DHCS maintains that they and DMHC have a comprehensive monitoring plan in place for Medi-Cal managed care plans. DHCS proposes to use the established process to ensure compliance with requirements. For the Drug Medi-Cal Organized Delivery System and for specialty mental health provided by county Mental Health Plans, there is limited information about how DHCS is monitoring or plans to monitor and enforce network adequacy requirements. **We ask that DHCS provide more information to stakeholders about the county Drug Medi-Cal and Specialty Mental Health monitoring and enforcement plan, and any corrective action that might be imposed for failure to maintain network adequacy.**

Thank you for the opportunity to provide comment on this proposal. If you have any questions please feel free to contact Meaghan McCamman at Meaghan@healthplusadvocates.org or (916) 440-8170.

Sincerely,

Andie Patterson
Director of Government Affairs