California Association of Health Plans

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Mr. Nathan Nau
Chief, Managed Care Monitoring and Quality Division
Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 95814

VIA ELECTRONIC MAIL:

dhcsmcqmdnau@dhcs.ca.gov

Re: Network Adequacy- Final Federal Rule

Dear Mr. Nau:

The California Association of Health Plans ("CAHP") represents 48 public and private health care service plans that collectively provide coverage to over 25 million Californians. We write today to provide feedback on the Medicaid Managed Care Final Rule: Network Adequacy Policy Proposal, which was released for comment on February 2017. We want to thank the Department of Health Care Services (the Department) for the opportunity to review the proposed changes to the network adequacy requirements. Following are our detailed comments on the proposal and we would welcome the opportunity to have a discussion with Department staff before the requirements are finalized.

Proposed Network Adequacy Standards

CAHP and its member plans appreciate the new county designations, which appear to be one way to account for the variables in member population and geographic availability and accessibility of providers. However, some challenges remain in truly representing network adequacy across a county, many of which may actually fall into more than one of the current designations of Rural to Small, Medium, and Large based on the geography in different parts of the county. Additionally, it is important to take into account not just the population but how long it actually takes to travel from one part of the county to another (for example during rush hour) or if the population in a certain part of the county is sparse and there are limited providers to contract with. Time and distance standards should not only be based on population but also geographic size of service area.

In many counties plans are serving a rural population, where people choose to live miles away from primary care and other providers. For example, some beneficiaries live in the far northeast corner of the state and the nearest primary care provider and/or hospital is almost 60 miles away. While plans make every effort to contract with every willing provider in good standing there is no way to meet the standards if there are no providers available. Regardless of population size, small and large counties have places where population is concentrated, where travel distance should be shorter. And small and large counties have places where population is sparse, and travel allowances should be longer.

We therefore suggest that the Department work with health plans to determine if in certain counties it would more accurately measure network adequacy if an additional layer was built into the new county designations. For example, in some counties it may be useful to use the California Medical Service Study Areas (MSSAs) developed by OSHPD. This allows counties to be broken up by zip code and has designations of Frontier, Rural, and Urban. Another suggestion is to leverage the standards that are used by NCQA, which is done on an urban, suburban, and rural designation system. While this may not be necessary in every county, and there are other resources that the Department may find useful, we offer these as examples of ways to work with plans to find the best measure of access in instances where a county can't be placed in a one-size fits all category.

It is also noted that the requirements are based on anticipated Medicaid enrollment. Over the past several years we have experienced a tremendous amount of growth in the Medi-Cal program and we are now looking at possible change at the federal level that may reduce enrollment in Medi-Cal. We request that the Department clarify how adjustments will be made to these standards if there are large increases or decreases in the Medi-Cal population.

Time & Distance Standards

We request that the Department clarify how to calculate the time and distance standards listed from the beneficiary's residence when the address on file is not the residence or there is more than one address on file for the member. For example, plans sometimes have P.O. Boxes listed and it is not clear if the plan will be required to obtain the address from the Department that it should use or if the one on file is sufficient. It would also be helpful if the Department would provide further details on approach, methodology, and systems it will use to calculate the minutes driving standard contained throughout the policy proposal.

When the standard is based on the county designations by population (rural to small, medium and large) please clarify how a plan can account for an open network arrangement. Some plans have networks where specialists are not contracted with the plan but are available for members and it is not clear how they will be included in this calculation.

It is also not clear how tele-health providers will be accounted for in these standards and we request additional discussion with the Department on this issue as it is important in many rural areas and for access to certain specialties, which is discussed in more detail below.

The time and distance standards should be updated to consider rural areas and federally designated Medically Underserved Areas, which is consistent with our request above to ensure that network standards go beyond just county size/population designations and reflect the reality of the service area.

4.1 Primary Care

Please clarify if General Practitioners are included in the PCP calculation.

4.2 Specialists

Plans support the use of telemedicine in considering network adequacy for certain specialty care providers because it is a critical and effective tool to provide access to services for beneficiaries in rural areas. We suggest that the Department use the location of the telemedicine port/hub as the point of calculation for meeting required time and distance standards. However, some of the specialties identified in the Department's proposal under specialists are not suitable for telemedicine (pulmonology, ENT, ophthalmology, orthopedic surgery, and cardiology). We request that for certain specialty provider types—where telemedicine is not suitable or is inappropriate—that the Department establish a "frontier standard." DHCS could use the MSSA standards, referenced earlier in this letter, which are used to determine professional shortage and medically underserved areas and populations. These MSSA standards define a service area as rural if the population density is less than 250 persons per square mile, and a service area as frontier if it has a population density of less than 11 people per square mile. Many rural counties consist of frontier areas. These frontier regions face severe challenges in maintaining their health care workforce, especially specialists. We recommend that the Department work with plans to determine if the establishment of a frontier standard of 120 miles or 150 minutes from beneficiary's residence in regions where MSSA designation is frontier would be appropriate or if there is another standard that would work for a certain county to accurately reflect the challenges of access in rural areas.

4.3 Obstetrics/Gynecology

Please clarify how OBGYNs should be accounted for. Plans assume that it will be based on how they contract with the plan but clarification is necessary to avoid confusion and inconsistency across plans.

4.4 Hospitals

Some plans would also suggest the same county designations used for PCPs and specialists, and the associated accessibility standards, apply to hospitals. Plans in rural counties often contract with every rural hospital that will accept Medi-Cal yet under these standards the plan would not be in compliance. This highlights the aforementioned need to work with the plans to determine where alternate access standards and other designations within a county may be appropriate across all provider types. It would also be helpful if the Department could work with plans to establish areas where the standards cannot be met due to lack of providers (either existing or accepting Medi-Cal) so that multiple plans will not have to file the same alternative access standards request if they operate in that service area.

4.5 Mental Health

Currently the standards are set at X miles and X minutes- depending on the size of the county. This proposal includes X miles or X minutes. Please clarify if plans have the option to meet either the miles or minutes standards or if both must continue to be met in each instance.

Plans recommend that the Large County standard for non-physician mental health services remain at 30 miles and 30 minutes.

4.6 DMC-ODS Waiver Services- Substance Use Disorder (SUD)

We recommend SUD opioid treatment have the same time and distance standard as outpatient SUD. These provider types are even more limited than outpatient SUD, wait lists for these services can be long, and many substance abuse centers require sobriety before the member can be seen (three days may not be enough time to establish sobriety).

Additionally, where this service is carved out of the plan contract please clarify what the responsibility is for the plan to demonstrate access requirements related to these provider types and how the Department intends to hold plans accountable. Please clarify in the final policy when these standards apply.

Please also clarify if "opioid treatment programs" include different drug treatments such as methadone, buprenorphine, and other medication assisted treatment.

4.7 Long Term Services and Supports- Skilled Nursing Facility (SNF)/Intermediate Care Facility (ICF)

There is often a challenge finding beds for Medi-Cal beneficiaries and having at the most two weeks for a placement may be challenging. We request additional discussions with the Department on how to account for a lack of available beds even if the plan contracts with every SNF/ICF in the county. Will the Department provide flexibility in its assessment of plan networks when a member with highly complex needs takes additional time for a placement if the plan can demonstrate that it is making the best efforts to transfer the member?

Additionally, we request clarification on if this applies to the following:

- Enrollees that are admitted to a SNF and are requesting appointments for a specialist or PCP.
- Access to ancillary services.
- Referring to placement in a SNF.

4.8 Pharmacy

We request that the Department clarify if there will be a percentage goal or a threshold within in each standard for pharmacy adequacy. Some plans believe that it might make more sense to align with the CMS standards for retail pharmacies and use designations for urban, suburban, and rural.

It appears that the requirement is in conflict with the requirements in the draft contract amendments, which states 24 hours. Please clarify.

4.9 Pediatric Dental

Some plans suggest that it may make more sense to rely on the Denti-Cal standard since most of the time these services are carved-out to Denti-Cal, other plans recommend that pediatric dental have the same time and distance standard as other specialties.

4.10 Alternative Access Standards

Plans appreciate that the Department continues to include alternative access standards as part of this proposal. It is important that this option be made available to address the realities of networks in certain parts of the state. Is the Department planning to develop a new template for alternative access standards? Plans have already developed systems to address alternative access issues based on the current requirements and any new standard or template would require a lot of work. It would be helpful to use the current process to the extent possible and we request more detail on why any changes are necessary. Also, we request that the Department clarify what it believes constitutes "reasonable options" under the alternative access standards criteria.

Stakeholder Engagement

It is noted in this section that the Department will issue All-Plan Letters (APLs) with the policy guidance to implement these network standards. Plans request that the requirements be placed in the contract to be clear and avoid confusion between differing requirements in the contract and language from an APL.

Additional Recommendations

CAHP and its member plans request that the Department align reporting requirements within the Department of Managed Health Care. As we have previously noted to both Departments, there are currently standards that use different definitions therefore the reporting for each report type and entity can cause confusion and a lot of unnecessary work for the plans to manage.

We want to thank you again for taking the time to review this letter. I am available at your earliest convenience to discuss any of the items outlined in this letter.

Sincerely,

[redacted]

Athena Chapman
Vice President of State Programs

[redacted]