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From: Mike Odeh [redacted]
Sent: Thursday, February 23, 2017 2:50 PM
To: DHCS MCQMD NAU [redacted]
Cc: Kelly Hardy [redacted]; Eileen Espejo [redacted]
Subject: Comments on Medicaid Managed Care Final Rule Network Adequacy Policy Proposal

Hello,

On behalf of the nearly five million children enrolled in a Medi-Cal Managed Care, Children Now is writing in response to the February 2, 2017 proposal from the Department of Health Care Services (DHCS) to implement network adequacy standards under the federal Medicaid managed care rules.

Pediatric Standards. The final federal rules explicitly require different standards for adult and pediatric services precisely because children have unique health care needs that are distinct from those of adults, and young children especially require more frequent and regular check-ups and preventive health services. We are extremely troubled that "DHCS proposes to set the same standards for both adult and pediatric services together" (pg. 15) without any rationale or justification for that direction. We believe this approach obscures the true picture of access to providers for children and that DHCS should adopt slightly more appropriate pediatric standards as clearly intended by the rule. For instance, DHCS could adopt a pediatric timely access standard of primary care within five or seven days of request (instead of 10 days) to further promote preventive care for kids, and we strongly encourage DHCS to explore such possibilities by convening stakeholders, consumers, and experts, as well as geo-mapping of networks under various standards. An additional approach would be to amend the standards to include the requirement that each child has an identified usual source of primary care that is either a primary care practice in their community, whether that practice is located within a medical center or hospital, community health clinic, or private community practice.

Pediatric Specialty Standards. The proposal does not articulate how pediatric services are incorporated or addressed in the standards related to specialists (p. 16). DHCS should clarify how their approach addresses specialists who practice on pediatric patients to understand if the pediatric networks, specifically, are adequate for children. Analyses of network adequacy standards for pediatric services should reflect only those specialists that are sufficiently trained and available to treat children. Under the current approach, while a practitioner of a particular specialty may be identified to practice within time and distance standards, a specialist in *pediatric* subspecialties may not be identified or available in the network. We strongly recommend that DHCS add language that addresses and assures pediatric subspecialty access, including specialists practicing within hospital systems and medical centers. Special attention and consideration should be paid to pediatric subspecialties that have been identified to be difficult to access, such as dermatology, developmental-behavioral pediatrics, genetics, mental health and physical/occupational therapy.

Differential Specialty Care Standards Based on County Size. We are extremely concerned about the proposal to establish different specialty care standards for consumers in different counties. We insist on assurances that the time and distance standards DHCS imposes are not birds-eye-view of distances, but rather, mileage and travel times on actual roads. The proposal to establish network standards Particularly, in rural counties, consumers

are forced to use windy roads or backroads, or take buses that may not be a direct route to a provider's office, both of which lead to longer travel time. A differential standard creates an unequal strain on families in rural counties because their managed care plan could be in compliance with DHCS's standard even if it takes 3 hours to travel to the appointment, as long as it's within the allowable 60 mile distance. We believe it creates a bad precedent to establish standards that effectively burdens rural residents by allowing much less stringent network standards. We are concerned that this creates unequal and inequitable access to care based on geography.

Monitoring. While the proposal is clear that DHCS is "responsible for monitoring health plans to determining compliance with the standards," (p. 25), the monitoring description in the proposal document is somewhat vague and seems to rest too heavily on data provided directly by health plans. The proposal also does not provide any detail on how DHCS will utilize the External Quality Review Organization (EQRO) to "validate" health plan networks in the context of the "network certification" requirements DHCS must submit to CMS annually. We expect DHCS to provide more detail on network adequacy monitoring activities, including: the specific network adequacy measures and data sources that might be included in future Managed Care Performance Dashboards; how the corrective action plan process will be amended to account for compliance with the numerous standards required under this rule; when the provider network data improvement project will be completed, and whether the full functionality will allow for sufficient monitoring and oversight of compliance with these standards. We also expect DHCS to establish a grievance process for the 22 COHS Medi-Cal plan counties, so that those consumers have a place of recourse to file a grievance about network inadequacies, the way DMHC-licensed plans have.
The option between a State Fair Hearing and contacting the Medi-Cal Managed Care Ombudsman is inadequate to address network adequacy concerns for COHS beneficiaries

Mental Health Services Standards & Monitoring. Similar to our comment above on pediatric specialty standards, we strongly encourage DCHS to modify its proposal to reflect child-serving mental health providers as a distinct standard to meet, since pediatric mental health and behavioral health access has historically been challenging. With respect to mental health plan monitoring, we encourage DHCS to review and certify mental health plan network adequacy annually, rather than just through the triennial compliance reviews (recognizing that network adequacy compliance is just one component). We are pleased that DHCS is working on an MHP performance dashboard and look forward to information about when that dashboard is expected to be available, and if/how child populations are disaggregated.

Obstetrics/Gynecology Standards & Monitoring. Women's access to OB/GYNs is critical for ensuring healthy pregnancies and birth outcomes. And in order to ensure access, it is important for DHCS to clarify *when* or *how* an OB/GYN appointment is considered "primary care" vs. "specialty care" for purposes of monitoring and enforcement. For example, are all OB/GYN appointments considered "primary care" unless there is a certain classification of the provider, or the subjective needs of the patient, or some other calibration that would designate it as a "specialty"? We are concerned that OB/GYN networks could appear more adequate than they really are if appointments are inappropriately considered to fit under the less stringent specialty standards.

Pediatric Dental Standards & Monitoring. We support the network adequacy standards applicable to pediatric dental outlined in the proposal. We remain concerned on how these standards are monitored and enforced. Whereas the proposal says that DHCS will monitor pediatric dentistry with the use of encounter data to confirm the number of available

providers that render pediatric dental services, we feel that there are several measures that the state could use to inform whether the network adequacy standards have been met. We recommend the State monitor timely access to dental services by tracking the following data by county:

- The number of appointments for routine care that fall within a two-week period of the request (as currently required by dental managed care plans);
- The number of appointments for routine care that fall outside a two-week period of the request and the wait time for appointments by week (e.g., appointment made within three weeks, four weeks, etc.);
- The number of appointments made for emergency care made that fall within 24 hours of the request (as currently required by dental managed care plans);
- The number of appointments made for emergency care made that fall outside 24 hours of the request and the wait time for appointments by days (two days, three days, etc.)

In addition, DHCS needs to specify whether routine appointments include routine dental appointments for children who need nitrous oxide anesthesia, including children with autism spectrum disorder (ASD) or other disabilities, so that these children are protected by routine appointment timely access standards.

Diversity and Language Access Standards. Fully 35% of children in Medi-Cal live in families that indicate Spanish as their preferred written language, nodding to the racial, ethnic, and cultural diversity of the Medi-Cal population. We encourage DHCS to explore methodologies that account for this diversity to ensure that the provider networks are adequate in terms of cultural congruency with the population being served. Since plans are required to provide oral interpreting for LEP individuals in *all* languages pursuant to 42 C.F.R. § 438.10 and enrollees to have assistance in their primary language pursuant to 28 CCR § 1367(e)(3), DHCS should issue guidance that incorporates these access standards so that all Medi-Cal managed care enrollees have assurances of these protections, not just non-COHS beneficiaries. To this end, we encourage DHCS to develop an additional network adequacy standard for access to language and interpretation services.

Stakeholder Engagement. We appreciate the opportunity to offer comments on the Departments proposal of network adequacy standards, and value DHCS' commitment to stakeholder engagement.

Review of Standards. We would encourage more frequent review of the standards than the proposed five year cycle, as fluctuations in networks and improvements in information technology can happen rapidly. Standards should reflect those changes in a timely way. Further, we encourage DHCS to move beyond time and distance standards and to include evidence of actual, timely availability of services (i.e., realized access to care). This can be accomplished through direct provider tests and "secret shopper" surveys. For instance, even though Medi-Cal providers may be identified as practicing within time and distance parameters, in practice, they may not be accepting new patients or may have wait times for access that do not meet standards for urgent access, and thus DHCS should review how these standards can incorporate these dynamic aspects of provider networks. This is of particular concern as it relates to access for children's mental health, pediatric dental care, and pediatric subspecialty services where access may theoretically be available because networks "look" adequate, but there are still serious and unacceptable barriers to care for kids.

Transparency & Oversight. We also encourage greater transparency and urge DHCS to do more than simply "publish network adequacy standards on its website", and also publish on its website the following: all plan guidance, monitoring methodology, plan procedures (e.g.,

on out-of-network access), compliance reports for all plans, and any alternative access standards requests and approvals. We strongly encourage DHCS to update these standards through the regulatory process rather than solely through the contracting and procurement process, as promulgating standards through regulation offer more public transparency and enforcement power.

We look forward to continuing to work with DHCS to ensure managed care plan networks are adequate to ensure and deliver access to care for the Medi-Cal populations.

Sincerely,

Children Now

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