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Submitted Via Email: dhcsmcqmdnau@dhcs.ca.gov

Department of Health Care Services

Re: Medicaid Managed Care Final Rule – Network Adequacy Policy Proposal

Greetings:

On behalf of the Health Consumer Alliance (HCA), we are writing to provide you with feedback on the Department of Health Care Services Network Adequacy Policy Proposal put forth to comply with the Medicaid Managed Care Final Rules. The HCA is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the National Health Law Program (NHELP), and the Western Center on Law and Poverty (WCLP). Our comments are joined by Asian Law Alliance, Maternal and Child Health Access, and Project Inform. We appreciate the opportunity to give you input. Our comments and recommendations are below.

Transparency

DHCS proposes to implement its network adequacy standards through health plan contracts that begin on July 1, 2018, All Plan Letters (APLs), and County Information Notice. Although we appreciate the opportunity to offer feedback on the proposal and APLs, DHCS must establish and update these standards through the regulatory process, in order to comply with the California Administrative Procedures Act. The scope of these standards qualifies as a regulation under Government Code section 11342.600, and are not subject to any exemption from rulemaking. Thus, they must be duly promulgated as regulations and recorded in the California Code of Regulations. Cal. Gov. Code § 11340.5.[1]

Placing these standards in regulation is also important for consistency. Knox-Keene licensed plans are subject to existing state statutes and regulations that set time and distance standards for primary care and hospitals and timely access standards. The Medi-Cal managed care standard for primary care also

[1] In addition, we strongly recommend that DHCS consider revising all of the Medi-Cal managed care regulations to come into compliance with the federal rules. Currently, the regulations governing MCPs span three different chapters of title 22 of the California Code of Regulations, many of which are duplicative. The result is a confusing patchwork of regulations that is difficult for MCPs, consumers, and their advocates. We urge DHCS to review the regulations in their totality, and consider a major overhaul to steam line them as it implements the new federal requirements.

already exists in regulation. CAL. CODE REGS., tit. 22, § 53885(a). Thus, the standards for other services delivered by Medi-Cal managed care plans should be promulgated in the same manner to avoid confusion, and to ensure plans understand that they are equally important.

County Designation

DHCS proposes to establish standards based on three county types, depending on population count and geographic size, modified from the Department of Finance county size categories. Although we would prefer one standard across the state, using the large county standard, we recognize California's diversity and the goal to limit exceptions which may necessitate designating areas with different standards. Therefore, we recommend collapsing large and medium counties together and applying the large county standard while keeping the rural to small county standard the same. Los Angeles County has cities that are much less densely populated than cities in medium counties and these areas should not be subjected to different standards merely because they are located in Los Angeles County. In addition, the large county standards are reasonable standards for medium counties to meet, considering many medium counties have densely populated cities. Eight of the ten largest cities in California are in counties outside of LA including San Diego, San Jose, San Francisco, Fresno, Sacramento, Oakland, Bakersfield, and Anaheim.

Exceptions

Regardless of how standards are determined, we recognize the need for exceptions and therefore recommend that DHCS set clear standards for the exception process. To be granted an exception, the Medi-Cal managed care plan must demonstrate that there is no provider that meets DHCS's time or distance standards. If there is a provider that meets time or distance standard but does not contract with the plan, then the plan must make may every effort to contract with that provider and detail those efforts as well as outline future efforts to meet time and distance standards. If there remains to be no contracted provider who meets time or distance standards within the plan's geographic region, then the plan must contract with the next closest provider. Exceptions should be granted as they are now, at the discrete zip code level, not the city or county level. Regardless, there should be no exception for timely access standards unless the plan has documented that there are no available providers in the plan's geographic region, in or out of network.

Accessibility – physical, cultural, language

DHCS' proposal does not address standards of physical, cultural, and language access. The Final Rule requires that network adequacy standards "physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities."[2] The Final Rule further requires that services be delivered in a "culturally competent

[2] §438.68(c)(vii-viii)

manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity."[3] In addition, California health plans are required to establish a Language Assistance Program for members who are limited-English proficient.[4] Over seven years later, we still do not know if health plans are meeting this requirement. We recommend 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. To this end, we recommend that DHCS convene a workgroup tasked with developing access adequacy standards.

DHCS Core Specialists

In addition to the core specialists provided, we recommend adding urology and rheumatology based on California Primary Care Association's experience of provider shortage which reflects our consumer reported shortages. As part of the proposed five year review of standards—or on a shorter two year time frame as fluctuations in networks and improvements in information technology can happen rapidly—we recommend the core specialists are reviewed and providers are added or removed as needed.

Pharmacy Standards

The proposed pharmacy standard is too generous. For individuals residing in rural to small counties, it is unreasonable to expect members to drive three-hours roundtrip to collect their prescription medicine, a journey some members are expected to make at least once a month. Even most rural to small counties have access to major chain stores and big-box stores that contract with Medi-Cal managed care plans. Therefore, we recommend reducing the pharmacy standard to 30 miles or 60 minutes from the beneficiary's residence, noting mail-order prescriptions may help managed care plans meet need. In line with previous comments, we recommend combining large and medium counties, applying the large county standard for medium counties, or 10 miles or 30 minutes in the case of pharmacy.

Long-Term Services and Supports (LTSS) Network Adequacy Standards

Standards are required for both providers that the enrollee travels to and for providers that travel to the enrollee, not just for LTSS services that require the beneficiary to travel to the provider. *See* 42 C.F.R. § 438.68(b)(2). Accordingly, California's network adequacy policy must include LTSS network adequacy standards for both providers that enrollees travel to and providers that travel to enrollees. In addition, for residential facilities, geographic access cannot be disregarded, since it is important for members to be placed in facilities as close as possible to their home communities so that they can

[3] §438.206(c)(2)
[4] CCR, Title 28, Section 1300.67.04

maintain ties with their family members and community institutions. We strongly recommend that DHCS convene a workgroup specifically tasked with developing LTSS network adequacy standards that comply with the rule's requirements and incorporate the elements outlined therein. LTSS includes the Multi-Purpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), Skilled Nursing Facility (SNF), Intermediate Care Facilities (ICF), Assisted Living Centers and Residential Care Facilities. We support Justice in Aging's comments on LTSS.

Pediatric Standards

We appreciate that DHCS proposes to set the same standards for both adult and pediatric services together. We do not see a need for the standard to be different for children than for adults. We do recommend, however, that DHCS require plans to measure and monitor compliance with the standards separately for children and adults. If plans are permitted to measure and monitor compliance for children and adults together, the findings could mask very real shortages in providers with pediatric expertise. For example, while we rarely hear complaints about access to cardiologists for adults, we do hear complaints from parents who experience difficulty identifying a cardiologist who is willing or able to treat young children. While we agree that the time and distance standard for adult and pediatric cardiologists need not differ, plans must measure the standards separately for providers who treat adults and those who treat children, to ensure that both populations have adequate access to the care that they need.

In addition, we request that DHCS make very clear that the timely access standards serve as an outside maximum for pediatric services, but that services must be delivered more quickly when medically necessary. For example, 30 days may be sufficiently quick for a routine appointment with an Endodontist, but if a child needs a root canal, waiting 30 days is too long. DHCS should remind plans that they must always deliver medically necessary care within clinically appropriate time frames, notwithstanding the timely access standards.

Monitoring

While the proposal is clear that DHCS is "responsible for monitoring health plans to determining compliance with the standards," the monitoring description in the proposal document is vague and rest too heavily on data provided directly by health plans. In reviewing DHCS' separate Monitoring Plan, there remains to be questions about the level of verification DHCS is employing especially in light of the 2015 auditor's report that found DHCS did not verify the provider network data it received from health plans were accurate.

While time and distance standards are important, having an in-network provider within 5 miles means very little to a patient who cannot schedule an appointment because that provider is not accepting new patients or has a wait list that spans months. Therefore, we emphasize the importance of

monitoring timely access through interagency agreements with the Department of Managed Health Care (DMHC) and internal efforts. We have some serious concerns with the weight plans are approaching timely access in light of DMHC's *Timely Access Report: Measurement Year 2015*. The report found 90 percent of data submitted by plans to the DMHC contained one or more significant data inaccuracies. The timely access data provided to the DMHC is much more detailed than anything submitted in the past to DMHC or DHCS, which raises concerns about the data Medi-Cal managed care plans are submitting to both departments as well as the validation of timely access data from plans who are not Knox-Keene licensed by DHCS.

Because DHCS uses the dashboard for monitoring efforts and public transparency, we reiterate the comments submitted by NHELP and WCLP on March 2015 related to Input on Medi-Cal Managed Care Performance Dashboard and Network Adequacy Monitoring Project.

Conclusion

Thank you again for the opportunity to comment. We look forward to continuing to work with you through the stakeholder process on the above issues. If you have any questions, please contact Linda Nguy at lnguy@wclp.org or 916.282.5117.

Sincerely,

[redacted]

Abbi Coursolle
National Health Law Program

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Linda Nguy
Western Center on Law & Poverty

And on behalf of
Asian Law Alliance
Maternal and Child Health Access
Project Inform