February 28, 2017

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services
Via email to dhcsmcqmdnau@dhcs.ca.gov

Re: Network Adequacy Proposal – LHPC Principles for New Network Requirements

Dear Nathan:

Local Health Plans of California ("LHPC") represents the 16 community-based, not for profit health plans that collectively cover 70% of Californians enrolled in Medi-Cal managed care. We are proud partners of the Department of Health Care Services ("DHCS") in delivering efficient, high quality, and accessible care to the nearly 7.5 million beneficiaries we serve in our own communities.

Thank you for the opportunity to comment on the long-awaited Network Adequacy Proposal ("Proposal") released pursuant to the requirements of the Medicaid Managed Care Rule ("Rule"). Like DHCS, and all other stakeholders to the program, local health plans have been looking closely at the Rule's many requirements since they were released last year.

As is often the case with California, we are ahead of most states in having existing network requirements in place. However, local health plans believe the Rule's requirement for states to establish standards by specific provider category is a valuable opportunity to modernize our access framework – so that it accounts for California's unique regulatory structure and reflects our diverse geographies, population densities, care patterns, and market dynamics. Accordingly, LHPC offers the following principles, and related comments, which we urge DHCS and policy makers to follow in finalizing network requirements pursuant to the Rule. We believe that these principles will produce a network adequacy framework that is administratively efficient, viable, and meaningful for our members.

(1) Health plans should be categorized, and time and distance standards applied, according to designations that reflect differences in service area population density, provider supply, and geography.

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In the Proposal, DHCS proposes to apply time/distance standards to a plan based on the size of the county in which the plan is located. DHCS's approach would bucket plans according to whether a county is (1) rural/small (2) medium or (3) large based on county population only. Then, provider time/distance standards would vary according to the plan's county/counties' size(s).

Local health plans agree with and support DHCS's general approach to establishing standards according by county. However, a county-wide approach does not reflect that there are many "large" or "medium" counties from a total population standpoint that are in fact largely rural. For example, the Inland Empire counties (San Bernardino and Riverside) would both be considered "large" and subject to more stringent "urban" standards by DHCS's approach, despite their large swaths of desert, protected wilderness areas, and low population densities outside a major city.

Instead, time/distance requirements – for all provider types – should be based on the reality of the service area's population density, provider supply, and geography. There are existing designations DHCS could incorporate into the framework to accomplish this, such as OSHPD's Medical Service Study Area, or HHS's Health Professions Shortage Areas. Or, the DHCS could incorporate another gross measurement by population (eg., PCP's/100,000). Following this alternative approach, service areas would be designated as frontier, rural, suburban, or urban per the enumerated factors. Then, the proposed time/distance standards re-examined and set for all provider types (eg., primary care, hospitals, specialists) according to those geographic designations. We anticipate that time/distance standards would be changed accordingly because travel times and distances, for rural areas in particular, would be longer.

Our approach may certainly seem more complicated at the front end; however, access is indeed complicated and multi-dimensional. We believe this approach would more accurately reflect the realities of California's unique service areas, make compliance more achievable, reduce alternate access requests, and set a baseline for reasonable regulator, provider, and consumer expectations.

(2) Time & distance standards for specialists should account for member utilization <u>and</u> provider supply, so that compliance is possible and expectations are reasonable.

DHCS's Proposal proposes time and distance standards for identified "core" specialists, an approach which plans generally support. However, the list of "core" specialists includes providers that are in notoriously short supply or otherwise generally do not contract with health plans. We believe Principle 1, described above, would help solve for this issue.

However, it is still important to note that, in establishing access standards for specialists, there are inherent and well-documented gaps not attributable to

plans' shortcomings. We assume that, where plans cannot meet the baseline time and distance requirement for a specialist, alternative access would be required. However, it is unclear whether alternative access would be required on a per-provider basis (as has been suggested in the past), across classes of providers, or when a plan falls below a certain compliance threshold (eg., when compliance drops below 75%). Plans ask for this clarity as soon as possible, as it is particularly critical to addressing concerns about establishing baseline time/distance requirements for specialists.

(3) Where requirements conflict with Knox-Keene, Medi-Cal program standards should apply and govern both DMHC and DHCS's plan audits, surveys, alternative access processes, enforcement actions, or any other oversight activities for Medi-Cal plans.

We believe this principle is self-explanatory and we have long advocated for and worked with DHCS and the Department of Managed Health Care ("DMHC") on regulatory simplification. This principle is not specific to the Proposal, as the Rule contains other requirements that intersect with Knox-Keene. However, the establishment of new and expanded network requirements for Medi-Cal plans presents the greatest potential for the most regulatory conflict. For example: What standards will Medi-Cal plans be held to for filings at DMHC (including routine network filings, alternative access requests, and related comment letters), medical surveys, grievances, complaints, and enforcement actions? Will the departments share information and/or utilize the same templates and instructions? Can streamlining be accomplished through agreement (eg., without statute)? We request that the Proposal incorporate a solution – or a pathway – for regulatory simplification.

In addition to the foregoing principles, we support the California Association of Health Plans' ("CAHP") specific comments on the Proposal. We appreciate the time DHCS has taken to create its thoughtful Proposal and solicit stakeholder feedback. With the incorporation of our principles into the framework, we are confident California will remain a leader on managed care and access. We look forward to continued dialogue.

Sincerely,

Brianna Lierman, Esq.
CEO

cc:
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