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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

Dear DHCS:

Thank you for the opportunity to comment on the Department of Health Care Services Network Adequacy Policy Proposal. MCHA supports and has signed onto the comments from the statewide Health Consumer Alliance (HCA) and submits these brief comments in addition. We have submitted comments in the past that address network adequacy, among them:

- The need for better monitoring of network adequacy was included in our 9-27-16 Medi-Cal Managed Care Quality Strategy joint comments with six other organizations

- The comments sent 9-19-16 on the DHCS Draft Fee-For-Service Access Monitoring Plan included our concerns with how provider ratios are calculated for adequacy

The Medicaid Managed Care Final Rule document states that approximately 80 percent of full scope Medi-Cal recipients receive care through a managed care plan. However, groups of beneficiaries vary in their percentage of managed care delivery; pregnant women, for example, are covered at the rate of about 60% in Fee-For-Service.

Establishment of Specialist Network Adequacy Standards: MCHA appreciates the access standards for specialists and for Obstetrician-Gynecologists. However, since the proposed time and distance standards are the same for specialists and primary care providers, for small/rural and medium counties, they should be the same for large counties. Instead of 15 miles or 30 minutes from the beneficiary's residence, the standards should be the same as for primary care: 10 miles or 30 minutes. We believe the variation to 15 miles is unnecessary and counterproductive.

Furthermore, how the distance and time is established should be available to the public in audit reports or as part of a dashboard, i.e, that each provider has a geographic range for the patients that can be assigned, and that distance is measured by X method, and travel time measured by X method. MCHA has repeatedly stated that to deliver in downtown, coming from the west side, women in labor must allow at least an hour during rush hour. The average travel time on Los Angeles County freeways is 17

miles per hour; rush hour would be much slower. Time and distance needs to be established during peak travel hours. We know of clinics on the west side of Los Angeles with managed care delivery contracts with downtown hospitals, which should be prohibited based on the travel time.

Monitoring: We want to reiterate the comments from the HCA: the monitoring description in the proposal document is vague and rest too heavily on data provided directly by health plans. MCHA continues to assist clients who must travel long distances, often because there is no provider who will see a pregnant woman who seeks care in her third trimester. We assist even more non-pregnant clients whose request for an out-of-network provider is only met occasionally, and often with someone outside the Knox Keene standards listed in the document for travel and distance. In addition to the inaccuracies in the *Timely Access Report: Measurement Year 2015* cited by the HCA, the California State Auditor concluded that DHCS did not verify that the provider network data it received was accurate and thus could not ensure network adequacy. DHCS states that it will certify network adequacy and make documentation available to CMS upon request. That documentation should be available to Medi-Cal Managed Care Advisory Group members, and to the General Public as well.

Again, thank you for the opportunity to comment and we look forward to working with DHCS to see that network adequacy is effectively monitored and maintained for beneficiaries.

Sincerely,

[redacted]

Lynn Kersey, MA, MPH, CLE
Executive Director