



# Medi-Cal Children's Health Advisory Panel



# Whole Child Model

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# WCM Overview

WIC section 14094.5 authorized DHCS to establish the WCM program to provide California Children’s Services (CCS) to Medi-Cal eligible CCS children and youth.

WCM Phase	WCM MCP	COHS County
Phase 1: Implemented July 1, 2018	CenCal Health	San Luis Obispo, Santa Barbara
	Central California Alliance for Health	Merced, Monterey, Santa Cruz
	Health Plan of San Mateo	San Mateo
Phase 2: Implemented January 1, 2019	Partnership Health Plan of California	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3: Scheduled July 1, 2019	CalOptima	Orange



# WCM Continuity of Care

## Covered Services

- MCPs must provide for the completion of covered services from a non-contracted treating provider for up to 12 months if the member has an existing relationship with the provider and has seen the out-of-network primary care provider or specialist at least once during the 12 months prior to the transition.



# WCM Continuity of Care

## Durable Medical Equipment (DME)

- MCPs must provide access to the specialized or customized DME provider for up to 12 months if the member has an established relationship.
- Continuity of care can be extended beyond 12 months if the DME is currently under warranty by the manufacturer and is deemed medically necessary by the treating provider.



# WCM Continuity of Care

## Case Management

- MCPs must ensure CCS-eligible members receive case management, care coordination, service authorization, and provider referral services.
- MCPs can meet this requirement by allowing continuity of care to the member's existing public health nurses (PHN) upon member request within 90 days of transition.



# WCM Continuity of Care

## Prescription Drugs

- MCPs must ensure continuity of care to previously authorized prescription drugs.
- The member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.



# Extension of Continuity of Care Period

- MCPs may extend the continuity of care period beyond the initial 12-month period.
- MCPs must provide a written notification to the member 60 days prior to the end of the continuity of care period regarding the member's right to request an extension and the WCM appeal process.





# Continuity of Care Scenarios

## CCS County Program to WCM Plan

- Continuity of care rights for up to 12 months if criteria is met.
- Members may request to extend.

## WCM Plan to WCM Plan

- Continuity of care rights can be requested by the member.
- MCP discretion to approve.

## WCM Plan to CCS County Program

- Non-WCM beneficiaries can see any CCS-paneled provider that accepts Medi-Cal and is Medi-Cal enrolled.



# Continuity of Care Monitoring

- DHCS collects data on continuity of care requests related to the CCS-condition, as well as denials for the following reasons:
  - No pre-existing relationship with providers
  - Quality of Care issue
  - Provider did not agree
  - Provider not CCS-paneled



# Access in Rural Areas

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Primary, Rural, and Indian Health Division

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# Primary Rural and Indian Health Division (PRIHD)

PRIHD administers several programs that are focused on increasing the capacity of California's rural healthcare infrastructure. These programs are supported by the Federal Health Resources Services Administration's Federal Office of Rural Health Policy. One of these programs is the California State Office of Rural Health (CalSORH). CalSORH provides information, training, and technical assistance to rural providers.

## California State Office of Rural Health (CalSORH)

- Provides technical assistance and training to rural providers on emerging public health issues
- Annually produces rural health report
- Administers the J-1 Visa Waiver Program
- Funds workforce projects and trainings
- Provides technical assistance in the development of rural health programs
- Disseminates grant and rural relevant research information via listserv
- Partners with state programs and associations



# California's Rural Areas



Data Sources:  
OSHPD, Healthcare Workforce Development Division  
U.S. Census Bureau  
January 2006



- The State definition utilizes Medical Service Study Area (MSSA) which are sub-city and sub-county geographical units used to organize and display population, demographic and physician data.
  - There are 541 MSSAs in California.
- Rural MSSAs have 250 persons or less per square mile and no Township of more than 50,000:
  - Total Rural MSSAs 173
- Frontier MSSAs have less than 11 persons per square mile:
  - Total Frontier MSSAs 54
- 44 out of 58 counties are designated as Rural.
- Rural and Frontier MSSA's represent approximately 80% of the total land mass of 158,706 square miles.



# California's Rural Population is very Diverse

- 109 Federally recognized Tribes
- 2<sup>nd</sup> highest Native American population in the US



- Over 1 million farm workers



- Highest population of Hmong people in the US; 65,000





# State Rural Demographics

- **Population**

California's total population in 2018 was 39.56 million, with 10.69 million people living in rural counties, and 28.86 million people residing in urban counties.

- **Age and Gender**

In 2018, 33.4% of the population in rural counties was between the ages of 0 to 24. 23.7% of the rural population is between the ages of 25 to 44 and 42.9% of the population is ages 45 and over.

Males represent 50.3% and females represent 49.6% of the rural population.



# Rural and Urban County Comparison

## Socioeconomic Indicators

### Calendar Year 2017

**Poverty-** . The nation's official poverty rate in 2017 was 14.6 percent

2017      California: 15.1%      Rural counties: 18.37% vs. Urban counties : 13.91%

**Household Income-** The median household income for the United States was \$57,652 in 2017.

2017      California: \$76,975      Rural counties : \$54,461 vs. Urban counties : \$82,710

**Employment-** In November 2018, the labor force participation rate for the U.S. was 62.9%

2017      Rural counties : 54% vs. Urban counties : 62.4%

- The top three categories of employment for Rural counties were Goods producing (includes manufacturing, mining, logging, and construction), State and Local Government, and Educational and Health Services.
- The top three categories of employment for Urban counties were Healthcare and Social Assistance, Goods producing, and Government



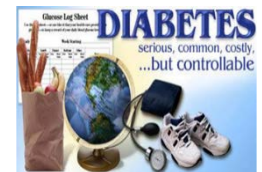
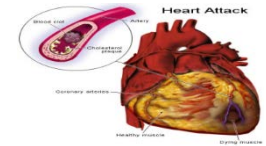


# Rural and Urban County Comparison

## Health Status Indicators

Calendar Year 2017

- In 2017, a higher percentage (18.8% vs. 17.1%) of rural residents consistently rated their health as fair or poor compared to their urban counterparts.
- A greater proportion of residents of rural counties compared with urban counties have been told by a health professional that they have:
  - Heart Disease (7.3% vs. 6.4%)
  - Hypertension (30.7% vs. 28.5%)
  - Diabetes (11.7% vs. 10.3%)
- A higher proportion of residents of rural counties compared with urban counties are:
  - smokers (12.1% vs. 9.5%) and are
  - at chronic risk of alcoholism (7.1% vs. 5.1%)
- A greater proportion of rural residents (9.4%) reported that a physical or mental health condition prevented them from working, attending recreation, or taking care of themselves during the past 30 days compared with residents of urban counties (6.2%).





# Rural Healthcare Providers





# Primary Care Physicians in California

## Calendar Year 2015

Figure PCPs per 100,000 Residents, by County, 2015



- The map shows the supply of primary care physicians by county in California.
- Generally, the number of primary care physicians per 100,000 population is higher in urban counties



# Primary Care Clinics In Rural Counties

Calendar Year 2018 and 2019

Primary Care Clinics	Rural	
	2018	2019
Federally Qualified Health Centers	411	459
Rural Health Clinics	277	272
Tribal Health Clinics	79	83

- The number of Federally Qualified Health Centers and Tribal Health Clinics increased from 2018 and 2019
- The number of Rural Health Clinics decreased between 2018 and 2019

Source: OSHPD Primary Care Clinic Utilization report, 2012-17

<https://data.chhs.ca.gov/dataset/healthcare-facility-locations>

DHCS Audits and Investigations, list of primary care clinics, 2018 and 2019



# Federally Qualified Health Centers

## Demographics of population served Calendar Year 2012 vs. 2017

Demographics	Rural			
	2012	Patients	2017	Patients
Patients by Age				
From 0 to 19 years	35.3%	685,982	34.2%	867,708
From 20 to 64 years	57.9%	1,123,979	57.3%	1,452,947
65 years and older	6.7%	130,684	8.5%	216,060
Total Patients	-	1,940,645	-	2,536,715

- Of patients that visited FQHC's, the percentage of patient population remained relatively constant in all age groups, except for the 65 year and older age group
- The number of total patients in each group increased dramatically between 2012 and 2017.



# Federally Qualified Health Centers

## Primary Care Staff

Calendar Year 2016 vs. 2017

	Rural		
	2016	2017	% increase
<b>Federally Qualified Health Centers</b>	466	477	2.3%
Physicians	875	937	2.4%
Physician Assistants	306	317	0.4%
Family Nurse Practitioners	419	453	1.3%
Cert Nurse Midwives	35	34	-0.04%
Visiting Nurses	6	2	-0.15%
Dentists	347	387	1.55%
All Other Primary Care Providers	553	612	2.3%
Total	2,542	2,742	7.8%

- The number of physicians, dentists and nurse practitioners increased from 2016 to 2017, while the number of visiting nurses decreased.

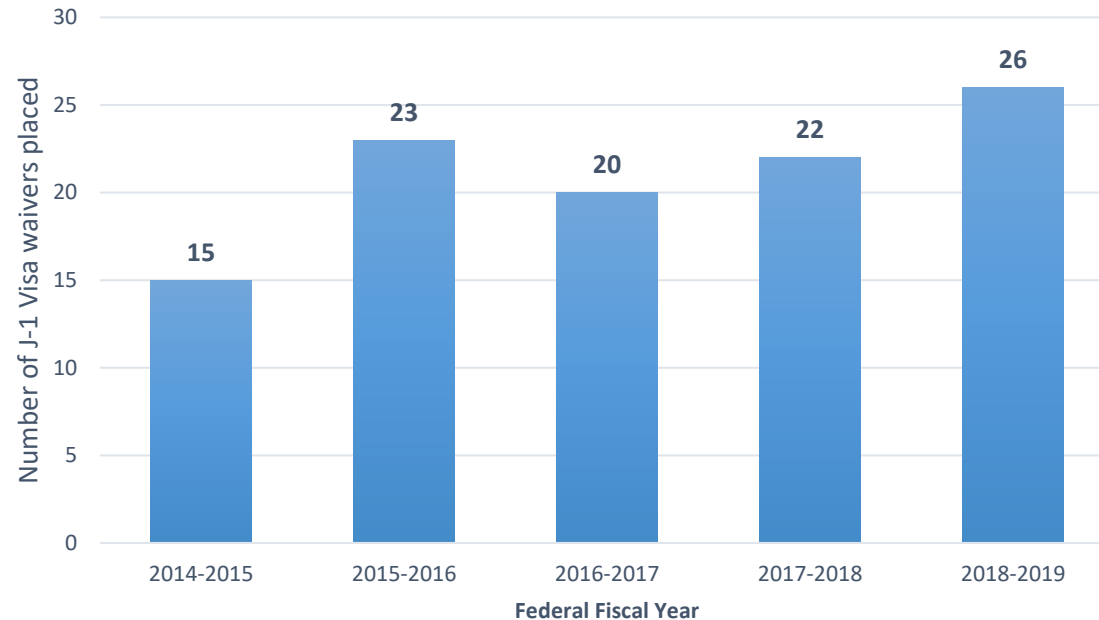


# Rural Counties

## CaSORH recommended J-1 Visas Waivers to Primary Care Providers

### Federal Fiscal Year 2014 to 2019

J-1 Visa Waiver placements for providers



- J-1 Visa waivers allows foreign born medical graduates to waive the requirement to return to their home countries for 2 years post graduation in lieu of a 3 year service obligation in underserved areas.
- Of the 150 total waiver placements available to California from 2014-2019, 108 were placed in rural counties.



# DHCS Primary Care Workforce Efforts

## Medi-Cal reimbursement for Primary Care Residents

- State Plan Amendment (SPA) 18-0032 was approved in September 2018 that allows Medi-Cal reimbursement for certain services performed by primary care residents at FQHCs and RHCs that qualify as Teaching Health Center Graduate Medical Education (THCGME) programs. Qualifying THCGME programs must be sponsored by Health Resources and Services Administration (HRSA), Office of Statewide Health Planning and Development's Song Brown grant program, or a State of California funded THCGME residency program. Note the Medi-Cal reimbursement is separate from the THCGME residency program grants from other agencies.
- Federal and State THCGME anticipated Fiscal Year 2020 grant funding: \$49,000,000. Of this amount, five rural counties and one urban county in California were funded

## CalMedForce

- Proposition 56, (Tobacco Tax) provided funds to graduate medical education programs to increase the number of primary care providers in order to serve medically underserved areas and populations. Some CalMedForce grantees qualify as THCGMEs.
- The total 2019-2020 CalMedForce THCGME funding is \$5.1 million. This amount went to FQHCs in six rural counties and one urban county

## CalHealthCares

- Proposition 56 allocates \$340 million for CalHealthCares to increase access to care for Medi-Cal beneficiaries
- The first physician cohort of 240 physicians will provide \$59,000,000 over 5 years in loan repayment funds.
- Eligible physicians and dentist are required to maintain a patient caseload that includes 30 percent of more Medi-Cal beneficiaries





**THANK YOU**





# Network Adequacy

# Time and Distance

Primary Care Physicians\*

Core Specialists\*

Outpatient Mental Health\*

OB/GYN  
(Primary and Specialty  
Care)

Hospitals

Pharmacy

# Mandatory Providers Types

Federally Qualified Health  
Center

Freestanding Birthing  
Centers

Rural Health Clinics

Indian Health Facilities

Midwifery Services

# Provider to Member Ratios

PCP Ratio

Total Physician Ratio

\* Adult and pediatric



# Time and Distance Standards

- MCPs submit geographic access maps and accessibility analyses that demonstrated compliance with time or distance standards
- DHCS verified the entire service area was covered to meet the standards
- Alternative access standard (AAS) requests required to be submitted if time and distance standards were not met
- Telehealth may be used as a means of meeting time and distance standards



# Alternative Access

- Alternative access standard (AAS) requests were approved for time and distance standards if either:
  - The Plan has exhausted all other reasonable options to obtain providers to meet the time and distance standards; or
  - DHCS determines that the Plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.



# Mandatory Provider Types

- Mandatory Provider Types include:
  - Federally qualified health center (FQHC)
  - Rural health clinic (RHC)
  - Freestanding birth center (FBC)
  - Midwifery services (certified nurse midwife and licensed midwife)
  - Indian Health Facility (IHF)



# Provider Ratios

- MCPs must meet current Full Time Equivalent (FTE) provider to member ratios
  - 1 PCP to every 2,000 members
  - 1 Physician to every 1,200 members



# Timely Access





# Timely Access Standards

<b>Urgent Appointments</b>	<b>Wait Time</b>
Services that do not require prior approval	48 hours
Services that require prior approval	96 hours
<b>Non-Urgent Appointments</b>	<b>Wait Time</b>
Primary care	10 business days
Specialty care	15 business days
Appointment with a mental health care provider	10 business days
Appointment for other services to diagnose or treat a health condition	15 business days



# Timely Access Survey

## Overview

- DHCS contracted with an External Quality Review Organization (EQRO) to conduct an annual timely access survey of all MCPs to ensure compliance with provider availability and wait time standards for urgent and non-urgent appointments among network provider types.
- The survey consists of calling a randomized sample of network providers by each MCP's county/region-based reporting unit.
  - 411 providers per each reporting unit
  - Total of 28,000 providers contacted statewide



# Timely Access Survey

The survey captures the following:

- The first three available times for urgent and non-urgent appointments;
- The differences in appointment times between pediatric and adult;
- Whether the provide is accepting new patients;
- Whether the network provider is contracted with other MCPs in the same service area; and
- The quality of the data that DHCS maintains for the network provider.

Network provider categories include:

- Primary care providers (PCP)
- OB/GYN
- DHCS core specialists
- Non-physician mental health providers
- Ancillary providers (physical therapy, MRI, and mammogram)



# Timely Access Focus Areas

## Access

- Compliance with urgent and non-urgent wait time standards

## Data Quality

- Incorrect/disconnected phone number
- Provider is not providing services at the office location
- Provider is not in an office that handles appointments (i.e., billing department, corporate office, etc.)

## Provider Training

- Caller reaches a voicemail during business hours
- Caller is put on hold for more than 5 minutes
- Refusal to participate in the survey



# DHCS Monitoring Process

- Through the Quarterly Monitoring process, DHCS releases each MCP its MCP-specific results and raw data.
- MCPs are required to analyze both data sets reflective of the current performance.
- DHCS provides technical assistance throughout the response process and works with MCPs to review their data and identify process improvements.



# Access Assessment



# Access Assessment

- The 1115 Waiver's Special Terms and Conditions (STCs) required required CA to conduct a one-time assessment of beneficiary access based on current MCP network adequacy requirements.
- Access Assessment was conducted by Health Services Advisory Group, Inc.
- Assessment focused on MCP beneficiary access to primary, core specialty, and facility services, as well as, compliance with MCP network adequacy standards and timely access requirements
- The assessment considered the following elements when reviewing beneficiary access:
  - Network Adequacy
  - Geographic Distribution
  - Availability of Services
  - Access to Care Monitoring



# Transportation





# Transportation

## Non-Emergency Medical Transportation (NEMT)

- MCPs are required to provide medically appropriate NEMT services when the beneficiary's medical and physical condition is such that private or public transportation is medically contraindicated.
- MCPs must also ensure door-to-door assistance for all beneficiaries receiving NEMT services.

## Non Medical Transportation (NMT)

- MCPs are required to NMT for all Medi-Cal services, including those not covered by the MCP contract (i.e., specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS)
- MCPs must notify their members of the available NMT benefit.



# Approaches to Improve and Monitor Rural Health Access

- Monitoring to ensure that network capacity is met with the required provider ratios
- Ensuring that each MCP provider network includes access to FQHC and RHC services
- Assessing that all adult and pediatric providers are within time and distance to beneficiaries
- Ensuring that if an MCP has an approved AAS, the MCP provides transportation to see a closer provider
- Monitoring Medi-Cal beneficiaries have timely access to appointments within the prescribed standards
- Ensuring medically necessary transportation services are properly authorized, referred, and coordinated