February 27 2016

VIA ELECTRONIC SUBMISSION

Department of Health Care Services
1501 Capitol Avenue Sacramento, CA 95814
ATTN: Jennifer Kent, Director

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
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RE: Medicaid Managed Care Final Rule: Network Adequacy Policy Proposal

Dear Director Kent:

The California Academy of Family Physicians (CAFP), representing more than 9,000 family physicians and medical students in the state, thanks you for your ongoing commitment to ensuring access and quality of care for the Medi-Cal population. We appreciate the opportunity to provide comment on the Department of Health Care Services' (DHCS) proposal, titled *Medicaid Managed Care Final Rule: Network Adequacy Policy Proposal*, and submit the following comments for consideration:

Defining Primary Care

DHCS defines service categories for the purposes of this proposal, two of which are "primary care" and "specialists." While these categories provide a useful baseline for an examination of network adequacy, CAFP is concerned that the definitions employed here are too broad to provide meaningful insight into patient primary care needs, and thus the expected utilization rates on which DHCS's adequacy standards will be based. CAFP recommends that the definition of a primary care physician account for the spectrum of care services provided by a doctor specializing in family medicine, internal medicine, or pediatrics, thus enabling DHCS to measure access to services rather than to individuals. A primary care physician is a specialist in Family Medicine, Internal Medicine or Pediatrics who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's comprehensive care. This care may include chronic, preventive and acute care in both inpatient and outpatient settings. The style of primary care practice is such that the personal primary care physician serves as the entry point for substantially all of the patient's medical and health care needs – not limited by problem origin, organ system or diagnosis. Measuring the spectrum of primary care services provided by a doctor, based on this definition, provides a fuller picture of network adequacy than measuring proximity or wait-times for non-urgent care.

Defining Network Adequacy

CAFP recognizes that DHCS's current adequacy standards are set out in DHCS-to-Managed Care Provider (MCP) contracts and, in many cases, already exceed standards set forth in the Knox-Keene Act of 1975. These performance standards go some

distance toward bringing DHCS into alignment with the *Federal Medicaid and CHIP Managed Care Final Rule* of 2016.

CAFP notes the Final Rule's stipulation that standards must be set in accordance with anticipated Medicaid enrolment and expected utilization of services. Services can include those required by individuals with limited English proficiency or physical or mental disabilities, women requiring direct access to women's health specialists, and those seeking a second opinion. Finally, CAFP notes that the Final Rule calls for providers to offer hours of operation comparable to those offered to commercial enrollees. CAFP is deeply concerned, however, that in Section 4.10 of its proposal, DHCS outlines the ways in which it is empowered to create alternative access standards in recognition of special situations, such as those in which a Managed Care Organization (MCO) has "exhausted all other reasonable options to obtain providers to meet either time and distance or timely access standards."

In light of the shortage of primary care physicians in the state, especially in rural areas, combined with DHCS's ability to exempt from standards those MCOs that exhaust all options to hire an adequate number of primary care physicians, CAFP is concerned that DHCS's proposed network adequacy standards may take into account only those instances in which a patient successfully locates a family physician willing to see him or her, or is able to locate a family physician equipped to provide services via telemedicine or similar technologies. CAFP is concerned that where exemptions from standards take place due to inadequate physician supply or inadequate access to telemedicine or similar technologies, this potentially overarching network inadequacy will not be captured in DHCS' data. CAFP is particularly concerned about waiving the requirement for adequate networks for primary care in rural areas. The very reason these standards are in place is to prevent and address situations where adequate access to care is not being met. Instead of exempting plans from meeting standards, DHCS should take aggressive action in partnership with the plan to ensure Medi-Cal patients have access to care. There are examples throughout the state, particularly in the Inland Empire, of plans that have found solutions to attracting physicians to rural and underserved areas. Moreover, DHCS should take aggressive action to provide access to telemedicine services. Where exemptions from standards are granted due to inadequate physician supply, these exemptions should be considered evidence of network inadequacy and made public.

CAFP notes in Section 3 of DHCS's proposal, that "DHCS-specific network standards already exist in addition to time and distance and timely access, for example, patient-to-provider ratios; these additional requirements are not further noted in this document." CAFP believes that DHCS's facility-based approach to understanding physician supply and setting patient-to-provider ratios may overstate that supply. Many physicians, especially in rural areas, practice in multiple settings (e.g., offices, clinics, hospitals and outpatient surgery centers). Stating that a patient has access to 10 providers in a given facility may not be accurate if each provider is only at the facility for one day per week or is rendering only a very specialized service. DHCS's analysis should clarify the amount of time each provider spends at a facility by using **full-time equivalents** to ensure that access in a given area is not overstated.

Finally, CAFP believes that the network adequacy standards, as proposed in determining distance and travel time, will not measure the time and distance to the actual provider seen by the beneficiary or whether the 30-minute/10-mile standard is applied to *any* primary care provider within that time/distance of a beneficiary, or whether the time and distance standards take provider specialty into consideration. A beneficiary could reside in an area that technically has many physicians, but if none can provide the care needed, that patient effectively has no access to care due to an inadequate network.

CAFP recommends that managed care network adequacy be measured holistically and incorporate:

1. Instances in which standards cannot be met because of inadequate physician supply;
2. Coverage ratios using full-time equivalents for primary care physicians, as this will account for how much of a provider's time is available to see Medi-Cal managed care patients, as opposed to fee-for-service Medi-Cal patients, Covered California or privately insured patients;
3. The specific services being provided by primary care physicians in a particular geographic area; and
4. Relative access to specialty care, a lack of which may increase demand for primary care services.

Procedures for monitoring network adequacy

In Section '438.207 - Assurances of Adequate Capacity and Services,' subsection (b) (2) of the Final Rule, CMS stipulates that each MCO, Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP) must submit documentation to the State demonstrating that it "maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area." With regard to measuring compliance with network adequacy standards, CAFP was pleased to see in DHCS's recent *Medi-Cal Fee-for-Service Monitoring Draft Plan* that "DHCS will have ongoing mechanisms in place for public input via hotlines, the Office of the Ombudsman, and a specific website with a dedicated email box." CAFP also appreciates the access DHCS provides to its Managed Care Performance Dashboard, which is updated quarterly.

DHCS makes clear in its proposal that it intends to monitor health plans to determine compliance with the standards (p. 25), but the methods for this monitoring seem to imply a continued reliance on self-reporting by the health plans. CAFP feels that relying heavily on MCO reporting, or MCO reporting on behalf of their enrollees in order to monitor access, will prove inadequate. CAFP recommends that DHCS provide additional detail about the specific tasks it will carry out to monitor network adequacy, 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.

Furthermore, CAFP believes that DHCS has an opportunity to proactively engage patient populations and primary care physicians to assess their experiences with access to care and gaps in services. As always, CAFP would be pleased to coordinate with DHCS to connect it with CAFP membership for the purposes of measuring and ensuring network adequacy. Family physicians have a unique view into the availability of specialists, dental services and mental health services as they are often the ones seeking those services on their patients' behalf. Additionally, CAFP supports reviewing standards every five years at a minimum, and publishing network adequacy standards on the DHCS website. CAFP also encourages DHCS to publish the number of exemptions from network adequacy standards issued as a result of an inadequate supply of providers.

Finally, CAFP encourages DHCS to leverage the expertise of the current access assessment committee when examining time and distance standards. Their insight may prove instrumental in determining how not only to ensure, but to improve upon, the standards articulated in the Knox Keene Act. CAFP strongly urges the state to use its current access assessment committee to inform its proposal.

Conclusion

CAFP believes it is of paramount importance that DHCS measure network adequacy in a way that describes the impact of the shortage of primary care physicians on access to care in California. Network adequacy based on Medi-Cal enrollment and expected utilization of services cannot be achieved without adequate support for primary care residency programs and without addressing the disparity between Medi-Cal and commercial payment rates. Measurements that imply inaccurately that networks are adequate may impede achieving these goals.

In 2015, CAFP, in partnership with the California chapters of the American Congress of Obstetricians and Gynecologists, the American College of Physicians and the American College of Emergency Physicians, the California Academy of Physician Assistants, the California Medical Association, the California Primary Care Association and the Osteopathic Physicians & Surgeons of California released a Medi-Cal Access Reporting Survey citing more than 60 examples from across the state of providers and patients who faced serious issues related to access in the Medi-Cal program. The majority of respondents were family physicians who described a dearth of specialists to whom they could refer their Medi-Cal patients. Neurologists, endocrinologists, psychiatrists, rheumatologists, pain management specialists, orthopedists and referrals for imaging or prescription medications were particularly hard to obtain. More than 50 percent of responses identified a lack of continuity of care because of these and other access barriers, including lack of transportation, severe delays in authorization and challenges for non-English speakers.

Access to care is an issue that family physicians take very seriously. In many cases, it can be the difference between life and death. The challenges revealed in our Access Reporting Survey continue to this day. We recognize the enormity of the task facing

DHCS in monitoring these issues, but we stand ready to assist in this vital activity. We are encouraged by this effort to measure and understand the full scope of access to managed care in the state and look forward to our continued collaboration.

Sincerely,

Susan Hogeland, CAE
Executive Vice President
California Academy of Family Physicians