Behavioral Health Concepts, Inc – California EQRO | www.caleqro.com | info@bhceqro.com
5901 Christie Ave, Ste 502, Emeryville, CA 94608 | Tel: (855) 385-3776 | Fax: (855) 385-3770

Date**: February 28, 2017**

From**: California External Quality Review Organization for Mental Health and Drug Medi-Cal Services**

To**: DHCS Network Adequacy Planning Group**

The following provides individual comments from select CalEQRO staff, all reviewers, including quality reviewers, IS reviewers and Consumer/Family Member team members. CalEQRO has compiled these comments for submission instead of each providing individual responses to DHCS.

CalEQRO visits all 56 California Mental Health Plans each year, and the review staff and consultants have in-depth understanding of various practical constraints to access and network adequacy from the hundreds of focus groups conducted with the providers and consumers/family members. In addition, CalEQRO is in the process of implementing similar reviews for the Drug Medi-Cal Organized Delivery System Plans in the upcoming fiscal year.

These comments reflect that on-site knowledge accumulated by the CalEQRO staff. The comments are mostly confined to the Mental Health and Drug Medi-Cal network adequacy issues.

As the department will note, the most commonly noted areas, where CalEQRO staff and consultants felt greater need for attention, are,

- Standards for small and rural plans
- How distance standards do and do not adequately address access
- Attenuating factors to distance standards such as availability and affordability of transportation, seasonal variations and others
- Need for special attention to Medical Service Study Areas (MSSA), especially those located in larger county plans
- Alternative access standards
- Need for addressing outreach to consumer's location including through telepsychiatry services, pharmacy delivery, and nurse visits for medication monitoring
- Need for separate and shorter standards for urgent care access

CalEQRO staff and consultants appreciate the opportunity to provide feedback to the proposed network adequacy standards, and applauds DHCS' approach with full transparency and a feedback mechanism.

Consultant 1

Thanks for sending this. I reviewed the MH part and it seems reasonable, but just wondered about the access standard for small rural. Some people live so "deep in the woods."

Consultant 2

Rural and Small MH access of 60 miles and 90 minutes and medium 30 miles/ 90 minutes is a clear barrier and inadequate access particularly for the severely ill and or disabled. The Large County standard is sufficient, but not the small/rural/mediums.

When one considers these individuals often lack the funds for personal transportation and that in these same areas public transport is very limited, those standards are insufficient.

Standards like this mean that individuals do not have access to care and are more likely to be served at the higher end, acute care, jails, etc. There should be a push for a standard of at least providing teleheath "station" in primary care clinics to augment in person care if this existing standard is to be kept.

I would assert (page 7) the same for SUD treatment. If it is not close to where one lives, it will not be accessed and treatment will not occur.

Staff 1

The proposed standards do not appear to include any access standards for MH or DMC residential treatment, day treatment/partial hospital (unless assumed to be an OP service), detox, or crisis services. Perhaps this first round DHCS was trying to do only the minimum required. It is not clear why certain billable services are omitted. Leaving these out will lead to less attention being given to access than for other services so perhaps they are folded into a broader category with specific attention to acuity or complexity of condition?? Again it just appears to be omitted or not addressed.

The MH non-physician distance, time and access standards seem reasonable if the person is not acute.

Also the DMC-ODS non-physician standards seem reasonable as long as the person is not at risk of overdose and/or in need of detox. The same for standards for narcotic treatment programs though I am not sure with the surge in opioid treatment demand how often this standard is being met. I would anticipate some push back from counties. Virtually none of the small counties and most of the medium counties could not currently meet this standard.

I like the idea of geomapping of services by site and level of care. Giving a visual access tool to clients and managers is a good idea.

I also like that you must document in your systems which providers are not taking new clients and for how long so clients and families and referral sources do not waste time.

It is clearly implied that EQRO is helping with this including the "certification related data" for the state to consider for their submissions to CMS. We have a role, but again it is not clear how DHCS compliance and EQRO divide up the work. Given the prior CMS directive that EQRO should be doing compliance, perhaps it is assumed we are already doing it by CMS. Again, not clear.

It also appears that July 2018 is target for implementation plan approval and launch. So there is time for thoughtful response and analysis and maybe a pilot test of methodology and data systems. The document said doctors are to be covered by 4.2 including psychiatrists and DMC ASAM physicians. I therefore assume acute care hospitals and PHFs would fall under hospital provisions.

It appears that if services are done via telemedicine or home visits that no standard applies or at least is proposed by DHCS. I do not think this is fair for homebound clients to wait longer for access than those that can use mobile access via cars, buses etc. But this might be an attempt to phase that in for 2019. We could clarify intention here.

Staff 2

My only comment would be to note that a number of counties I have been to recently are not meeting the 10 day non-medical appointment standard (and some are not even close). How will DHCS handle those situations (ie: time to rectify) and what, if any, will the repercussions be for MHPs not meeting standards (if not rectified in a specific time period).

Consultant 3

It appears the timely access to non-urgent is covered.

I wonder if DHCS is considering including timely access to urgent care.

Each MHP seems to define this individually from 1 day to 10 day response. Standardizing it may help.

I have included the regulatory language from the Barlclays CCR document which was referenced in the DHCS Proposal.

https://govt.westlaw.com/calregs/Document/IAEB5B380101711DFBF14F83A306F765F?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

Its located in CCR Section 1300.67.2.2. (c) (A) as stated below:

§ 1300.67.2.2. Timely Access to Non-Emergency Health Care Services

(c) Standards for Timely Access to Care.

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G).

Staff 3

This DHCS document for implementation of the federal Medicaid Managed Care Plan regulations appears to apply to just routine outpatient services. It may not apply to the other 5 measures that we do for timeliness: i) to first psychiatry visit; ii) for first

urgent/emergency service/response; iii) for first follow-up visit after hospital discharge; iv) rehospitalization rates; and v) No Show Rates.

For routine outpatient services, this document appears to:

1. Require that time and distance standards to providers to be used along with with timeliness to first routine appointment. Though CalEQRO measures, and DHCS Metrics Workgroup is addressing statewide timeliness standards -- this implements the CMS requirement for MHPs to actually report them -- and to report time and distance as well as timeliness.
2. The CMS timeliness standard is 10 business days
3. The CMS time and distance standards vary by county size.-- but the timeliness standards do not.
4. The time and distance standards for MHPs give either miles or travel time. It does not say whether the lesser or greater value applies. By default, I would guess the greater of each standard (e.g., the greater of 60 miles or 90 minutes in Small Rural and Small counties) would apply for each time standard.
5. The "provider type" is **Mental Health (non-physician)**. It may not be defined, or be unclear, whether "non-physician means only licensed mental health practitioners, or whether it includes all certified MHP providers and/or case managers. Presumably, this would not include any non-billable (i.e. non-Medi-Cal) staff such as peers, community workers, or volunteers who may serve consumers, but whose services are not billed to Medi-Cal.
6. This DHCS Implementation Plan may -- or may not -- include a standard for time to first psychiatrist appointment. The intent is unclear, but there are time and distance standards to **Specialty Care (adult and pediatric)** on Page 5 of 37. Page 15 of 37 includes Psychiatry as among the **DHCS Core Specialists**. It is unclear if specialty mental health psychiatry is meant by this.
7. There is no discussion whether the time standard assumes consumers have their own private transportation, or is weighted for any proportion of consumers who would rely on public transportation.
8. On Page 13, and in other places, the term "expected utilization of services" is used. It may be unclear what "expected utilization" means.
9. The CMS Final Rule provides for exceptions from both the time and distance and timeliness standards when: i) providers travel to the beneficiary and/or a community-based setting to deliver services; ii) modalities such as telemedicine (i.e.. telepsychiatry and telemental health) and pharmacy mail order/delivery are used; and iii) there are seasonal considerations (e.g. winter road conditions) to time and distance standards.

I think the seasons are critical barriers in a number of our counties and would have to be considered under "Alternative Access Standards". And for many under 200% federal poverty level (FPL)/Medi-Cal consumers -- public transportation or providers being able to go where the consumer sare (e.g., community and cultural centers, Family Resource Centers, Senior Centers, homes, etc.) are probably realistic where consumers do not have vehicles.

The CMS Final Rules do not include evening or weekend appointments. Is DHCS going to require some capacity for non-business hours?

Staff 4

The Network Adequacy Policy proposal never defines or uses the term “Medical Service Study Areas” or “frontier” - both which are recognize by U.S. Health Resources and Service Administration (HRSA) and California Office of Statewide Health Planning and Development (OSHPD) when measuring network adequacy. Which I believe is an oversight in the current version.

California has some large counties that span all MSSA definitions - urban, rural, and frontier. To require all large counties to meet the standard - *Large Counties*: 15 miles or 30 minutes from the beneficiary’s residence (1) is unrealistic. Three counties come to

mind are Riverside, San Bernardino, San Diego that will be impacted by the 15 miles or 30 minutes standard. And I'm sure there are some medium size counties that will be impacted as well.

Consultant 4

If more stringent standards were adopted, beneficiaries would have real vs fantasy access to care, and it would promote broader implementation of telemedicine and partnering with health clinics for telemed sites.

The frontier or distant standard is virtually zero access when you are speaking about folks who are poverty level and either lack vehicles or funds for gas, etc.

The distance standard does not provide for routine and regular access consistently.

If one wants to see "real" access occur the reasonable distance standard needs not to be based on some unrealistic travel expectation of consumers.

Staff 5

Here are a few thoughts on the Medicaid Managed Care Final Rule: Network Adequacy Proposal.

1. The standard of 10 days to first non-psychiatric appointment is more stringent than the state standard (reported by the MHPs) of 14 days and 26 days for psychiatrists (in our EQRO annual report). So the state will have a difficult task in reaching the 10 days standard. I assume the same will be true for DMC-ODS.

2. The final rule requires that specific standards are set for MHPs and DMC-ODS plans (p. 14). In reality, CalEQRO is the only entity that has data that we collect each year that can help with establishing these Network Adequacy Standards.

3. On page 24 it says that the Final Rule provides for exceptions. It seems, based on our recent annual report that exceptions are needed for the MHPs and DMC-ODS. The document says that "Alternative access standards will only be approved in circumstances where the applying entity has exhausted all reasonable options…."

4. The DHCS triennial compliance review is not often enough, it would seem, to effect system changes throughout California, where Network Adequacy, as defined by time and distance or timely access standards, needs to improve. DHCS could consider using the EQRO's access measures.

Staff 6

I would add that the provision of time and distance (minutes and miles) does not take into account seasonal differences, and **should be based on the most inaccessible weather conditions** - winter conditions in some places, and summer conditions in others. This is mentioned in the final rule, and needs to be carried forward here.

In California this impacts a large portion of the State and there needs to be inclusion of this variable - mountain snow and passes closed, flooding, wildfires, etc. A summer trip of 25 miles can take 15 minutes, but in the winter can take four hours when consumers must drive a circuitous route to access these same services.

The discussion of *consumer means of transportation* does include designation for private vs. public transportation - see page 29 (Attachment B). It seems the weighting is inferred by the phrase "ordinarily used by the Medi-Cal enrollee".