KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.

February 28, 2017

Mr. Nathan Nau
Chief, Managed Care Monitoring and Quality Division
Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 95814

VIA ELECTRONIC MAIL:

dhcsmcqmdnau@dhcs.ca.gov

Re: Provider Network Adequacy Proposal

Dear Mr. Nau:

Kaiser Permanente (KP) would like to thank the Department of Health Care Services (DHCs) for the opportunity to review and respond to the recently released Provider Network Adequacy Proposal. We are submitting the following comments for consideration.

Population Alone Should Not Define Time and Distance Standards

Defining counties as small, medium, or large -- by referring solely to population -- does not serve as a useful tool for developing time and distance standards as it fails to take into account the geographic size of a county. For example, San Francisco County, with just 47.9 square miles, and Kern County, with over 8,100 square miles, are subject to the same proposed time and distance standards. These two counties are vastly different in geographic size and population density (approximately 3,575 people per square mile vs. 105 people per square mile, respectively), and thus have very different patterns of practice for traveling to services, despite being close in overall population by county. Los Angeles County, the only large county as defined by DHCS, has some rural pockets, such as near Gorman and within multiple National Forests and State Mountain areas, which would likely fail to meet a 10 miles or 30 minute time and distance standard for certain specialty services.

As such, KP suggests that DHCS either (i) increase time and distance standards for counties of larger geographic size, or (ii) lower the threshold for compliance to something less than 100%. For example, if DHCS modifies the standard to reflect that "at least XX%" of beneficiaries" must receive services within X miles or X minutes, DHCS can account for remote, rural areas of larger counties. This would avoid the need for multiple alternative access applications where standards cannot be met solely due to the fact that no providers are located close enough to such remote, rural areas.

Primary Care (adult and pediatric)

KP recommends the proposed standard be mapped to the Knox-Keene standard of 15 miles or 30 minutes from the beneficiary's residence rather than the proposed mapping of 10 miles or 30 minutes so Plans have one geographic standard.

Specialty Care (adult and pediatric)
Time and Distance Standards for Specialty Services Should Focus on High-Volume Providers

DHCS lists 15 different specialty services which are subject to new time and distance services. While all MCPs provide these services, we suggest that DHCS focus only on high-volume specialty services (in other words, those used frequently by members). Assessing compliance for time and distance for 15 specialties, presumably by all California zip codes, for all plans, will create a large administrative burden on both DHCS and MCPs. We suggest narrowing the list to the top 5 or 6 most frequently utilized specialty services, allowing both DHCS and MCPs to focus on access improvements that will have the highest beneficiary impact.

Monitoring Timely Access for Specialty Services Should Align with DMHC's Reporting Requirements

While all specialty services are subject to the current Timely Access standards, DMHC currently requires MCPs to report rates of compliance for only certain defined specialties (cardiology, allergy, dermatology, psychiatry, and child/adolescent psychiatry, along with non-MD mental health). We suggest that DHCS align any monitoring initiatives on timely access to specialty care with those established by DMHC. Monitoring all 15 specialties on the DHCS' proposed list would be overly burdensome for both MCPs and DHCS, especially given the current challenges for many MCPs in collecting timely access data.

Please let me know if you have any questions.

Cordially,

Christine Nelson
Director, California Medi-Cal and State Sponsored Programs

cc: Nathaniel Oubre, VP, Medi-Cal, CHIP, Charitable Care and Coverage
Gwendolyn Leake Isaacs, Managing Director, Southern California
Sarita Mohanty, MD, Executive Director, Northern California
Kari Dreyer-Goldman, Executive Director, CA Medi-Cal Administration
Elizabeth Reno, Regional Director, NCAL Medi-Cal Strategy and Operations
Elizabeth Elson, Senior Counsel
Kaycee Velarde, Practice Leader, Health Plan Regulatory Services