

July 1, 2020

Department of Health Care Services  
Contract Services Branch  
1501 Capitol Avenue  
Sacramento, CA 95814

*Sent via email to CSBRFP8@dhcs.ca.gov*

**Re: Draft Request For Proposal #20-10029, Medi-Cal Managed Care Plans**

To Whom It May Concern:

On behalf of more than 50,000 physician members and medical students of the California Medical Association (CMA), we would like to thank you for considering stakeholder input on the Department of Health Care Services' (DHCS) Draft Request for Proposal (RFP) #20-10029, Medi-Cal Managed Care Plans. Through a comprehensive program of legislative, legal, regulatory, economic, and social advocacy, CMA promotes the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession, and to achieve health equity and justice. CMA's physicians are committed to working to improve the Medi-Cal program and to ensure that patients have access to care. CMA continues to seek opportunities to help develop this proposal in a way that supports physicians and their patients.

**Draft RFP 20-10029 Main**

**O. Qualification Requirements**

We strongly suggest that DHCS evaluate the conduct, competency and history of plans when they bid to enter the managed Medi-Cal market. Plans should be required to admit, disclose and document where they have tried and failed in other Medicaid markets - both in California and elsewhere in the country. DHCS should consider whether plans are currently under investigation for Medicaid-related billing, claim or reimbursement issues, and also look at complaints by beneficiaries and physicians. Plans should be required to disclose enforcement actions, corrective action plans, sanctions and penalties in other states. DHCS should prioritize plans that have an extensive history of success in providing medical coverage to underserved or low-income populations, and prioritizing care and access for beneficiaries rather than shareholders or stock options. DHCS should look to managed care plans' (MCPs) history of compliance, any fines and penalties levied, other administrative sanctions, financial solvency, and any reports that have been submitted to DHCS, the Department of Managed Health Care (DMHC), or other regulatory or governmental bodies. These factors should also play in the Department's default algorithm, so that plans are

rewarded with beneficiaries defaulting into their plans based on higher quality rather than lower cost.

With the growth of Medi-Cal managed care and the State's efforts to expand health care coverage, some health insurance companies have chosen to increase profits at the expense of patients' access to quality health care. At the same time that some health plans are struggling to ensure Medi-Cal patients have timely access to quality care, for-profit health insurance companies' profits and stock prices are soaring. Many MCPs have reported large profits in California, with many of those reporting the largest profits having the worst performing quality scores and access to care. For-profit health insurers, whose primary obligation is to their shareholders, are failing to meet their obligation to provide effective and quality medical care to California's residents. DHCS should prioritize the bids of non-profit health plans who seek to enter or renew their contracts in the medical market. Additionally, DHCS should support the plans that consistently have medical loss ratios that reflect a commitment to supporting a robust provider network and the delivery of timely medical services.

### **Exhibit A, Attachment I**

We ask that DHCS clarify the definitions of "Contractor" and "Network Provider." As currently written, the definitions are circular and merely refer to each other. It is unclear when a physician or physician group would be considered a Contractor or a Network Provider, which significantly impacts their obligations under the proposed contract.

### **Exhibit A, Attachment III**

#### **1.1.7 Health Equity Officer**

We appreciate the requirement that the Health Equity Officer engage and collaborate with Network Providers. We believe physician involvement and input is key to understanding and addressing health disparities in the Medi-Cal population. Please see our comments on sections 2.2.3 and 2.2.4 for further discussion of this topic.

CMA supports DHCS's efforts to address health equity with the goal of eliminating disparities via better measurement and quality improvement. DHCS should prioritize data collection and quality improvement metrics that capture the diversity of all populations (including racial, ethnic, sexual orientation, gender, disabled and other underrepresented groups) in clinical practices to fully understand the health status and needs of all individuals as well as to recognize the burdens and disparities they face in obtaining equity-oriented, quality care. In order to fully understand the inequities and disparate outcomes for minoritized and marginalized communities and to guide public policies, equitable allocation of health care resources, and public health interventions, additional data is needed. There is a need to collect, analyze, and make available to the public, explicit, comprehensive, standardized data on race, ethnicity, and patients' preferred spoken and written language. This data should be disaggregated so that it is useful to the public, for example, by including county and MCP.

However, all data collection on race, ethnicity, language ability, sexual orientation, gender, and disability should be culturally sensitive and appropriate and respect individual privacy.

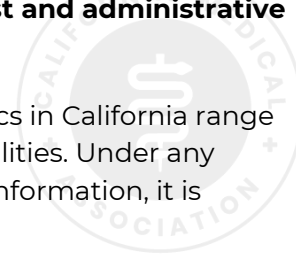
Many health care systems have begun to explore ways to integrate data related to social determinants with patients' clinical records. However, many challenges remain before data related to the social determinants of health are readily accessible and actionable. Key challenges are a lack of consensus on standards for capturing or representing social determinants of health in electronic health records. There is no single standard that captures the breadth of information necessary for documenting the determinants in a manner appropriate for clinical care, quality improvement, and research. To address these challenges and effectively use social determinants in health care settings while minimizing additional administrative burden on patients and physicians, **we recommend that DHCS implement uniform standards for the MCPs for representing data related to social determinants of health, the data be easily extracted, and the collection of the data be incentivized through financial or quality measures.**

#### **2.1.1. Management Information System (MIS) Capability and 4.3.2 PHM Data Integration**

We appreciate the requirement that a Contractor's MIS must have the ability to communicate with any sources needed to support Care Coordination. We are concerned, however, about whether plans are prepared to meet these requirements and the lack of specifications as to system implementation. MCPs should be required to implement health information technology (HIT) to support population health principles, integrated care and care coordination across the delivery system. **We believe the development and funding of this HIT infrastructure is key to the success of the CalAIM proposal, and request that DHCS provide more specific information in future stakeholder meetings and written documents as to how it will build and fund interoperable health information technology and health information exchange infrastructure.** We also request more details as to the data exchange protocols MCPs will be required to develop in order to ensure care coordination with their physicians as well as between physicians and other health care providers including behavioral health specialists.

CMA supports improving access to complete patient data, including for physicians and other providers. CMA recognizes the importance of and fully supports the secure exchange of data among providers to reduce costs, improve quality of care, and reduce administrative burdens. Data should follow the patient and should be available to any appropriate provider at the point of care. Secure and robust data exchange, however, cannot be achieved without sufficient funding for necessary technology infrastructure and training. In addition, **CMA urges DHCS to ensure that MCP data collection obligations are not passed down to individual physicians without the appropriate considerations of cost and administrative burdens.**

Technologically and financially, physician practices, hospitals, and clinics in California range from large and sophisticated systems to small, strained offices and facilities. Under any statewide policy requiring stakeholders to meaningfully share health information, it is



reasonable for certain providers with limited infrastructure and means—such as independent physicians, rural hospitals, and safety-net clinics—to expect public subsidies and incentives to help defray the costs of participation. Moreover, other states' efforts to advance health information sharing through both strong requirements and funding have seen success.

**DHCS should require health plans to offer financial incentives to help smaller network providers achieve data-sharing and help defray costs for certain onboarding and maintenance activities associated with sharing through HIN/HIEs, such as EHR integration and contract renegotiation fees.**

Additionally, it is critically important that Contractors use standard processes for encounter data exchange with network providers. CMA encourages DHCS to ensure that ANSI-accredited standards are adopted to facilitate the exchange, integration, sharing, and retrieval of electronic health information.

### **2.2.3 QIHEC and 2.2.4 Provider Participation**

While CMA appreciates the Department's ongoing commitment to improved quality outcomes for beneficiaries, we request specific changes to the draft RFP that better reflect the need for a MCP and its network providers to be working in a closer and more collaborative effort when it comes to quality improvement and health equity. Specifically, **we would request that the MCP's Governing Board include at least three (3) network physician members with a membership that reflects diversity of geography within the MCPs service region, specialty and primary care as well as physicians serving in safety net facilities or locations.** We also request the Quality Improvement and Health Equity Committee (QIHEC) be composed of at least twelve (12) network providers with annual meetings directly with the Governing Board. We do not support the QIHEC being led by a medical director's designee – we believe this committee and function should be a direct responsibility of the MCP Medical Director.

### **2.2.9 External Quality Review (EQR) Requirements**

We strongly encourage limiting the number of data points on which physicians need to report so that physicians can spend their time providing medical care instead of completing administrative tasks. We encourage DHCS to consider the following guiding principles for selecting incentive measures:

- The quality performance standards tied to value-based payment models must be physician-validated clinical measures.
- Quality reporting measures should be consistent and aligned with other programs and payers (such as Covered California and CalPERS). Developing mechanisms for sharing standardized quality measure data among different programs will reduce time and resources spent reporting duplicative or redundant measures.



-The development and revision of these measures should be an ongoing process that reflects new clinical evidence and quality data.

- When new quality measures are adopted, other measures should be reviewed and evaluated before being retained. Minimizing additional administrative burdens on physicians should be a priority. Currently, physicians are required to report multiple quality measures in different ways to different entities. This imposes significant burdens on physician practices and impedes comprehensive improvement in overall quality of care. A recent study indicates physicians and their staff can spend upwards of 15 hours per week dealing with various quality measures with different payors. The physician time alone spent dealing with quality programs is estimated to be enough time to care for approximately nine additional patients and the staff time spent is incredibly costly to practices.

We encourage DHCS to emphasize quality measures that can be assessed based on available data, and to use existing claims and encounter data rather than requiring physicians to complete additional reporting. Ensuring these measures can be automatically extracted from encounter data would reduce the need for physicians and their staff to manually extract and manipulate data measures according to the individual specifications of each entity requiring quality data reporting. **CMA strongly supports using existing sources of data when evaluating physician participation in this program and that any assessment of the proposed measures be done through existing claims and encounter data. CMA also strongly opposes any measures that require manual review of medical records by physicians, their staff, or external auditors.**

**Additionally, if MCPs are requiring physician involvement as part of their Performance Improvement Plans (PIPs), they must provide adequate resources, funding and training to enable physician practices to improve their performance as needed on specified measures.** MCPs should have to demonstrate the quality improvement support and technical assistance they are providing to network providers to DHCS.

### **3.1.5 Financial Viability of Network Providers and Subcontractors**

Since the passage of Proposition 56 in 2016, DHCS and CMA have worked closely together to design and implement the supplemental payments for physicians. This collaboration has been both productive and instructive in how these supplemental payments can be targeted to incentivize certain services (i.e., preventive screenings) as well as provide necessary funding to support existing Medi-Cal providers and the work they do in stabilizing our safety net. CMA supports the important work done by the Department when it comes to rate-setting and overseeing the supplemental payments directed through the managed care plans. As the state moves to regional rate setting, CMA understands that this will dramatically reduce the number of rates that must be developed by the Department and approved by the federal government. **While we are pleased that the State has increased the availability of supplemental Medi-Cal payments for certain services, this should not be viewed as a reason for plans to reduce base Medi-Cal rates.** As the Department begins to implement these regional rates, CMA would urge caution as the potential downward pressure on

capitated rates that some plans may experience because of this shift to regional rates may result in downward pressure in physician contracted rates. Physicians already struggle to participate in the Medi-Cal program due to low reimbursements, and further reductions in already low rates could have serious negative consequences for network adequacy and access to care.

Managed care plans are increasingly reliant on the use of delegated, capitated financial arrangements to providers, especially primary care physicians. While the state requires each MCP to “evaluate and monitor” the financial viability of its providers and subcontractors that are at financial risk, there is no other specificity on this important – and generally overlooked – function.

**CMA would request that the draft RFP be modified to include the following:**

***“Contractor must provide at least 180 day written notice of any planned rate decrease to affected providers and offer an opportunity for affected providers to meet with MCP executive leadership to understand the data and reasons behind such a rate decrease. At the conclusion of these meetings with impacted providers, the MCP shall be required to demonstrate how such a rate decrease does not otherwise jeopardize the financial viability of the affected providers to the Department.”***

#### **4.3 Population Health Management and Coordination of Care**

CMA supports the requirement that all MCPs maintain a population health management (PHM) program that improves the ability of physicians and other health care providers to identify social factors and needs that impact health. We believe that a more comprehensive strategy that accounts for screenings, health assessments, case management, data collection and monitoring and risk stratification is a fundamental and much-needed improvement to the overall managed care plan responsibility. However, the plans should not develop these population health management programs in isolation. We note that 4.3.3.D requires MCP’s to engage a wide variety of stakeholders and providers when developing its Population Needs Assessment, but physicians are not mentioned, and Network Providers inclusion is only briefly mentioned in a different section (2.2.4). **We recommend that the plans be required to include practicing physicians from the plans’ geographic service areas in the development and operationalization of their program.** This local input will ensure that plans receive feedback directly from practicing physicians on the most effective ways to improve care coordination, communication and data sharing.

One of the challenges in managing high-risk populations is the inability to share appropriate levels of data with providers in a meaningful and timely way. Physicians and patients would greatly benefit from additional information about a patient’s social needs, including their access to food, clothing, household goods and transportation. **If a health plan is obtaining this information through its patient risk assessment, CMA would recommend that a mechanism be developed to appropriately and legally share this patient information with the physicians that are caring for the patients directly.** This information should also

be available electronically, integrated with the patient's existing health records, and updated in a timely fashion.

The data should also be collected in such a way so that it can be easily transmitted in a usable format and incorporated into the risk stratification process. We recommend that initial risk assessment be standardized to the extent that the Department is able to compare data across plans and develop methods to evaluate the success of their population health management programs. Additionally, to the extent that member-contact screening requirements are passed down to physicians, the Department should make sure there is adequate reimbursement for such screenings and for any subsequent data collection and submission done by physicians. Screening tools should be separate from screenings used for clinical screenings, cost-effective, and not negatively impact medical care or create additional burden for physicians.

### Risk Stratification

As part of their PHM programs, MCPs will be required to risk stratify the population to determine the level of intervention that members require based on all available data sources, as well as the results of the member-contact screening. CMA urges the Department to ensure that it implements efforts to identify and address bias in the use of these risk stratification algorithms and to avoid introducing or exacerbating health care disparities in connection with the use of these tools, particularly since they will be used for vulnerable populations. While recognizing there is some proprietary intellectual property in the development of risk stratification algorithms, we would also encourage greater transparency about how these tools are being deployed as well as the underlying data being used to generate any outputs. Any algorithms used by plans should be validated nationally and required to use as complete a set of data as possible.

The reliance of risk stratification algorithms on inputted data can lead to certain associated risks. These algorithms require access to large quantities of high-quality data during training and validation. Without accurate and meaningful data, algorithms may not be correct or may not be applicable to different populations. The source of the data used during training will impact the algorithm significantly, and models must be tested on a variety of data sets for validation purposes in order to create an algorithm that works accurately across patient populations. Otherwise, an algorithm may be trained and validated, only to produce inaccurate results when used with a population that varies based on race, gender, or socioeconomic background, medical history, hospital setting, or geographic location.

Furthermore, the biases of training data can risk exacerbating existing health disparities. If models only reflect the limited populations on which they are trained, they will be less accurate for minority groups, and majority groups will have better access to accurate algorithms and thus superior health care. In addition to training and validating across broad populations, MCPs should work towards increased transparency in order to provide opportunities to disclose and address system bias. Understanding data provenance, including key attributes of the training data population, is necessary to evaluating the

accuracy of the risk stratification algorithms and the risks of applying the system to a different population.

#### Enhanced Care Management

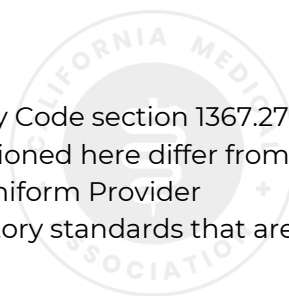
CMA continues to support the new Enhanced Care Management (ECM) Benefit proposed as part of CalAIM and would encourage this benefit to be made part of contract requirements for MCPs. **CMA supports efforts to promote well-coordinated and adequately funded case managers for people with complex medical and social needs.** Many social and economic conditions often lead to health disparities, or differences in health outcomes, and vary by socioeconomic status, race/ethnicity, geographic location, educational attainment, sexual orientation, gender, and occupation. Strong evidence has accumulated over the last decade that links unmet social needs with poor health status.

We understand that the ECM benefit is designed to be provider-based and in-person, and that MCPs will contract out for these services. Additionally, we would ask DHCS to clarify in its written policies, that unlike the existing case management and complex case management benefits provided by the MCPs, ECM will be done at the provider level. We would encourage the utilization of existing provider relationships and networks, and for MCPs to continue to build on the success of existing programs like the Whole Person Care pilots. Additionally, **we strongly support contracted models where MCPs will provide direct funding for physician practices to hire additional case managers who can provide this benefit to patients.** If physicians do need to refer patients out for care management, they should be able to refer the patient directly to the plan through a streamlined process that allows the physician to remain informed and involved with the patient's care.

While supporting the addition of this important benefit that holds a lot of promise for tackling the most high-cost and high-risk populations, physicians report to CMA that oftentimes when managed care plans are given additional requirements for enhanced care management that require high-touch, on the ground and face-to-face contact, either programmatic or data-related, that these requirements tend to be delegated downstream to treating physicians, often without discussion or additional financing to support the new requirements. Providers, both physical and behavioral health, will be key to successfully driving these changes with individual patients. However, in order to successfully implement this new benefit, **plans cannot simply add additional unfunded contract requirements to provider contracts and expect this to be absorbed into practice flows. CMA would urge the Department to require plans to include any additional requirements and associated reimbursement for enhanced care management responsibilities in physician contracts.**

#### 5.1.3.H Member Information – Provider Directory

We appreciate the requirement that MCPs comply with Health & Safety Code section 1367.27. We would note, however, that some of the specific requirements mentioned here differ from those contained the regulations implementing that 1367.27, DMHC's Uniform Provider Directory Standards. We would request that DHCS have provider directory standards that are





as consistent as possible with these regulations, and that DHCS either mirror these requirements in the contract language or incorporate them by reference. We recognize that there may be some additional directory requirements that are specific to Medi-Cal, such as including the link to the Medi-Cal Rx Pharmacy Locator. However, to the extent that provider directory elements fall under those covered by the existing regulations, MCPs should be required to comply with the DMHC standards.

## 5.2 Network and Access to Care

Network adequacy and timely access continue to be an issue for many beneficiaries, with access to care varying widely across plan and region. If MCPs are seeking to renew their contracts in the Medi-Cal market, they should be required to demonstrate progress in expanding and improving their networks year over year. DHCS should look to the data submitted in the annual network certification process and look to limit the participation of plans that have relied heavily on alternative access standards rather than robust networks. DHCS should also review complaints about access to care submitted to either DHCS or DMHC.

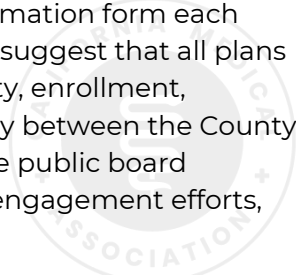
MCPs should not receive approval for the same alternative access requests year after year. Instead, MCPs should be required to specify the measures they are pursuing to actively improve their networks and to contract with additional providers. DHCS should evaluate a plan's claim that there are no providers available by looking to the networks of other Medi-Cal and commercial plans in the same region, and examining why an MCP has failed to contract with providers in that area. We recommend that DHCS take aggressive action in partnership with the plans to ensure Medi-Cal beneficiaries 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. **MCPs should be required to demonstrate efforts they are making to contract with providers, including provider incentives, value-based payments, loan repayments, and any other programs that help to maintain provider relationships. Where exemptions from standards are granted due to inadequate physician supply, these exemptions should be considered evidence of network inadequacy.**

CMA has concerns about the multiple levels of delegation utilized by certain plans and the lack of transparency around delegation. The multiple levels make enforcement and monitoring of contract requirements difficult. They create confusion for beneficiaries and billing providers because of the lack of information at the point of care through DHCS' systems, and leave physicians spending excessive time dealing with administrative hurdles related to the division of financial responsibility and determining which delegated entity is responsible for payment. **We request that DHCS increase the oversight and contract requirements around delegation.** With regard to network adequacy in particular, we would appreciate more detailed requirements for the MCPs as it is ultimately the responsibility of MCPs to ensure that beneficiaries have access to adequate networks, including appropriate in-network services. **Delegation should not be used to avoid compliance with the network adequacy requirements.** In particular, beneficiaries have frequently experienced difficulties

obtaining referrals to specialists because the sub-delegated networks are inadequate. It does a beneficiary little good to have DHCS certify the aggregated network of an MCP if the sub-network to which the beneficiary has access is not adequate. MCPs must have policies and procedures to impose corrective action on subcontractors who fail to comply with network adequacy requirements and must report subcontractors' non-compliance to DHCS. DHCS should specify that it may impose sanctions on a MCP when a subcontractor's deficiencies result in the MCP's non-compliance with the APL. It is ultimately the responsibility of the MCP under its contract with DHCS to ensure that all beneficiaries have timely access to services, including those beneficiaries served by subcontractors.

DHCS has relied heavily on plan reporting in order to monitor access. Stakeholders have long contended this method was inadequate, and that DHCS should tighten the monitoring of MCPs. DHCS should not rely exclusively on data provided directly by health plans. A California State Auditor's report concluded that DHCS did not verify that the provider network data it received from health plans was accurate, thereby failing to ensure that the MCPs had adequate networks of providers to serve Medi-Cal beneficiaries. **DHCS must verify the accuracy of data submitted by MCPs as part of their responses to the future procurement RFP. We would urge DHCS to examine plan submissions in conjunction with each other so as to determine whether one provider is listed in multiple networks, and thus is necessarily unable to serve a full panel of beneficiaries in each of those networks. DHCS should also work with DMHC to understand how many commercial networks a provider participates in. Additionally, we request that DHCS provide more detail in the boilerplate contract on the enforcement measures it will take when a MCP fails to meet network adequacy standards, including escalating measures for ongoing deficiencies.**

We are also concerned that lack of access is often due to MCP's failure to contract with physicians to ensure adequate access. Community engagement by the MCP should include both beneficiaries and local physicians. MCPs should be required to implement stakeholder and advisory committees and the local level, including clinical and provider forums. We have seen from past experience, particularly in rural counties, that outreach by MCPs varies wildly, and in those counties with limited provider outreach, there are serious access issues as has been documented by DHCS's External Quality Review Organization (EQRO) and the State Auditor. Outreach and responsiveness to physicians is particularly important in recruiting specialists to join MCP networks. MCPs should be required to submit detailed plans about how they will be engaging with both primary care and specialists in every county and the resources they will be dedicating to provider relations. MCPs should also submit details about how plan medical directors will work directly with physicians as well as county public health officers and other local stakeholders. DHCS should list the contact information for each Medical Director in an easily accessible location on its website. We also suggest that all plans be required to regularly report to County Board of Supervisors on quality, enrollment, providers satisfaction, and grievances and appeals. This will create parity between the County Organized Health Systems/Local Initiatives (COHS/LIs) that already have public board meetings and thus greater accountability and success with their local engagement efforts, and other plans that do not currently do so.



Lastly CMA requests that the Department consider dedicating incentive payments to some of the underlying fundamentals associated with the managed care delivery system. There are currently a very large number of plans subject to Corrective Action Plans (CAP) with 20 MCPs placed under a CAP as of December 2020 for noncompliance with the Annual Network Certification requirements.<sup>1</sup> MCPs continue to rely heavily on alternative access standards (AAS); as of December 2020, DHCS was still in the process of reviewing approximately 15,000 AAS requests.<sup>2</sup> **To date, the state has never offered plans an incentive payment for achieving or exceeding network adequacy standards. Given the necessity of keeping an adequate network and meeting time-and-distance standards for all Medi-Cal beneficiaries, the CMA suggests that incentive dollars be provided to plans that not only meet but exceed their minimum requirements in these critical access measures.**

### 5.2.10 Access Rights

In Medi-Cal managed care, the health plans are responsible for providing language access but generally pass this obligation on contractually to the physician. (42 C.F.R. §438.10.) While this language specifically requires that the plan provide interpreters at no cost to members, it is silent as to the provider's obligation to pay for those services. **CMA urges that the financial burden of providing access to interpreters for limited English proficient patients not be borne by physicians and we request that DHCS modify this section so that physicians' language services to their patients be fully reimbursed by MCPs.**

Additionally, we note that many MCPs do not have the ability to provide access to interpretation services on short notice. Patients do not necessarily notify physicians that they need interpretation services prior to their appointment. Physicians are often unable to secure same day interpretation services from the plan. Even when advance notice is given, it is very rare that live, in-person interpretation services are provided by the plan instead of phone services. **MCPs should be required to prioritize live, same-day interpretation services in all threshold languages, to arrange and facilitate these services for the appointment, and to pay for these services.**

### 6.3 Member Emergency Preparedness Plan

Protecting the financial viability of medical practices during an emergency is of the utmost importance, as the loss of physician practices, especially in rural and remote areas, will exacerbate the access to care crisis and will make it very difficult for a community to recover. As a result of the pandemic, California stands to lose critical health care infrastructure, and health plans and insurers will be unable to maintain their physician networks in order to meet the demand for care. Health plans and insurers have an obligation to maintain physician networks, however, the economic strain of the COVID-19 crisis threatens the pool of physician practices available to participate in certified networks created by health plans and

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<sup>1</sup> <https://www.dhcs.ca.gov/Documents/MCQMD/2020-December-Corrective-Action-Plan-Report.pdf>

<sup>2</sup> <https://www.dhcs.ca.gov/Documents/MCQMD/2020-December-Alternative-Access-Standards-Report.pdf>



insurers. **DHCS should include a provision in its MCP contracts requiring plans to have procedures in place to support providers during declared state or national emergencies, and should seek all necessary federal approvals to implement this.**

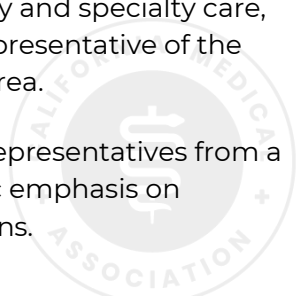
In addition, the capitation rates paid by DHCS should be used for clinical services and not be reported as higher earnings by health plans and insurers. Recently, there has been national press that health plans and insurers are seeing massive profits during the pandemic due to the fact that the costs of the coronavirus pandemic were offset by the cancellations of routine medical appointments and elective surgeries. MCPs should provide necessary financial assistance and resources to physician practices facing financial hardship and lost revenue during emergency situations in order to ensure they are able to maintain their physician networks and they are spending funds on clinical services. These could be in the form of grants or the provision of necessary resources such as PPE.

### **Need for Physician Clinical Advisory Committee**

While the draft RFP requires each of the contracting MCPs to have various committees or community advisory bodies, there is no requirement for each MCP to maintain a clinical advisory body composed of a broad representation of its contracted provider network. CMA requests that such a requirement be included in the RFP, along with specific directives that will serve to make this body an active participant in the overall clinical activities of the MCP. Language is suggested below and similar to language in the draft RFP under the Community Advisory Committee (5.2.11 Cultural and Linguistic Programs and Committees). Suggested language modified below:

#### Physician Clinical Advisory Committee

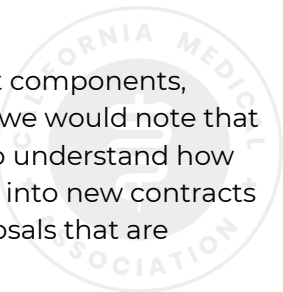
1. Contractor must have a diverse Physician Clinical Advisory Committee (PCAC) to implement and maintain quality improvement programs within the provider network as well as review clinical opportunities to improve, enhance or otherwise include additional support for high-quality medical care. The Committee may also advise the MCP on the plan's utilization control, case management and other related clinical activities.
2. Membership and Meetings
  - a. The Contractor must convene a PCAC of at least twelve (12) network providers, three (3) of whom shall be chosen to sit on the Contractor's Governing Board. Providers selected shall include representation in primary and specialty care, large group and individual practice modalities as well representative of the geographic, cultural and linguistic needs of the service area.
  - b. The Contractor shall make good faith efforts to include representatives from a variety of clinical practices and modalities, with a specific emphasis on providers serving Medi-Cal or other vulnerable populations.



- c. The Contractor shall select members to the PCAC no later than 180 days from the effective date of this contract.
  - d. Should a member resign, is asked to resign, or otherwise unable to serve on the PCAC, Contractor must promptly replace the vacant seat within 60 calendar days of the vacancy.
  - e. The Contractor's Medical Director shall be responsible for overseeing the activities and meetings of the PCAC. A coordinator may assist the Medical Director in the scheduling and administrative activities of the PCAC meetings, but the meetings shall be chaired and led by the Contractor's Medical Director.
  - f. PCAC meetings shall be scheduled when a majority of members are able to join and participate, either in-person or electronically, but no less than on a quarterly basis.
3. Duties of the PCAC
- a. The PCAC shall be responsible for reviewing the Contractor's quality improvement strategic plan, objectives, individual measures and data to support its quality improvement activities.
  - b. The PCAC shall be provided an opportunity to advise the Contractor's Medical Director of any new clinical changes that should be made to the plans' utilization control, benefit or case management activities.
  - c. The PCAC shall be allowed to provide advice and input on:
    - i. Medical innovations including new pharmaceutical treatments, diagnostics, procedures or other advances that may benefit the Contractor's members.
    - ii. Priorities in quality activities and the methods by which the Contractor is developing those activities.
    - iii. Any changes the Contractor is making to clinical oversight by the plan or other clinical changes that may impact the contracting provider network.

### **Address Gaps in the Draft Documents**

Finally, we note that the draft is missing a number of critically important components, without which, it is hard to fully evaluate the overall effort. In particular, we would note that the draft documents make little mention of CalAIM, making it difficult to understand how aspects of the Department's highest priority initiative will be embedded into new contracts going forward. Similarly, the draft does not incorporate important proposals that are



included in the budget, such as the new access to dyadic services, doula care benefit, population health management service platform, and community health workers. Finally, the draft does not include detail on the scoring criteria that the Department will use to evaluate potential bidders. Given these omissions, we request that the Department issue new drafts for public review and comment that incorporate stakeholder comments as well as these critical elements.

## **CONCLUSION**

Thank you in advance for your consideration of our comments on DHCS's RFP. California's physicians look forward to working with you to develop strategies and recommendation that improve quality care for Medi-Cal beneficiaries. We hope this letter will serve as guidance as the MCP procurement process continues. If you have additional questions, please contact Jessica Rubenstein, Associate Director of Health Policy, at [jrubenstein@cmadocs.org](mailto:jrubenstein@cmadocs.org).

Sincerely,



Peter N. Bretan, Jr., M.D.  
President  
California Medical Association

