HEALTH CENTER PARTNERS
of Southern California

July 1, 2021

Will Lightbourne, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

**Submitted via electronic mail to CSBRFP8@dhcs.ca.gov**

**Re: Public comments on RFP # 20-10029**

Dear Director Lightbourne:

On behalf of Health Center Partners of Southern California, representing 17 member organizations, including 12 Federally Qualified Health Centers, 4 Indian Health Centers, and Planned Parenthood of the Pacific Southwest, we would like to thank you for the opportunity to offer comments on the **DRAFT *RFP # 20-10029 Medi-Cal Managed Care Plans (MCP)*** released by DHCS on June 1, 2021. Members of this consortium operate over 160 practice sites in five counties, serve 917,000 patients with 3.9 million patient visits per year, and produce $2.2 billion in economic impact to the region and $1.4 billion in savings to Medi-Cal.

We appreciate the hard work and vision you and your team have for Medi-Cal in California through the California Advancing and Innovating Medi-Cal (CalAIM) initiative and the commitment to Medi-Cal system transformation demonstrated in this draft RFP.

**Comments on changes to Medi-Cal Geographic Managed Care model**

As board chair Dr. Patel and I shared during our teleconference with you and Jacey Cooper on June 24, the proposed changes to the Geographic Managed Care (GMC) model, whereby the number of plans is reduced from seven to two, is an issue of concern. The primary concern that our member health centers and I share is that the elimination of managed care plans serving the region may further limit access to care in San Diego County and lack the quality improvement results anticipated by this change.

This membership agrees that a reduction is warranted as the complexity of seven administrative payer processes creates challenges by increasing the administrative burden and cost, while lacking a return on quality outcomes. This planned reduction should be thoroughly analyzed to identify the appropriate number of health plans for the San Diego market to ensure that a competitive market will drive quality outcomes, meet patient expectations, and ensure access standards are met. A radical reduction to two managed care plans will have unintended consequences for our community including:

- Reduction of patient choice of health plan;
- Reduction in patient satisfaction;
- Reduction of health plan focus on quality due to limited plan choice;

- Limitation of competitive negotiations among providers and payers;
- Reduction of provider panels due to lack of negotiation ability;
- Reduction of patient access due to provider panel loss; and,
- Impact upon payer and provider innovation that would advance value-based care/payment due to lack of ability to negotiate.

Four health plans account for 87.5% of Medi-Cal enrollees in San Diego County. Elimination of plans will have a significant impact on access, particularly for low-income seniors and dual eligible members. There is a potential for some Medicare (D-SNP) plans to lose their ability to operate in the county with this change. In addition, the geographic coverage and capacity of plans to manage new enhanced case management (ECM) services under CalAIM is not equal across all plans. Therefore, this change will impact seniors' and dual eligibles' access and choice, if DHCS strips important Medicare plans of their ability to participate in Medi-Cal in San Diego County. Furthermore, upon implementation, this change will impact CalAIM as the exiting Medi-Cal plans will exhibit diminishing engagement, while those plans remaining will have questionable ability and capacity to manage new, complex care systems in CalAIM, to say nothing of new entrant's lack of experience and track record serving the local population.

| San Diego Medi-Cal Plans | Medi-Cal Enrollment as of May 2021 | 2019 AQFS Score |
|---|---|---|
| Community Health Group | 290,174 | 85.79% |
| Molina | 224,025 | 68.95% |
| Care1st / Blue Shield Promise | 106,659 | 58.95% |
| Health Net | 77,869 | 59.47% |
| Kaiser | 58,316 | 92.63% |
| UnitedHealthcare | 23,240 | -- |
| Aetna Better Health | 20,230 | -- |

Health plan quality is a multi-dimensional construct that includes elements of patient engagement, patient satisfaction, health plan design and benefit offerings, clinical care, coordination of care, access, and payer-provider relationships. As the intermediary between patients and providers, health plans do not have a direct impact upon quality unless they have the mechanisms in place to thrive through balanced competition, accountability, and the alignment of quality outcome expectations with value-based purchasing reform.

Our understanding is that the focus of the Medi-Cal leadership is to improve quality outcomes for patients through the reduction of plans. Health Center Partners of Southern California is dedicated to patient care and quality as its members serve the most vulnerable of populations and produce

impressive quality outcomes while maintaining costs. The concern of improving quality by limiting choice is that quality is consistent within today's seven-payer market, suggesting that there are foundational changes needed to the expectations of the payer community outside of reduction. When analyzing 2019-2020 HEDIS quality, most payers performed at the fiftieth percentile, therefore reflecting that the historic payer expectations have not incentivized improvements or bred innovation for this community.

In making such changes, we recommend that criteria be established to guide health plan expectations within the San Diego Geographic Managed Care model to include:

- Measurable and sustainable improvements in patient care and health quality outcomes;
- Improvements to network adequacy standards including transparency and accountability in network operations and oversight, and sufficiency of primary care providers, specialists and hospital facilities within and across provider networks;
- Increased and sufficient geographic coverage across the diverse county with access to primary care, specialty care, and hospital facilities, and regarding sufficient access, acceptable travel times, and wait times;
- Limited network disruptions;
- Patient choice;
- Continuity of care; and,
- Increased innovation in value-based care and payment design.

Based on these criteria and a review of current member lives assigned to the plans, we would recommend that at least three plans be allowed in the Geographic Managed Care model. Increasing from two to three plans would make delegation less necessary. Also, we are recommending that delegation authorities be reviewed during any Geographic Managed Care health plan reduction as delegation could make the intended reduction changes null and void as the remaining payers will have the indirect ability to increase the number of plans through delegation.

**Comments on draft RFP**

We have summarized questions and comments on the draft RFP documents in the table below. In addition, we include some general comments that apply to multiple sections of the draft RFP, including:

- In our experience, health plans have individual interpretations of policy as specified in the manage care plan contracts as well as negotiations with DHCS. This leads to unnecessary variability and duplication of efforts at the provider level.

- Managed care plans that operate within the same county should be required to streamline provider training efforts, assessments, and forms to ensure that there is as little operational variation as possible to decrease administrative burden, improve data management and data capture, and care coordination within systems.

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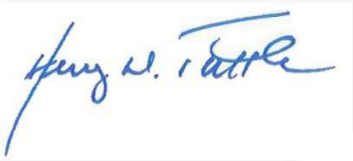
Again, we appreciate this opportunity to submit comments on the draft RFP # 20-10029. Should you have any questions or wish to discuss further, please contact me at your convenience at (619) 542-4343 or by email at htuttle@hcpsocal.org.

Sincerely,



Henry N. Tuttle
President and Chief Executive Officer

cc: Members of the Health Center Partners of Southern California Board of Directors;
Jacey Cooper, Chief Deputy Director and State Medicaid Director, DHCS; and,
Robert Beaudry, Acting President and Chief Executive Officer, California Primary Care Association

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| Fernando Sanudo<br>Vista Community Clinic | | |

| RFP Reference | Section and Page Number | Issue, Question or Comment | Remedy Sought |
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| RFP Main | F, Pg. 16 | I agree that a reduction in the number of health plans in the Geographic Managed Care Model for San Diego is warranted as the complexity of seven administrative payer processes creates challenges which increase administrative burden and cost and lacks a return to quality outcomes. The reduction should be thoroughly analyzed to identify an appropriate number of health plans within the San Diego market to ensure a competitive market that will drive quality outcomes, meet patient expectations, and ensure access standards are met. | I would recommend that at least 3 plans be allowed in the GMC model. I am also recommending that delegation authorities be reviewed during the GMC health plan reduction as delegation could make the reduction changes null and void as payers will have the indirect ability to increase the number of plans through delegation. |
| Exhibit A, Att III | Section 1.1.7, Pg 5 | I appreciate the emphasis on health equity and the inclusion of this provision in the draft RFP. I look forward to working with plans to identify and address health inequities in the communities that HCP members serve. | I ask for more specificity in regard to how plans would turn the spirit of this provision into community-based actions including the engagement or collaborate with subcontractors and providers to carry out this provision, including the inclusion of enforceable and auditable goals. Anything delegated by the plans to providers must be adequately compensated on a PMPM basis. |
| Exhibit A, Att III | Section 2.1.1.A.2), Pg 34 | HCP member health centers often receive inaccurate patient contact information that renders the patient unreachable. | I request that contract language instruct plans to maintain an MIS with correct, current, reachable information on “Members Enrolled with Contractor” and must ensure such data is available to assigned PCPs. |
| Exhibit A, Att III | Section 2.1.1.A.5), Pg 35 | Health center member assignments must be made to the health center site, rather than to the individual PCP provider. | Member assignments must be made to health center by site not to individual PCP providers. |
| Exhibit A, Att II | Section 2.1.2.C, Pg. 35 | Data that health plans submitted to DHCS has been scrubbed and cleaned by clearing houses. The common feedback we hear is that data was removed from the submission form and relevant information was lost. There must be a system that is capable of recovering lost data. | Suggested language:<br>Contractor must put in place a process to recover data that is lost during transmission through data clearinghouses. |
| Exhibit A, Att III | Section 2.1.2.D, Pg. 35 | Data that health plans submitted to DHCS has been scrubbed and cleaned by clearing houses. The common feedback we heard was that data was removed from the submission form and relevant information was lost. A process by which plans provide information and/or training on the form and manner by | Suggested language:<br>Contractor must submit complete, current, accurate, reasonable, and timely Encounter Data to DHCS within 60 calendar days of the date of adjudication of a claim or receipt of an Encounter, |

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| | | which data is reported to the state may improve data loss issue. | or as mandated through federal law, in a form and manner specified by DHCS. Contractor must submit complete, current, accurate, reasonable, and timely Encounter Data to DHCS on at least a monthly basis in a form and manner specified by DHCS. Contractors shall make available to network provider information regarding the form and manner by which data should be submitted to DHCS. Subcontractors and Network Providers must comply with this Section for submission of Encounter Data to Contractor. All Encounter Data must be submitted to Contractor no later than 12 months from the date of service. |
| Exhibit A, Att III | Section 2.1.4.B, Pg. 37 | To ensure seamless care coordination and referral, it is necessary for providers to access the most up-to-date provider network data. | Suggested language:<br>Contractors must make available to network providers these policies and procedures and clearly specify network provider's roles and responsibilities to comply with this Contract. |
| Exhibit A, Att III | Section 2.1.4.D, Pg. 37 | To ensure seamless care coordination and referral, it is necessary for providers to access the most up-to-date provider network data. | Suggested language:<br>Contractor must make available network provider data on its Web site and upon request by its network provider. Contractor must post policies and procedures by product on the contractor Web site. |
| Exhibit A, Att III | Section 2.2.3.A, Pg. 44 | Provider representatives of the QIC must be proportional to the composition of the provider network. | Suggested language:<br>Contractor must ensure that network providers actively participate and are well-represented in the QIHEC or in any medical sub-committee that reports to the QIHEC. The subcontractors and network providers that are part of QIHEC shall be representative of the composition of the provider network including but not limited to, safety net providers including Federally Qualified Health Centers, network providers who provide health care services to members affected by health disparity, limited English proficient (LEP) members, children with special health care needs (CSHCN), seniors and persons with disabilities (SPDs) and persons with chronic conditions. |

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| Exhibit A, Att III | Section 2.2.4, Pg 44 | A concern raised by health centers is that plans may not communicate QIS updates in a timely manner. | Suggested language:<br>Contractor shall develop necessary policies and procedures that detail ways in which QIS updates are to be shared with providers as well as the specified cadence. |
| Exhibit A, Att III | Section 2.2.8, Pg. 48 | While I appreciate DHCS' vision and effort to standardize and ensure plans achieve NCQA accreditation, I do not agree that network providers require NCQA accreditation. This is an extreme duplication of effort. Accreditation is intended to exist at the managed care plan level. If the managed care plan has accreditation, that is inclusive of the plan and network as a whole. This would serve as an unfunded mandate on providers.<br>In addition, I am concerned with the requirement that network providers and subcontractors must achieve NCQA's distinction in multi-cultural health care.<br>Requiring NCQA accreditation will impose administrative burden and/or financial hardship on small to medium size providers. | Remove the requirement that health plan subcontractors achieve NCQA accreditation, and that network providers and subcontractors achieve NCQA's distinction in multi-cultural health care. |
| Exhibit A, Att IIII | Section 2.2.11, Pg. 51 | In practice, credentialing is delegated to network providers, but funding for these administrative actions is not provided.<br>In addition, health centers experience long delays in completing credentialing processes. This is a burden considering existing workforce shortages. | Contractor to reimburse for delegated credentialing activities to network providers on a PMPM basis.<br>I urge DHCS to consider developing a deeming process whereby when a provider is credentialed through another Medi-Cal managed care plan or DHCS process, that provider will be deemed a credentialed provider. |
| Exhibit A, Att III | Section 2.3.D, Pg. 55 | Some health plans, or their plan sub-delegates (e.g., behavioral health vendor), have issues with provider data management – where data at the plan is maintained in silos between credentialing, P4P programs, and/or claims payment systems. This causes claim denials and mistakes in P4P / performance due to inconsistencies in contracted network provider data. The burden of correcting this falls to the provider. | I urge DHCS to consider developing a deeming process whereby when a provider is credentialed through another Medi-Cal managed care plan or DHCS process, that provider will be deemed a credentialed provider. |

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| Exhibit A, Att III | Section 3.3.3 | Ensuring that all contracted health plans offer a P4P program is essential to support meeting quality performance targets. | Contractor *must (change from may) develop and maintain* and incentive payment program and shall compensate network providers through financial incentive program payments. |
| Exhibit A, Att III | Section 4.3.2.B-C, Pg 106 | Plans may have already delegated this function to subcontractor or network providers, or desire to do so. Additionally, it is important that plans share population analytics with contracted network providers, as appropriate. | Suggested language: B. Expanding interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks in support of population health principles, integrated care, and care coordination across delivery systems; details on the interoperability of contractor's MIS will be shared with network provider or make available publicly and<br><br>C. Developing and using predictive population analytics to identify and address members emerging as high risk. Contractor may delegate this function but must ensure delegated entities or subcontractor complies with this section. If contractor delegates this function, it must provide clearly in the agreement for its roles and responsibilities and the subcontractor's roles and responsibilities. Data regarding high-risk members must be shared with appropriate network providers who are the members' assigned care providers. |
| Exhibit A, Att III | Section 4.3.3, Pg. 106 | Race and ethnicity (R/E) should be considered when interpreting health disparities. | I suggest that race and ethnicity should be specified within the requirements listed in this section. |
| Exhibit A, Att III | Section 4.3.4, Pg. 107 | Risk stratification calculation should be clear and not be different to what is already being used at the network provider level. Plans should seek input on the proper tool and algorithm to risk stratify patients. | Specify that risk stratification tool must be developed in consult with network providers. |
| Exhibit A, Att III | Section 4.3.5, Pg. | Add a minimum timeframe for developing and making available a community resource directory. | Specify that contractor develop or provide access to a current and continuously updated community resource directory to the network providers on at least an annual basis. |
| Exhibit A, Att III | Section 5.1.4.E. | Availability of timely encounter data is necessary for management of performance and P4P programs. | Add language that DHCS will review and validate encounter data within 6 months. |

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| Exhibit A, Att III | Section 5.2.11 | Safety net providers play key roles in caring for racially and ethnically diverse community members, and community health centers have long histories of caring for diverse and foreign language-speaking patients. Community health centers must be specifically called out as a representative to plans' cultural and linguistic programs and committees. | Suggested language:<br>2) CAC Membership<br>a) Contractor must convene a CAC Selection Committee tasked with selecting the members of the CAC. The CAC Selection Committee must be comprised of, in equal numbers:<br>i. Persons who sit on contractor's governing board should include representation in the following areas: safety net providers including Federally Qualified Health Centers, behavioral health, regional centers, local education authorities, dental providers and home- and community-based service providers. |
| Exhibit A, Att III | Section 5.6.1.B.3), Pg. 227 | I recommend that DHCS take a thoughtful approach in developing the new state-approved screening tool for referral to specialty mental health services to support timely referral processes for specialty mental health services. | I recommend adding clarifying language to this section. |