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Subject: Draft Request for Proposal #20-10029, Medi-Cal Managed Care Plans

Dear Ms. Soares:

The California Academy of Family Physicians (CAFP) and our more than 10,000 family physicians and medical students appreciate the opportunity to comment on the Department of Health Care Services (DHCS) draft Request for Proposal (RFP) #20-10029. As noted in the background material, DHCS is looking for Managed Care Plans that demonstrate their ability to deliver the following:

- Quality
- Access to care
- Continuum of care
- Children services
- Behavioral health services
- Coordinated/integrated care
- Reducing health disparities
- Increased oversight of delegated entities
- Local presence and engagement
- Emergency preparedness and ensuring essential services
- Addressing the Social Determinants of Health
- CalAIM
- Value-based purchasing
- Administrative Efficiency

Nearly every one of these areas is deeply influenced by how strongly and effectively a health plan supports a comprehensive primary care foundation for every patient. Primary care must be at the heart of the RFP and procurement process. As evidence shows, primary care-oriented systems achieve better health outcomes, promote health equity, increase the supply of primary care providers, and lower costs. Despite this strong evidence, primary care has been chronically underfunded, in part because of a payment system that does not incent primary care. California [spends](#) from 6.1 percent to 10.8 percent on primary care, while the average among OECD countries is 14 percent. A [Commonwealth Fund analysis](#) identified underinvestment in primary care as one of four fundamental reasons the U.S. health system ranks last among high-income countries. It is critical that the State aggressively support primary care if it seeks to bend the cost curve and improve outcomes.

It is also important to know which health plans perform well on key priorities. As has been said so often in management practices, “If you don’t measure it, you can’t improve it.” The RFP is an important opportunity to measure and add greater weight and higher scoring for health plans with a demonstrated commitment to improving health equity, supporting and growing primary care, and ensuring broad access to culturally competent care. CAFP urges you to prioritize these criteria, as they will improve health access and patient outcomes, promote health equity, and reduce health care spending. The following are proposed changes to the RFP that will help achieve these results.

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEMS – Page 34

In DHCS's efforts to develop data-informed policies, CAFP urges you to prohibit health plans from passing on onerous reporting requirements onto individual physicians who should be spending their time providing patient care. Health plans have troves of data, as well as the resources and expertise to aggregate and report on that data. Adding reporting requirements to already over-burdened primary care physician practices will be unsustainable and further limit already inadequately short patient visits.

Family physicians are experts in care coordination and management of high-risk patients who have chronic conditions and comorbidities. However, many physician practices do not have the resources to adequately coordinate the care of these patients and to manage population health. A true population health, patient-centered approach cannot be achieved without ensuring individual clinicians have the support they need to reform care delivery and improve outcomes. Accordingly, CAFP urges DHCS to require MCPs to provide physician practices the financial resources and data needed to support patient-centered, coordinated, comprehensive, equitable care that is central to successfully transitioning to alternative payment and delivery models.

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT – Pages 55-60

Little information is known about the accumulated rates at which a health plan approves or denies requests for services or medication. Patients increasingly face challenges in accessing health care and physicians face significant administrative burdens getting their patients the care that they need. Necessary medical care and medication are often delayed or even abandoned by patients due to prior authorizations and care denials. In Medi-Cal, where access to care is already limited, DHCS should only contract with health plans that ensure no patient is unnecessarily denied care or medication because of byzantine and inappropriate health care policies that save money at the expense of patient health.

As such, CAFP urges DHCS to require health plans to report on the number of times services were modified, delayed, or denied for each of the preceding three years, and the reasoning behind modifications, delays, and denials. This information will be crucial to analyzing trends, providing solutions and correction plans, and overall evaluation of health plan applicants. In particular, CAFP encourages DHCS to focus the collection of this data as it relates to primary care. Primary and preventive care are the only health services where more delivery of care leads to less overall spending and improved outcomes. In primary care, burdensome prior authorization processes and care denials contribute to adverse events for patients and delays in treatment, when instead, Medi-Cal patients should receive high value, timely, and personalized levels of care.

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS – Pages 80-90

CAFP believes DHCS must go further than just requiring a listing of timing of payments and a description of financial incentive programs for physicians. CAFP urges DHCS to require plans to pay for value over volume at the physician level. DHCS has the potential to address many of the complex challenges facing California's most vulnerable residents through payment and delivery reform. However, payment and delivery reform must be done at both the plan and provider level. DHCS will fall short of its goals if it is simply delegating responsibilities to health plans without supporting payment and delivery reform at the provider level. As such, CAFP urges DHCS to require plans and their delegated entities to transition their downstream payments from fee-for-service to alternative payment models. Without this requirement, California will only be making a superficial impact on reforming the current payment and delivery system.

In addition, CAFP urges DHCS to require plans to align payments and measurements with those established by current prospective, risk-adjusted models in use in California and nationally. Efforts on primary care payment reform have been isolated, limited, inconsistent, and disjointed and disjointed efforts will not achieve the necessary changes to our health care system. To make impactful, overall health care system changes, and to reduce administrative burdens, alignment among plans on a primary care payment reform model, practice transformation investments, and quality measurements (EXHIBIT A, ATTACHMENT III – 2.2 – Page 5) and reporting must be achieved. By harmonizing programs, it will incentivize additional providers to pursue these reforms, harmonize quality metrics and reporting obligations, and decrease administrative burden.

Finally, CAFP asks DHCS to require plans to report on:

- 1) The percentage of total spending and spending amount each applicant dedicates to support and incentivize primary care.
- 2) The level of primary care participation and results of the financial incentive programs offered.

Primary care alternative payment models have proven results. In a primary care initiative launched by the self-insured Fresno Unified School District and the California Academy of Family Physicians that included an alternative payment model, the district saved nearly \$1 million and health outcomes and patient satisfaction improved significantly one year after the launch of the initiative. Savings were in part due to a three percent decrease in emergency department visits and a 22 percent decrease in inpatient admissions. The initiative continues to expand to this day. Other states that have invested in primary care have also seen significant reductions in expenditures. Oregon found that every \$1 increase in primary care expenditures resulted in \$13 in savings in other services, such as specialty care and emergency department and inpatient care. In addition, Oregon saved an estimated \$240 million over the first three years of the initiative.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE – Pages 106-128

CAFP supports DHCS' efforts to promote population health management and coordination of care. Population health management and care coordination involve a proactive, team-based approach to care that focuses on prevention, early intervention, and close partnerships with patients to tightly manage chronic conditions. This results in better health outcomes and lower overall costs. Population health management and coordination of care are the core of the patient-centered medical home (PCMH) and other advanced primary care models. However, it requires significant clinical and nonclinical hours to manage and rarely receives sufficient financial support. Accordingly, CAFP urges DHCS to require health plans to report on how they are supporting provider transition to advanced primary care models, including through financial resources and usable data. Plans should also report on the proportion of practices with which they contract that are advanced primary care models, including PCMHs.

In addition, while CAFP appreciates the requirement that plans “[s]ubmit policies and procedures for identifying Members in need of preventive services and increasing appropriate utilization of preventive services,” we believe more fruitful information would include more than just a submission of “policies and procedures,” and would also include information detailing a record of support and success in achieving increased delivery of preventive services, easy and available referrals to subspecialists, well-managed care coordination, and reduced hospitalizations, among other measures.

Finally, the RFP should require plans to describe how they support extended visits for enrollees with their primary care physician and describe what support they offer to practices to co-locate physical

and behavioral health services. Family physicians receive extensive training in behavioral health, but do not have the time during visits to address all of the patients' needs.

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE – Pages 14-16

CAFP urges DHCS to hold health plans more accountable for ensuring adequate networks and timely access to care. Several recent [reports](#) from the State Auditor have detailed the challenges patients face accessing care, particularly in [rural regions](#). These reports are especially concerning given that they were not a comprehensive assessment of all regions. For decades, family physicians have faced obstacles when referring patients for subspecialty care. Often there is no immediate access, and the care that is available requires patients to travel hours away for the services and care they need, which is particularly difficult for Medi-Cal patients. When surveyed, our members indicate a dearth of neurologists, endocrinologists, psychiatrists, rheumatologists, pain management specialists, and orthopedists. Imaging services are also particularly hard to obtain.

Of additional concern, telehealth appears to be an afterthought throughout the RFP. It is essential that comprehensive telehealth coverage and payment be supported by health plans. The telehealth flexibilities provided during the COVID-19 public health emergency have been vital to ensuring that physicians can continue providing care while keeping patients and physicians and their staff safe. It has also made some of the services provided even more accessible to patients. Patients value the option to access health care services via telehealth, and they will continue to expect telehealth options after the pandemic ends. Moreover, tremendous progress and investments have already been made by providers to implement telehealth. As such, it is essential that the flexibilities afforded during the pandemic are made permanent to ensure timely care remains an option, especially for patients who face transportation, geographic, and other barriers to accessing services. This includes continued payment parity for both audio-video and audio only visits. Paying providers less for the same service solely because there is no video technology ignores the reality that Medi-Cal patients are using, and sometimes prefer, audio visits.

Moreover, CAFP urges that audio visits for new patients must also be reimbursed. Patients who use Medi-Cal should have the same access to telehealth modalities as those with commercial insurance. These patients should not be required to have a face-to-face visit prior to being able to access services using telehealth. Restricting the availability of audio visits to established patients, with no clinical justification, limits options for Medi-Cal enrollees if they do not have access to video conferencing technology, reliable internet service, or adequate mobile phone data plans. This will prevent many Californians from establishing care, causing them to delay care or forgo care altogether, leading to worse health outcomes.

Thank you for your attention to these concerns, and your dedication to providing California's most vulnerable populations with accessible, high-quality care. If you have any questions, please contact CAFP Legislative Advocates Bryce Docherty at bdocherty@tdgstrategies.com or (916) 769-0573 or Vanessa Cajina at vcajina@ka-pow.com or (916) 448-2162.

Sincerely,



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