June 30, 2021

Jacey Cooper
Chief Deputy Director Health Care Programs and State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue, Sacramento, CA 95814

Sent via email: CSBRFP8@dhcs.ca.gov

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

Dear Ms. Cooper:

California's hospitals support DHCS' goals of focusing on reducing health disparities, increasing oversight of delegated entities and their local presence and engagement, and expanding access to high-quality care. During this period of reform in the Medi-Cal program, it is vital that managed care contracts are robust enough to provide the needed assurances to successfully implement the California Advancing and Innovating Medi-Cal (CalAIM) initiatives.

For these reasons, and on behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) is pleased to submit comments on the draft Request for Proposal #20-10029, Medi-Cal Managed Care Plans, released for public comment on June 1.

California has committed to Medi-Cal managed care as the delivery system of choice. Today, more than 10 million beneficiaries are enrolled in Medi-Cal managed care, and as DHCS estimates, the program is expected to surpass more than 12 million beneficiaries by 2022. Medi-Cal managed care enrollment accounts for more than 15% of the national Medicaid and Children's Health Insurance Program enrollment — more than the total populations of 44 states. The magnitude and historic perspective are not lost on hospitals, and the reality is, many of the existing health plans have not gone through a competitive procurement process in decades. The process that DHCS will lead in selecting its health plan partners should be a thorough, transparent endeavor to ensure that health plans, providers, county partners, and beneficiaries trust the selection process.

To support the overarching goal of building trust in the process, based on the feedback from our members, CHA's comments, beginning on page 3, reflect a set of guiding principles:

1) Increase oversight and network adequacy requirements of delegated entities
2) Ensure timely and accurate payments to providers
3) Strengthen and clarify the requirements that what occurs in Medi-Cal fee-for-service (FFS) is the bare minimum for health plans
4) Increase accountability through greater specificity and more transparency

The overarching goal — building trust in the process — should not only apply to the commercial health plan procurement but should also extend to the department's decisions on approving county model changes. As you are aware, many of the local regions and counties that have submitted a letter of intent have already approached the stakeholder community, seeking to obtain their support for these changes. Hospitals understand there are many steps in the process between now and October and that there is no guarantee of approval; however, providers are being put in difficult situations where there is no clear line of sight into the process.

Even assuming a county can obtain the necessary local and state approvals, the process for obtaining the necessary federal approvals is unclear. Amending federal statute for a California-specific provision is a complicated task in the climate of Washington, DC. For counties required to obtain these federal changes, this could easily become a very lengthy process, and stakeholders need to understand how these federal timelines will be considered in the final RFP. If federal authority or approvals cannot be obtained, what does a "Plan B" look like, especially for proposed single plan only model changes? As DHCS refines its internal expectations and processes, it is critical that regular updates be shared with the stakeholder community. As questions remain unanswered, the void is being filled by politics and misinformation, which does not inspire the trust or collaboration at the local levels that will be needed to successfully implement CalAIM.

CHA appreciates the opportunity to comment on the draft RFP and sample contract. While our comments express the importance of a robust contract and our desire to see greater accountability of the plans, we also want to acknowledge the significant strides made by the department with this sample contract. Compared to the current contract, there have been considerable changes that we believe are a step in the right direction. Unfortunately, due to the timing of this draft RFP release, some significant elements are not available for public review — most notably, many of the CalAIM requirements, state budget decisions and their accompanying trailer bills, the narrative proposal requirements, and DHCS' evaluation and scoring criteria. Therefore, our comments on the draft RFP should be viewed as incomplete. These comments pertain only to the draft documents available for review. ***For a more complete process, we respectfully request that DHCS solicit public feedback on these missing elements before a final RFP is released later this year.***

Starting on page 3, you will find our feedback in the requested specific format. This feedback is based on several workgroups comprised of hospital managed care contracting experts; CHA's member forum on this topic, where nearly 100 hospitals participated; and the extensive feedback received by our regional hospital association partners.

Once again, CHA appreciates the opportunity to provide comment. If you have any questions, please do not hesitate to contact me at rwitz@calhospital.org or (916) 552-7642.

Sincerely,

/s/

Ryan Witz
Vice President, Health Care Financing Initiatives

CHA Comments on Draft Request For Proposal #20-10029, Medi-Cal Managed Care Plans

RFP Reference	Section Page #	Issue, Question, or Comment	Remedy Sought
Exhibit A, Attach I	1.0, Page 1	Request to add "Administrative Day" to the contract. Currently, health plans do not universally recognize this service as a covered service under the Medi-Cal program.	Add the following definition (source: DHCS): "Administrative days" are inpatient stay days for recipients who no longer require acute hospital care and are awaiting placement in a nursing home or other subacute or post-acute care. In accordance with California Code of Regulations, Title 22, Sections 51542 and 51511, a DP/NF-B of an acute care hospital will receive the lesser of its projected costs or the DP/NF-B median rate as their Administrative Day rate. Acute care hospitals without a DP/NF-B will receive the facility-specific rate as their Administrative Day rate.
Exhibit A, Attach I	1.0 Page 6	Request to clearly define "Covered Services" to include all Medi-Cal full scope services provided by Medi-Cal fee for service (including EPSDT), unless expressly omitted under state Law, California State Plan, this contract, and All Plan Letters. An example of a benefit expressly omitted could be Medi-Cal Rx or the major organ transplants for non-Whole Child Model counties.	Request to clarify or add a "catch-all" phrase that Covered Services include all Medi-Cal full scope services provided by Medi-Cal fee for service (including EPSDT), unless expressly omitted under state law, California State Plan, this contract, and All Plan Letters. This could be within the body of the definition or included after the specific (A) through (T) provisions.
Exhibit A, Attach I	1.0 Page 11	Request to add "General Acute Care hospital."	Add the following definition: "General Acute Care hospital" as defined under subdivision (a) of section 1250 Health and Safety Code.
Exhibit A, Attach I	1.0 Page 9	Request to add "Directed Payment."	Add the following definition: "Directed Payment" as defined under 42 CFR 438.6(c)

Exhibit A, Attach I	1.0 Page 18	Correct typo on Page 18, Pass-Through Payment	Reference should be 42 CFR 438.6(d) not 42 CFR 438.6(a)
Exhibit A, Attach I	1.0 Page 23	Request to amend "Safety Net Provider."	Amend the following definition: "Safety Net Provider" – "means any **public or private** Provider of comprehensive Primary Care or acute hospital inpatient services that provides services to a significant number of Medi-Cal recipients, receive charity, and/or are medical indigent, in relation to the total number of patients served by the Provider. **At a minimum, this definition shall include all Disproportionate Share Hospitals (DSH), as determined annually by DHCS."**
Exhibit A, Attach I	2.0 Page 27	Add "DPL" acronym	"DPL": Dual Plan Letter
Exhibit A, Attach I	2.0 Page 27	Add "DP-NF" acronym	"DP-NF": Distinct-Part Nursing Facility
Exhibit A, Attach I	2.0 Page 28	Add "D-SNP" acronym	"D-SNP": Dual Special Needs Plan
Exhibit A, Attach I	2.0 Page 28	Add "GME" acronym	"GME": Graduate Medical Education
Exhibit A, Attach III	1.1.4 Page 4	Contract Performance — request to define "adequate." Previously, the contract language included in this provision "sufficient to result in the effective conduct of the plan's business," which is similarly vague.	Request to define "adequate."
Exhibit A, Attach III	1.1.11 Page 9	Diversity, Equity, and Inclusion Training — please clarify this provision, as currently written, would apply to "all Contractors, Subcontractors, and Network Providers."	Request to clarify and amend. Does this requirement apply to **all** hospital staff (assuming they are in network)? Tens of thousands of people who work at hospitals who could interact with a Medi-Cal beneficiary. Not all are staff; for example, private hospitals cannot employ physicians due to a corporate practice ban in state law. Therefore, would a Network Provider that is a hospital be responsible for ensuring their independent contractors (i.e., doctors) who provide services to the

			Medi-Cal beneficiaries also receive this training? We recommend excluding Network Provider or clarify and narrow the requirement.
Exhibit A, Attach III	1.2.1 Page 11	Financial Viability and Standards Compliance — please clarify if the Tangible Net Equity (TNE) cross reference in 28 CCR section 1300.76 applies to Gold Coast Health Plan.	Request to amend this requirement to specify the requirement also applies to those not regulated by DMHC or include a reference to the 28 CCR section 1300.76 requirements.
Exhibit A, Attach III	1.2.2 Page 12	Contracts Financial Reporting Obligations — as one hospital system and one independent rural hospital shared with CHA during the COVID-19 pandemic, there is a growing issue with hospitals experiencing significant delays in receiving payments from plans even when determined it is a "clean claim." Included below is a real snapshot of accounts receivable balances for these two entities.	Request to expand the reporting requirements in Schedule F: Unpaid Claims Analysis. At a minimum, it should delineate the specific ranges for how long claims are pending payments (61-90, 91-120, etc.). Additionally, Schedule F should include a requirement for plans to explain why claims are not being paid within a timely manner (less than 60 days).

Example A

System: 17 hospitals
Location: Northern CA, Central Valley, LA
Gross Revenue (in thousands)

Payer	Not Aged	1-30	31-60	61-90	91-120	121-180	180+	Total	>30 Days	>60 Days
LA Care	$2,458	$39,840	$20,892	$9,184	$6,490	$12,267	$29,294	**$120,425**	**$78,127**	**$57,235**
Health Net	$2,893	$38,060	$11,168	$7,511	$4,862	$4,908	$13,853	**$83,255**	**$42,302**	**$31,134**
Kern	$2,953	$25,966	$12,468	$4,622	$2,226	$2,882	$4,746	**$55,863**	**$26,944**	**$14,476**
Blue Cross	$3,546	$34,348	$13,183	$3,273	$1,621	$3,488	$8,999	**$68,458**	**$30,564**	**$17,381**
CA Health and Wellness	$2,003	$12,331	$4,733	$2,335	$2,684	$6,798	$7,322	**$38,206**	**$23,872**	**$19,139**
Partnership	$814	$17,499	$6,739	$1,238	$951	$1,293	$3,033	**$31,567**	**$13,254**	**$6,515**
Healthplan of San Joaquin Mcal	$737	$11,114	$4,162	$2,064	$847	$791	$4,761	**$24,476**	**$12,625**	**$8,463**
Gold Coast	$412	$7,228	$5,740	$3,548	$1,731	$1,480	$723	**$20,862**	**$13,222**	**$7,482**

Example B

Hospital/System: 1 hospital
Location: Northern CA
Gross Revenue (actuals)

Payer	Not Aged	1-30	31-60	61-90	91-120	121-180	180+	Total	>30 Days	>60 Days
Medi-Cal Managed Care	$694,585	$360,458	$313,427	$198,964	$154,471	$80,718	$471,374	$2,273,996	**$1,218,953**	**$905,526**

Exhibit A, Attach III	1.2.5 Page 15	Medical Loss Ratio (MLR) — request that these annual reports are made public by either the contractor or DHCS, and this requirement is included in the contract.	As the Office of Health Care Affordability (OHCA) is implemented, this effort will complement the transparency efforts undertaken by the Office and will clarify the "net cost of health coverage" assumed in the Medi-Cal managed care rates.
Exhibit A, Attach III	1.2.5 Page 15	Medical Loss Ratio (MLR) — request that any MLR calculations occur at rating region level, not allow for aggregation across all health plan servicing areas.	The OHCA will establish health care cost targets (including net cost of health coverage) at a sector and/or geographic region. Therefore, any aggregation by health plans servicing more than one region or county in the Medi-Cal program will not align with the geographic regions established by the OHCA. These calculations would compete with the OHCA's calculation and could result in different/duplicative administrative penalties should the plan exceed the cost target or miss the MLR requirements set forth under this contract.
Exhibit A, Attach III	1.2.5 Page 15	Medical Loss Ratio (MLR) — request that specific timelines be added to this provision.	There is nothing included in the contract that pertains to the timeline expected to complete the MLR work. CHA recommends aligning the timeline required in the contract with that of the OHCA's expectations of reporting by 12/31 of every year.
Exhibit A, Attach III	1.2.5(e) Page 15	Medical Loss Ratio (MLR) — request to strike "Network Providers" in the 42 CFR 438.6(d) passthrough payment section, and to add Graduate Medical Education (42 CFR 438.6).	There is no federal requirement for providers that receive passthrough payments to be in network. Lastly, an allowable directed payment could be Graduate Medical Education. This should be added.
Exhibit A, Attach III	1.2.5(G) Page 20	Medical Loss Ratio (MLR) — request to specify that MLR calculations are by rating region, not aggregated over the entire plan.	Same note as above regarding the OHCA.

Exhibit A, Attach III	2.1.1 Page 34	Management Information System Capability — will the contractual requirements include interfacing with the OSHPD All Payer Claims Database? What about the payer reporting requirements to the OHCA?	Suggest clarifying these new and expanded reporting requirements in 2.1.1(A).
Exhibit A, Attach III	2.1.2 Page 35	Encounter Data Reporting — request to add a new provision specifically for managed care directed payments.	Add the following new provision: "Contractor is responsible for submitting complete, accurate, reasonable, and timely Encounter Data to DHCS, which includes the Encounters related to the Managed Care Directed Payments (as approved by CMS and permitted through 42 CFR 438.6(c)). Contractor shall work with Subcontractors and Network Providers to reconcile the applicable Encounter Data within the timelines as specified by DHCS."
Exhibit A, Attach III	2.1.2 (F) Page 36	Encounter Data Reporting — request to amend existing (F).	Amend the following provision: "If DHCS finds **or is notified by a Subcontractor or Network Provider of** deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Encounter Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Encounter Data, Contractor must ensure that corrected Encounter Data is resubmitted within 15 calendar days of the data of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Encounter Data, **which shall include any potential recalculations of Managed Care Directed Payments that are dependent upon the Encounter Data**."
Exhibit A, Attach III	2.1.2 (G) Page 36	Encounter Data Reporting — request to amend existing (G).	Amend the following provision: "DHCS or its agent will periodically, but not less frequently than once every three years,

			conduct an independent audit of the Encounter Data submitted by, or on behalf of, Contractor, in accordance with 42 CFR section 438.602(e). **The independent audit will include an analysis of the Contractor's compliance with submitting applicable Encounter Data that supports Managed Care Directed Payments to Network Providers."**
Exhibit A, Attach III	2.1.4 Page 38	Network Provider Data Reporting — request to add new provision (G) specifically for managed care directed payments.	Add the following new provision (G): "Contractor is responsible for submitting complete, accurate, reasonable, and timely Network Provider Data to DHCS, which includes the Network Provider status related to the Managed Care Directed Payments (as approved by CMS and permitted through 42 CFR 438.6(c)). Contractor shall work with Subcontractors and Network Providers to reconcile the applicable Network Provider Data within the timelines as specified by DHCS."
Exhibit A, Attach III	2.1.4 (F) Page 38	Network Provider Data Reporting — request to amend existing (F).	Amend the following provision: "If DHCS finds **or is notified by a Subcontractor or Network Provider of** deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Network Provider Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Network Provider Data, Contractor must ensure that corrected Network Provider Data is resubmitted within 15 calendar days of the data of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Network Provider Data, **which shall include any potential recalculations of Managed Care Directed Payments that are dependent upon the Network Provider Data**."

Exhibit A, Attach III	2.1.8 Page 41	MIS/Data Correspondence — request to add to the end of the paragraph the following requirement. This information should be made publicly available, so that providers who may be adversely impacted by reductions of revenue from utilization-based directed payments will understand the additional requirements the plan is undergoing with DHCS to return to compliance.	Request to add to the end of the paragraph: "…If DHCS requests revisions, Contractor Must submit a revised Corrective Action plan for DHCS' approval within 15 calendar days after receipt of the request. Contractor's failure to complete the Corrective Action plan as approved by DHCS shall subject it to sanctions, pursuant to Exhibit E. Section 1.19 (Sanctions). **DHCS will publicly disclose on the DHCS website any Contractors that have entered into Correction Action plans, or that have been subject to sanctions due to non-compliance."**
Exhibit A, Attach III	2.2.1 Page 43	Accountability — please clarify what metrics are included in a QIHEC review and who will audit any findings.	Request to include clarification language.
Exhibit A, Attach III	2.2.1 (D) Page 43	Accountability — request to add specific references to types of Network Providers that should be consulted in developing QIS.	Request to amend (D): "The participation **of a broad range of** Network Providers**, including but not limited to hospitals, clinics, and physicians,** in the process of QIS development and performance review."
Exhibit A, Attach III	2.2.2 (A) Page 43	Governing Board — request to ensure QIS and annual report are made public.	Request to amend (A): "Approving the overall QIS and the annual report of the QIS**, which shall be made available to public."**
Exhibit A, Attach III	2.2.5 Page 45	Delegation of QI Activities — request to add new (C) to ensure contact information of actual individuals is regularly updated so there are open lines of communication and tracking of issues brought to the health plan.	Request to add new (C): "Contractor shall maintain a public contact list for the QIS staff, including but not limited to staff names, phone numbers, and email addresses."
Exhibit A,	2.2.7 Page 47	Quality Improvement and Health Equity Annual Report —request to add new (D) to	Request to add new (D):

Attach III		ensure the annual report is made public. Question and request for clarification: how will this annual report align with the community needs assessment already filed by hospitals to OSHPD?	**"Contractor shall publicly post the annual report on Contractor's website, following submission to DHCS."**
Exhibit A, Attach III	2.2.10 Page 51	Disease Surveillance — request to include a requirement within the procedures that includes notification of Network Providers, including but not limited to hospitals and health systems.	Request to add new: "Contractor shall implement and maintain procedures for reporting any serious diseases or conditions to public health authorities **and Network Providers** and **shall** implement directives from the public health authorities as required by law."
Exhibit A, Attach III	2.3(D) Page 55	Utilization Management Program — request to add new (D) to ensure the training is available for new Network Provider staff. Given challenges with staffing turnover, there is no guarantee that staff trained at the start of the executed contract remain for the life of the contract.	Request to amend (D): "…within 30 calendar days of contracting with a Network Provider, **or upon the request of a Network Provider."**
Exhibit A, Attach III	2.3 Page 55	Utilization Management Program—to add a new section, (J) which shall require the Contractor to use the 42 CFR Section 438.114 Emergency and Post stabilization Services definition as "emergency medical condition."	Ensure consistency with the Utilization Management Program requirements that assume the 42 CFR Section 438.114 citation for emergency medical condition. Request to add a new (J). "Contractor must implement UM activities that assume the criteria required under 42 CFR Section 438.114 for evaluating emergency medical condition. This requirement is also referred to as the "prudent layperson" standard and citation."

Exhibit A, Attach III	2.3.1(E) Page 57	Prior Authorizations and Review Procedures — request to ensure retroactive authorizations are not using a different set of criteria as prior authorizations.	Request to amend E: **"Retroactive authorizations shall be evaluated and approved or disapproved using the same criteria as used for prior authorizations."**
Exhibit A, Attach III	2.3.1(F) Page 58	Prior Authorizations and Review Procedures — request to define "well-publicized" and to require the Contractor to include the appeals procedure in the Provider Manual.	Request to define "well-publicized." Additionally, the contents of the Provider Manual (3.2.4) should include "member grievance and appeal process," and we request the inclusion of "provider grievance and appeal process" as well.
Exhibit A, Attach III	2.3.1(G) Page 57	Prior Authorizations and Review Procedures — request to define "timely."	Request to define "timely." In the spirit of aligning with CalAIM's key goal, the contract should include a standard that is adhered to by all plans, not interpreted differently.
Exhibit A, Attach III	2.3.1(J) Page 58	Prior Authorizations and Review Procedures — request to specify a time period in (J) for the Contractor to comply with notifying a Provider when the Service Authorization is less than requested.	Request to provide greater clarification.
Exhibit A, Attach III	2.3.1(K) Page 58	Prior Authorizations and Review Procedures — request to clarify that parity is more inclusive than just 42 CFR 428.910.	Request adding to the only reference to 42 CFR 438.910. Should include additional references to 42 CFR 438.900, 438.905, 483.915, and 483.920.
Exhibit A, Attach III	3.1.2 Page 64	Ensuring Compliance — request to amend existing language where the Contractor should be required for establishing policies and procedures for when a Network Provider flags non-compliance from a delegated entity or Subcontractor.	Request to amend: "Contractor must maintain policies and procedures, approved by DHCS, to ensure Network Providers and Subcontractors fully comply with all applicable terms and conditions of this Contract. **Within the Contractor's policies and procedures there must be a process for obtaining feedback from Network Providers when a Subcontractor has failed to comply with the specified requirements, which shall**

			include a written disclosure from the Contractor to DHCS, when confirmed. Contractor shall…"
Exhibit A, Attach III	3.1.4 Page 65	Requirements for Network Provider Arrangements and Subcontractor Agreements — It is our understanding that not all the requirements currently under APL 19-001 and APL 19-001 Attachment A are included in this new definition 3.1.4. Can DHCS clarify if this is the case?	If the requirements for a Network Provider Agreement are changing, we urge DHCS to release subsequent guidance either through an amended APL 19-001 and Attachment A, or a new APL that supersedes APL 19-001. This APL should be released well in advance to allow for providers to comply with the changes.
Exhibit A, Attach III	3.1.4(A) Page 65	Requirements for Network Provider Arrangements and Subcontractor Agreements —request that DHCS include the specific Title 22, CCR citations that are included as references in the APL 19-001 and Attachment A in this contract.	Request to include Title 22 CCR citations within this contract. For example: "A. Network Provider Agreement Requirements 1) Specification of the Covered Services to be ordered, referred, or rendered. **Citation: Title 22, CCR, Sections 53250(c)(1) and 53867.** 2) Specification of the term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, Phaseout, and termination. **Citation: Title 22, CCR, Sections 53250(c)(4) and 53867.** …"
Exhibit A, Attach III	3.1.5 Page 71	Financial Viability of Network Providers and Subcontractors — request to add "hospitals" to the requirements.	Request to add "hospitals" after "medical groups."
Exhibit A, Attach III	3.1.7 Page 71	Network Provider Agreements with Safety-Net Providers —updating the definition of Safety-Net Providers will allow for all DSH hospitals to be considered in this section.	Request to update definition of Safety Net Providers to include DSH hospitals, at a minimum.

Exhibit A, Attach III	3.1.8 Page 72	DHCS Approval of Network Provider Agreements and Subcontractor Agreements —request to add a specific provision that holds DHCS accountable to a timely review and approval.	Request to add the following: "DHCS shall review and issue approval or denial to the Contractor within 30 days of receipt of Network Provider Agreements and Subcontractor Agreements."
Exhibit A, Attach III	3.2.4 Page 77	Contractor's Provider Manual — request to specify a requirement to include the Prior Authorizations and Review Procedures (2.3.1(F)) as a new section.	Request conforming amendments to ensure the "Provider Grievance and Appeal Process" is included.
Exhibit A, Attach III	3.2.4 Page 77	Contractor's Provider Manual — request to clarify that plans cannot impose additional obligations on providers (including administrative obligations) or implement any changes that reduce reimbursement to providers, without following the contract renegotiation process.	Request including the requirement that: "Contractor shall not implement changes through the Provider Manual that impose additional obligations on providers, including but not limited to, changes that may potentially reduce reimbursement, without following the explicit contract renegotiation process specified under this contract."
Exhibit A, Attach III	3.2.5 Page 77	Network Provider Training — please clarify when this requirement includes the following: "Contractor shall ensure that **all** Network Providers receive training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contract and all applicable federal and state statutes...."	Request to clarify and amend: Does this requirement apply to **all** hospital staff (assuming they are in network)? Tens of thousands of people who work at hospitals who could interact with a Medi-Cal beneficiary. Not all are staff; for example, private hospitals cannot employ physicians due to a corporate practice ban in state law. Therefore, would a Network Provider that is a hospital be responsible for ensuring their independent contractors (i.e., doctors) who provide services to the Medi-Cal beneficiaries also receive this training? We recommend clarifying this requirement for Network Provider training.

Exhibit A, Attach III	3.2.5(D) Page 77	Network Provider Training — request to add the expectation of frequency of trainings for Network Providers.	Currently, there is no expectation on the frequency of these trainings offered by the Contractors.
Exhibit A, Attach III	3.3.3(A)(2) Page 80	Provider Financial Incentive Program Payments — request to remove the limiting requirement in (A)(2), which references APL 19-005. This APL only applies to FQHCs and RHCs and would limit the plan's ability to implement Financial Incentive Program Payments to non-FQHC/RHC providers.	Request to strike 3.3.3(A)(2).
Exhibit A, Attach III	3.3.5 Page 81	Claims Processing — request to add "Subcontractor" to clarify that the requirements extend to delegated entities.	Request to add "and Subcontractor(s)" after every reference of "Contractor" in 3.3.5(A)-(D).
Exhibit A, Attach III	3.3.5 Page 81	Claims Processing — request to define "clean claims."	Request for DHCS to define clean claims as follows: A clean claim is a submitted claim without any errors or other issues, including incomplete documentation that delays timely payment.
Exhibit A, Attach III	3.3.5 Page 81	Claims Processing — request to add a new provision that specifies that directed payments calculated by the state meet the definition of clean claims.	Request to add a new (E): **"Contractor shall issue payments to specified Network Providers at the direction of DHCS in accordance with 42 CFR 438.6 and within 30 days of receipt of the direction from DHCS."**
Exhibit A, Attach III	3.3.14 Page 86	Major Organ Transplants — request to add clarification about CCS in non-WCM counties.	Request to add this clarification about CCS in non-WCM counites: "**Nothing within this provision shall apply to the Contractor for children enrolled in the California Children's Services (CCS) program in counties that are not**

			participating in the Whole Child Model (WCM).”
Exhibit A, Attach III	3.3.15 Page 86	Long-Term Care Services — request to clarify the expectation. In establishing rates for care provided in skilled-nursing facilities, we recommend that the Contractor must differentiate separate rates and payment levels for 1) post-acute transitional care services, and 2) long term residential care.	Request to clarify this provision. Also recommend considering the original Coordinated Care Initiative legislation, which included this specific distinction and requirement.
Exhibit A, Attach III	3.3.16(A)(1) Page 86	Emergency Services and Post-Stabilization Care Services —request amendment to (A)(1).	Request the following amendment to (A)(1): “Contractor is responsible for coverage and payment of Emergency Services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor. Contractor **shall** not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR section 438.114(a) of the definition of Emergency Medical Condition. Further, Contractor **shall** not deny payment for treatment obtained when a representative of Contractor, **including but not limited to another Network Provider, physician, or emergency transportation**, instructs the Member to seek Emergency Services. **Emergency services must not be subject to prior authorization by Contractor.**”
Exhibit A, Attach III	3.3.16(A)(3) Page 86	Emergency Services and Post-Stabilization Care Services —please clarify what “good standing” means.	Request to clarify or define within (A)(3) what “good standing” means.

Exhibit A, Attach III	3.3.16(A)(1) & (A)(2) Page 86	Emergency Services and Post-Stabilization Care Services —request conforming amendments to (A)(1) and (A)(2).	Request amendments to (A)(1) and (A)(2), where all instances of "Contractor may not" are converted to "Contractor shall not."
Exhibit A, Attach III	3.3.16(A)(5) Page 86	Emergency Services and Post-Stabilization Care Services —request amendments to (A)(5). These requests clarify the requirement for Contractor to reimburse Providers (regardless of Network Provider status). Additionally, amendments remove the perverse incentive for plans to default all payments to providers at the lowest level and forcing providers into appealing for a more appropriate level of payment.	Request the following amendments to (A)(5): "At a minimum, Contractor must reimburse the **~~non-contracting~~** emergency department and, if applicable, its affiliated Providers for Physician Services at the lowest level of the emergency department evaluation and management Physician's Current Procedural Terminology (CPOT) codes~~, unless a higher level is clearly supported by documentation~~, and for the facility fee and diagnostic services such as laboratory and radiology, **unless the Providers are considered Network Providers, and the Contractor and the Network Provider mutually agree to reimbursement in a different amount, in a form and manner acceptable to DHCS.**"
Exhibit A, Attach III	3.3.16(B)(2) Page 87	Emergency Services and Post-Stabilization Care Services —Question: Why is there a one-hour window? This requirement is unnecessary. Contractor should authorize services to make a patient stable for transfer under the same time frame.	Request to remove the one-hour requirement.
Exhibit A, Attach III	3.3.16(B)(5) Page 87	Emergency Services and Post-Stabilization Care Services —recommend replacing reference to "lower rate" with "**different** rate."	Request the following amendments: "…inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a **different** rate is agreed to in writing and signed by the hospital."

Exhibit A, Attach III	3.3.16(C) Page 86	Emergency Services and Post-Stabilization Care Services —request amendment to (C) by striking all references to "Out-of-Network" and leave "Provider."	Request amendment to (C) by striking all references to "Out-of-Network" and leave "Provider."
Exhibit A, Attach III	3.3.16 Page 89	Emergency Services and Post-Stabilization Care Services —request to include behavioral health services in this provision.	Request to ensure behavioral health parity is included in this provision.
Exhibit A, Attach III	3.3.19(A) and (B) Page 90	Compliance with Directed Payment Initiatives & Related Reimbursement Requirements — request conforming amendments with clean claims and timely payments. Today, hospitals generally are waiting on average from 60-90 days before they receive all the directed payments as directed by DHCS. For providers that contribute toward the non-federal share associated with directed payments, this is placing many hospitals in a distressed financial position —while many health plans delay in issuing payments.	Request amendments to both (A) and (B): Following "technical guidance," add "**and 30 days of receipt of funding or the direction of payment from DHCS, whichever is later.**"
Exhibit A, Attach III	4.1.2 Page 95	Marketing Plan — request to make the DHCS-approved marketing plans public information. This is especially important if a Network Provider happens to be included their marketing materials or plan, or a plan includes references to ECM and ILOS that are not shared with all providers.	Request to add a new "O:" "Contractor shall make approved marketing plan public no later than 30 days following DHCS approval."

Exhibit A, Attach III	4.3.1 Page 106	Population Health Management Program requirements — request to add key Network Providers as an entity that the health plan should consult with prior to finalization.	Request to add "**and key Network Providers**," after "departments." Otherwise, Contractor will need to engage only with public, behavioral health, and social services department.
Exhibit A, Attach III	4.3.2 Page 106	PHM Data Integration — request to add "existing" before of "Health Information Exchange (HIE)." Today, there is already a robust network of HIE networks amongst plans and network providers. Including the word "existing" clarifies the intent is to utilize these existing networks, and not establish new HIE infrastructure.	Request to add "**existing**" before of "Health Information Exchange (HIE),""
Exhibit A, Attach III	4.3.3(D) Page 106	Population Needs Assessment (PNA) — request to replace "public hospital systems" with "Safety Net Providers." This is a conforming edit with the expanded definition.	Request to replace "public hospital systems" with "**Safety Net Providers.**"
Exhibit A, Attach III	4.3.5 Page 112	PHM Delivery — general comment regarding the discharge plan. We believe the contract should align with state and federal law, which do not require hospitals to provide a discharge plan to every single patient — only those who are likely to suffer adverse health consequences after discharge if they do not have a plan. Additionally, the assumption discharge can be to a "specific agency or home recommended by the hospital after discharge" is a violation of the federal Freedom of	Request to make necessary amendments conforming with state and federal law. Suggestions below. **Contractor must, in coordination with the hospital and in alignment with state and federal requirements, identify, at an early stage of hospitalization, those inpatients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning, and must provide a discharge plan for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.**

		Choice law, which requires hospitals to provide a list of suitable post-discharge providers and let the patient choose.	**The Contractor's discharge plan must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.**
Exhibit A, Attach III	4.3.5(3)(a)(iii) Page 112	PHM Delivery — Transitional Care 3(a)(iii). Request the following clarifying amendment, which outlines the time period that the Prior Authorization is pending. This 48-hour gap is not specified.	Request the following amendments: "Process for ensuring all Prior Authorizations **(PA)** required for the Member's discharge are processed within two calendar days, including authorization for therapy: home care, medical supplies, prescription medications, and Durable Medical Equipment (DME). **During the time period that the PA request is pending (i.e., the days between the date the PA request is made and the date the PA determination is made), the patient will remain in the hospital and Contractor will reimburse the hospital for their care at the appropriate rate.** **If the PA request is denied, Contractor shall do all of the following: 1) provide written documentation of the denial of PA, including documentation of physician review and clinical rationale for denial, 2) communicate a process for timely peer-to-peer ("doc-to-doc") discussion and review of the determination, and 3) recommend alternative plan of care, including suggestions for disposition and in-network referrals as appropriate."**
Exhibit A, Attach III	4.3.5(3)(a)(vi) Page 112	PHM Delivery — request to clarify that the health plan should establish processes to avoid delaying discharges that do not screen out transitions to a lower level of care based on network provider status.	Request amending (3)(a)(vi): "Processes for preventing delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care **regardless of network status**; and"

Exhibit A, Attach III	4.3.5 Page 112	PHM Delivery — request to clarify the requirement that health plans have the responsibility for the continuous coverage of a member who is awaiting discharge and transition to a post-acute care setting.	Request to add new (3)(c)(v): "In situations where a Member transition cannot occur timely from an acute care hospital to a skilled-nursing facility or other subacute or post-acute care setting, the Contractor must have a process to reimburse the Provider for each Administrative Day at the amount the Provider could collect if the Member accessed those services in the Medi-Cal fee-for-service delivery system, as defined by DHCS in the Medi-Cal State Plan and other applicable guidance, unless Contractor and the Network Provider mutually agree to reimbursement in a different amount, in a form and manner acceptable to DHCS."
Exhibit A, Attach III	5.2.1(C) Page 168	Access to Network Providers and Covered Services — request to define "adequate."	Request to define "adequate."
Exhibit A, Attach III	5.2.11 Page 183	Cultural and Linguistic Program and Committees — request for DHCS to define "health equity" and what specific types of training are required for Network Providers.	Request additional clarification.
Exhibit A, Attach III	5.2.13 Page 190	Network Reports — request to require the Contractor to make their annual certification report public.	Request to require the annual certification report be made public.
Exhibit A, Attach III	5.3.1 Page 197	Covered Services — request for conforming changes to include the changes in the definition. Request to clearly define "Covered Services" to include all Medi-Cal full scope services provided by Medi-Cal fee-for-service (including EPSDT), unless expressly	Request to make conforming changes with the change in the definition in Exhibit A, Attachment I, 1.0.

		omitted under State Law, California State Plan, this Contract, and All Plan Letters.	
Exhibit A, Attach III	5.3.7 Page 209	Services for All Members — request to clarify (F)(5).	Request to clarify (F)(5): "Contractor must ensure coordination of care between all Providers, **Subcontractors, non-Medi-Cal health plans when applicable,** organ donation entities, and transplant centers to ensure the transplant is completed as expeditiously as possible. This coordination of care must include care for all living donors."
Exhibit A, Attach III	5.3.7 Page 210	Services for All Members — request to clarify (G)(4).	Request to clarify (G)(4): "Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level of care is not available, **including but not limited to Administrative Days as defined in Exhibit A, Attachment I, Section 1.0 (Definitions),** unless otherwise provided by contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level of care, including by offering to contract with facilities within and outside of the Service Area."
Exhibit A, Attach III	5.5.2(A) Page 220	Outpatient Mental Health Care Services and Substance Use Disorder Services — request to clarify the requirements apply to delegated entities.	Request to add (A) "**and Subcontractors**" after "Contractor."
Exhibit A, Attach III	5.5.2(B) Page 220	Outpatient Mental Health Care Services and Substance Use Disorder Services — request to expand the definition in (B) to account for upcoming changes in	Expand definition in (B): "…in accordance with APLs 17-018 and 15-008, **and any changes to the definition of Medical Necessity through the**

		CalAIM and changes to the Medical Necessity definition.	**implementation of California Advancing and Innovating Medi-Cal (CalAIM).**
Exhibit A, Attach III	7.0 Page 241	Operations Deliverables and Requirements — request to add "Made Public" under the Recipients Column for several items. This information should be automatically displayed on a regular basis. By doing so, it will hold the plans more accountable and will share important information with stakeholders.	Require the plans to make the following reports public and add "Made Public" under the Recipient Column: D.0002—Key Personnel D.0008—Medical Loss Ratio Report D.0014—Data Corrective Action Plans D.0015—Network Provider Data Report D.0018—MIS/DSS Audits D.0019—Quality Improvement and Health Equity Committee Meeting Minutes D.0020—Quality Improvement and Health Equity Annual Report(s) D.0021—External Performance Measures Report D.0022—Performance Improvement Projects (PIPs) Report D.0023—Consumer Satisfaction Survey D.0040—Population Health Management Strategy D.0046—Member Information Provider Directory D.0047—Member Information Member Handbook (EOC) D.0048—Alternative Access Standard Requests D.0049—Network and Access Changes to Covered Services D.0053—Annual Network Certification Report

			D.0056—Report of DUR Program Activities D.0060—Outpatient Mental Health Services Provider Report(s) D.0063—Emergency Preparedness and Response Plan D.0064—Emergency Contact Information Update
Exhibit E,	1.17 Page 13	Phaseout Requirement — request to strengthen the requirements in this provision. Today, Medi-Cal supplemental payments account for nearly 20% of the overall reimbursement to providers. In managed care, this is growing as more directed payments are implemented, and the managed care delivery system continues to grow through CalAIM. Since Medi-Cal managed care supplemental payments do not pay timely —most at the two-year federal claiming limit — we request this provision be expanded upon to ensure no provider is adversely impacted because a Medi-Cal managed care plan leaves a particular market. We note that this contract is only for 60 months, which increases the risk sooner rather than later.	Request to increase the three-month capitation withhold to no less than four months. Additionally, request to include specific references to the data reconciliation process and network provider contract status process, as these are important elements for providers receiving directed payments. There should be explicit requirements where the plan must reconcile data and network provider status, even as much as two years after they may have existed in the market. Lastly, the health plan should not receive the withheld capitations until all supplemental payments are processed by the state.