July 12, 2024

Amanda Levy
Deputy Director, Health Policy and Stakeholder Relations
Office of the Director
California Department of Managed Health Care

Dear Ms. Levy:

On behalf of more than 400 hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to comment on draft changes to network review standards and methodology, as proposed by the Department of Managed Health Care.

CHA sees firsthand the devastating impact of the lack of timely access to medically necessary care. When care is delayed or denied, patients suffer, and medical outcomes are compromised.

The inadequacy of provider networks has emerged as one of the most significant contributors to delays in care access. In the 2024 CHA analysis, *Insurance Company Red Tape, Inadequate Networks, and Authorization Denials Leave Patents Stranded in Hospitals*, hospital discharge planners consistently ranked "inadequate provider network" as one of the top three reasons for delayed discharge. Moreover, when medically necessary services are not available through the plan network, hospital staff must take additional time-consuming and administratively burdensome steps to obtain prior authorization for an out-of-network facility and wait for the negotiation of a letter of agreement.

CHA strongly supports the Department's efforts to update the network adequacy standards to reflect the current needs and range of services required by enrolled beneficiaries. These efforts become particularly important in the context of California's implementation of California Advancing and Innovating Medi-Cal (CalAIM), which relies on numerous managed care plans to coordinate access to care across the full continuum. CHA believes that the proposed standards would benefit from consideration of the following:

Mental Health Network Adequacy Standards
CHA commends the Department's efforts to address network adequacy issues for persons with behavioral health needs as demonstrated by its updated standards for access to mental health services.

Required Network Provider Types
CHA applauds the inclusion of an expanded list of required network provider types, particularly the establishment of categories for "Facilities and Clinics" and "Ancillary Providers." The lists appear to be inclusive of many/most of the medically necessary services that a beneficiary may require. However,

home health services have been omitted, and CHA strongly recommends that the list be revised to add this essential provider type.

Home health services provided by a licensed home health agency (HHA) play a critical role in a patient's successful transition from a hospital or skilled-nursing facility (SNF) to their home. Timely and adequate access to home health services can support successful discharge, reduce or eliminate the need for additional hospitalization or skilled-nursing care, and reduce unnecessary hospital re-admissions. Home health care is a medical service primarily provided by licensed clinicians, including registered nurses and therapists, and is a separate and distinct service from home care services, which provide non-medical support for activities of daily living. **CHA urges the Department to add HHAs to the list of required network provider types.**

While the expansion of the list of required provider types is a welcome improvement, additional steps must be taken to ensure that plans are providing access to "covered services in a timely manner," as required by Health and Safety Code 1367.03. **The Department must develop and implement specific measures and clear standards to ensure plan compliance.**

Such guidance is especially important when assessing access to SNF care following acute hospitalization, which the CHA analysis demonstrated was a major contributor to frequent and lengthy delays in hospital discharge. CHA offers the following suggestions for additional access measures for the Department's consideration.

1. *Elapsed time from referral to admission to required facility/service*: Plans would be required to report the number of hours/days between the time/date the provider requested access to the required service and the time/date that the patient was transferred/admitted to that facility or received the service. A standard/threshold of elapsed time would be identified as a measure of compliance (e.g., 72 hours for admission to SNF).

2. *Avoidable days:* Plans would be required to report "avoidable days" – days that an enrolled beneficiary remained in an acute care facility when they were medically ready to transfer to another care level or to be discharged home with services. Plans would be required to track increases or decreases in avoidable days over time and develop plans to reduce or minimize their occurrence by improving network adequacy.

3. *Service/facility admission of plan members*: CHA suggests that the Department adopt a standard similar to the "Accepting New Patients" standard for primary care and mental health for other required provider types. This recommendation is made in the context of CHA members' experience in seeking post-hospital SNF care. CHA receives frequent reports that facilities designated as "in-network" by a plan repeatedly decline to admit plan patients. Requiring the plans to report which of their network providers can timely admit their enrollees, and how frequently members had to access out-of-network providers, would allow for a meaningful assessment of patient care access.

Thank you for the opportunity to provide this input. Should you have any questions or require additional information, please do not hesitate to contact me at pblaisdell@calhospital.org.

Sincerely,

Patricia Blaisdell
Vice President, Policy
California Hospital Association