

MCHA comments – California’s Draft FFS Access Monitoring Plan

MCHA’s comments address the following points. We would be happy to have you use or expand on any of these points that you would like to use, but especially the fourth point dealing with CPSP. If you’d like to sign onto our full document, contact Lynn Kersey (lynnk@mchaccess.org).

- 1) The Access Monitoring Plan should be clarified to explain that Medi-Cal-funded deliveries in the fee-for-service system include those for citizen and lawfully present women, not just undocumented women.
- 2) The Fee-for-Service Access Monitoring Plan should clarify that women in Pregnancy-Related Medi-Cal have the right to substantially the same medically necessary services as are provided to adults under Full-Scope Medi-Cal and should include utilization by procedure code among access measures.
- 3) Healthy People 2020 measures are not enough: the significant racial disparities not only in birth outcomes but also in maternal deaths should be a strong focus of the Fee-for-Service Access Monitoring Plan.
 - a. Maternal outcomes should also be addressed in the Access Monitoring Plan, in addition to birth outcomes.
 - b. In addition to birth and maternal outcomes, the Access Monitoring Plan should also address access issues within the overall quality of maternity care. Some examples include: adequacy of prenatal care; access to risk-appropriate prenatal care and hospital/out of hospital delivery; “unbundling” regions for data and reporting by county, since the grouped regions mask real disparities; and the impact of visit limits on access to services for women with chronic or high-risk conditions.
 - c. The Access Monitoring Plan should also address both birth and maternal outcomes by income.
- 4) The Fee-for-Service Access Monitoring Plan should include the specific monitoring requirements of Medi-Cal’s Comprehensive Perinatal Services Program (CPSP), including those for addressing social determinants of health. These include assistance with transportation, housing and food insecurity, safety from domestic violence, and maternal depression and other mental health issues, regardless of whether the woman has a DSM diagnosis.

- 5) The Obstetric Services and Births Outcomes Domain should examine more than initiation of care and birth outcomes.
- 6) The Access Monitoring Plan should address the current confusion and lack of leadership in oversight of Medi-Cal coverage for pregnant women in the fee-for-service system.
- 7) The draft Plan should clearly provide for a rigorous assessment of utilization and access for all fee-for-service populations:
 - a. The Plan must evaluate for comprehensive, full-scope equivalent care during pregnancy and the post-partum period.
 - b. The Plan must also evaluate access to all “ambulatory prenatal care” through Medi-Cal’s PE for Pregnant Women program
 - c. Other apparently omitted fee-for-service groups that should be added to the access monitoring plan
 - d. Limiting analysis to an 11-month enrollment period should be dropped.
 - e. Other concerns about the draft’s “access analysis limitations” for subpopulations: don’t use catch-all groups of aid codes whose populations are dissimilar; define all the aid codes used in a category; clarify why finite time in FFS impedes access measures like wait times and time and distance.
 - f. The proposed provider ratio should be revised to incorporate crucial access elements – how much time is spent seeing FFS patients; don’t count providers who may see only one Medi-Cal FFS patient; measure by county, not geographic regions, since those mask shortages; count providers by the needs of the population, i.e. language capabilities, specifics of pediatric or adult primary care, and specialties. Measure access to care for women with Medicare as primary coverage and for women in disability aid codes who need prenatal or other reproductive health services.
 - g. The proposed dental provider ratio should also be revised to address the access needs of specific populations.
 - h. “Primary care service areas” need to be defined when evaluating time and distance barriers to access.
 - i. Use fee-for-service help lines, not helplines for managed care, to evaluate “realized access” here.