State of California—Health and Human Services Agency
Department of Health Care Services

MEDICAID MANAGED CARE FINAL RULE: NETWORK ADEQUACY STANDARDS

Updated March 26, 2018

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1. EXECUTIVE SUMMARY

The Medicaid Managed Care and CHIP Managed Care Final Rule (Final Rule) establishes network adequacy standards in Medicaid and CHIP managed care for certain providers and provides flexibility to states to set state specific standards. California currently has network adequacy standards in place that meet many of these requirements. The State also maintains network adequacy standards/requirements that exceed those that are required in the Final Rule. Assembly Bill (AB) 205 (Chapter 738, Statutes of 2017) codified and amended California's network adequacy standards.

This document outlines California's network standards in response to meeting compliance with the network adequacy provisions of the Final Rule. These federal requirements are described in Section 2.1, Federal Medicaid and CHIP Managed Care Final Rule, and incorporated in Attachment B of the Appendix. In this document, "current standards" refers to the network adequacy standards that California had in place prior to the implementation of the Final Rule requirements and AB 205.

This document was initially published in July 2017, and has been amended as a result of AB 205, as follows (for a full list of changes, please refer to Attachment F in the Appendix):

- Time and distance standards that were previously determined based on county population size now reflect county population density.
- County categorization, "rural," "small," "medium," and "large" are maintained, however the counties that were grouped in each category now reflect population density groupings rather than population size.
- Dental pediatric timely access standards for specialist appointments are adjusted from 30 business days to 30 calendar days.
- Timely access standards for Skilled Nursing Facilities and Intermediate Care Facilities for small and rural counties are adjusted from 14 business days to 14 calendar days.
- "Proposed Standards" are renamed as Final Standards, which were codified as a result of AB 205.

Section 4, Final Network Adequacy Standards, of this document describes the approach to determining and reasoning for California's standards. DHCS will be responsible for monitoring compliance with the standards described in this document.

Table 1. California's Final Network Standards

Provider Type	Time and Distance	Timely Access for Non-Urgent[1] Appointments
Primary Care (adult and pediatric)	10 miles or 30 minutes from the beneficiary's residence	Within 10 business days to appointment from request
Specialty Care (adult and pediatric)	Based on county population density as	Within 15 business days to appointment from request

[1] Timely access applies to both initial requests and continuation of services. Non-urgent refers to routine appointments for non-urgent conditions.

Table 1. California's Final Network Standards		
Provider Type	**Time and Distance**	**Timely Access for Non-Urgent[1] Appointments**
	follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties*: 45 miles or 75 minutes from the beneficiary's residence *Medium Counties*: 30 miles or 60 minutes from the beneficiary's residence *Large Counties*: 15 miles or 30 minutes from the beneficiary's residence	
Obstetrics/ Gynecology (OB/GYN)	Primary Care or Specialty Care standards as determined by beneficiary access to OB/GYN provider as primary care or specialist services *Primary Care*: 10 miles or 30 minutes from the beneficiary's residence Specialty Care is based on county population density as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties*: 45 miles or 75 minutes from the beneficiary's residence *Medium Counties*: 30 miles or 60 minutes from the beneficiary's residence	Primary Care or Specialty Care standards as determined by beneficiary access to OB/GYN provider as primary care or specialist services *Primary Care*: Within 10 business days to appointment from request *Specialty Care*: Within 15 business days to appointment from request

Table 1. California's Final Network Standards		
Provider Type	**Time and Distance**	**Timely Access for Non-Urgent[1] Appointments**
	Large Counties: 15 miles or 30 minutes from the beneficiary's residence	
Hospitals	15 miles or 30 minutes from beneficiary's residence	
Mental health (non-psychiatry) *Outpatient Services*	Based on county population density as follows: *Rural Counties: 60 miles or 90 minutes from the beneficiary's residence* *Small Counties: 45 miles or 75 minutes from the beneficiary's residence* *Medium Counties: 30 miles or 60 minutes from the beneficiary's residence* *Large Counties: 15 miles or 30 minutes from* the beneficiary's residence	Within 10 business days to appointment from request
Substance Use Disorder *Outpatient Services*	Based on county population density as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties:* 60 miles or 90 minutes from the beneficiary's residence *Medium Counties*: 30 miles or 60 minutes from the beneficiary's residence *Large Counties:* 15 miles or 30 minutes from the beneficiary's residence	Within 10 business days to appointment from request

Table 1. California's Final Network Standards		
Provider Type	**Time and Distance**	**Timely Access for Non-Urgent[1] Appointments**
Substance Use Disorder *Opioid Treatment Programs*	Based on county population density as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties*: 45 miles or 75 minutes from the beneficiary's residence *Medium Counties*: 30 miles or 60 minutes from the beneficiary's residence *Large Counties*: 15 miles or 30 minutes from the beneficiary's residence	Within 3 business days to appointment from request
Pharmacy	10 miles or 30 minutes from beneficiary's residence	Request for prior authorization made via telecommunication: 24 hours Dispensing of at least a 72-hour supply of a covered outpatient drug in an emergency situation
Pediatric Dental	10 miles or 30 minutes from beneficiary's residence	Routine appointment: Within 4 weeks to appointment from the request Specialist appointment: Within 30 calendar days to appointment from the request
Long-term Services and Supports (LTSS) *Skilled Nursing Facility (SNF)*	None	Based on county population density as follows: *Rural Counties*: Within 14 calendar days of request *Small Counties:* Within 14 calendar days of request *Medium Counties*: Within 7 business days of request

Table 1. California's Final Network Standards		
Provider Type	**Time and Distance**	**Timely Access for Non-Urgent[1] Appointments**
		Large Counties: within 5 business days of request
Long-term Services and Supports (LTSS): *Intermediate Care Facility (ICF)*	None	Based on county population density as follows: *Rural Counties*: Within 14 calendar days of request *Small Counties:* Within 14 calendar days of request *Medium Counties*: Within 7 business days of request *Large Counties*: Within 5 business days of request
Long-term Services and Supports (LTSS): *Community-Based Adult Services (CBAS)*	None	Capacity cannot decrease in aggregate statewide below April 2012 level

2. Background and Overview

2.1 Federal Medicaid and CHIP Managed Care Final Rule

On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid and CHIP Managed Care Final Rule.[2] This issuance was the first significant overhaul of the federal Medicaid managed care regulations since 2002. It addresses many key areas including beneficiary rights and protections, quality, program integrity, care coordination, and network adequacy, among others. Varying requirements of the Final Rule become effective on different dates over the next decade with some happening in concurrence of the issuance of the Final Rule and others over a longer period.

CMS provided flexibility in the Final Rule with respect to network adequacy – requiring states to implement state specific standards under the broad requirements set forth in the Final Rule. These requirements are specific to time and distance and timely access.

In addition, states must now annually certify networks to CMS demonstrating compliance with the state established standards and the adequacy of health plan networks to provide timely access to care for all Medicaid managed care beneficiaries.

Three sections of the Final Rule comprise the majority of network adequacy standards as set forth by

[2] Managed Care Final Rule, Federal Register, Vol. 81, No. 88: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016- 09581.pdf

the federal government. These sections – §438.68 Network adequacy standards; § 438.206 Availability of services; and §438.207 - Assurances of adequate capacity and services – are included in Attachment B of the Appendices.

Time and distance means the number of minutes and miles from the beneficiary's residence when traveling to the provider type. While states are required to establish time and distance standards, plans are required to meet the standards for time *OR* distance. For example, the primary care provider must either be within 10 miles from the beneficiary's residence or be within a 30 minute drive from the beneficiary's residence in order to meet the primary care provider standards. As required for Long-Term Supports and Services (LTSS), timely access standards will be established for services when the provider travels to the beneficiary and/or community locations to deliver services. Timely access references the number of business days or calendar days from the date of request that an appointment must be available within for the type of service.

The Final Rule requires states set network adequacy standards for the following types of providers:

- Primary care (adult and pediatric)
- Specialty care (adult and pediatric)
- Behavioral health (including mental health and substance use disorder treatment) providers
- OB/GYN
- Hospital
- Pharmacy
- Pediatric dental
- Long-term services and supports (LTSS) that require the beneficiary to travel to the provider

It also requires that all services covered under the State Plan are available and accessible to beneficiaries of Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) in a timely manner. These new requirements are effective during the 2018 health plan contract year that begins on July 1, 2018 in California. As described in further detail below, applicability of these requirements vary in California depending on the delivery system and the type of services that it covers.

2.2 MANAGED CARE DELIVERY SYSTEM IN CALIFORNIA

DHCS provides Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care. DHCS funds health care services for an estimated 14 million Medi-Cal members in 2016-17, or about one-third of Californians.

Services in California are provided through two delivery systems (managed care and fee-for-service (FFS)) depending on the geographic area of the state, type and level of service, diagnosis including severity, among other factors. Physical health services, mental health and substance use disorder services, and Dental Managed Care (DMC) are provided through several delivery systems. Different

aspects of the overall delivery system are held to the Final Rule requirements depending on the type of delivery system category they fall into - Medi-Cal managed care health plans (MCPs) and DMC plans are MCOs[3]; and County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) health plans are Prepaid Inpatient Health Plans (PIHPs).

Medi-Cal Managed Care Health Plans

DHCS administers physical health services through two components of the delivery system – managed care and FFS. Approximately 80 percent of full-scope Medi-Cal recipients receive care through an MCP, a significant shift from just five years ago when approximately 45 percent of beneficiaries were in managed care. In California, there are six models of managed care (see Attachment D in the Appendix):

- County Organized Health Systems (COHS) – 22 counties, only one plan operates in each of these counties
- Two-Plan – 14 counties, two plans operate in each of these counties
- Geographic Managed Care (GMC) – 2 counties, four or five plans operate depending on the county
- Regional – 18 counties, two plans operate in this grouping of counties
- Imperial – 1 county, two plans operate in this county
- San Benito – 1 county, one plan operates in this county

MCPs are responsible for coverage of the majority of physical health services including primary and specialty care, as well as non-specialty mental health services for beneficiaries with mild to moderate functional impairments. Coverage of long-term care skilled nursing services varies across the state depending on the plan model and county. MCPs do not provide specialty mental health, substance use disorder, or dental services.

Mental Health and Substance Use Disorder Services

Pursuant to the terms of a 1915(b) Freedom of Choice Waiver[4], Specialty Mental Health Services (SMHS) in California are provided to Medi-Cal beneficiaries in each county through a Mental Health Plan (MHP). DHCS contracts with 56 county MHPs who are responsible for providing, or arranging for the provision of, SMHS to beneficiaries who meet medical necessity criteria in a manner consistent with the beneficiaries' mental health treatment needs and goals as documented in the beneficiary's treatment plan. The 56 county MHPs provide outpatient SMHS in the least restrictive community-based settings to promote appropriate and timely access to care for beneficiaries.

Pursuant to the terms of the 1115 Medi-Cal 2020 Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration waiver[5], counties that opt-in to the waiver will provide substance use disorder

[3] COHS plans are considered Health Insuring Organizations (HIO) but are held to the same requirements as MCOs per the DHCS to MCP contract.

[4] 1915(b) Medi-Cal Specialty Mental Health Services Waiver: http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi- cal_Specialty_Mental_Health_Waiver.aspx

[5] Drug Medi-Cal Organized Delivery System (DMC-ODS) Demonstration

services in a continuum of care model to Medi-Cal beneficiaries. This demonstration waiver authorizes the State to test a pilot program for the organized delivery of health care services for Medicaid eligible individual with a substance use disorder. The DMC-ODS will be offered as a delivery system in counties that choose to opt into and implement the pilot.

Dental Managed Care

DHCS also maintains two separate dental delivery systems to provide care to beneficiaries – these systems are managed care and FFS. Approximately 912,000 Californians are enrolled in Dental Managed Care (DMC), among which approximately 406,000 are pediatric patients under the age of twenty-one. In California, there are two models of dental managed care:

- Geographic Managed Care – Enrollment is mandatory for most county residents wherein select populations are able to "opt-out" to fee-for-service. California also passed legislation wherein if a beneficiary experienced access to care issues, they are allowed to "opt-out" through a beneficiary dental exemption process. This delivery system is only present in Sacramento County.
- Prepaid Health Plan – Enrollment is only available when a beneficiary elects to "opt-in"; otherwise beneficiaries access their benefits through FFS. This delivery system is only in Los Angeles County.

DMC plans are responsible for dental care and coordination of care related to dental services.

3. CURRENT NETWORK ADEQUACY REQUIREMENTS

All of the managed care delivery systems within the Medi-Cal program must come into compliance with the Final Rule network adequacy standards, including time and distance and timely access to care. California, however, currently maintains established network adequacy requirements for most MCP and DMC plans. Most MCP and DMC plans must obtain a Knox-Keene license through the Department of Managed Health Care (DMHC) in order to operate as a health insuring organization in California. For non- Knox-Keene licensed MCPs, DHCS imposes the same network adequacy requirements through the DHCS to MCP contract[6]. KKA licensing requirements do not apply to MHPs or DMC-ODS Waiver Plans; as such, network adequacy standards have not previously been established for behavioral health services in those Medi-Cal delivery systems.

Both DHCS and DMHC are responsible for ensuring that plans provide timely access to care for Medi-Cal beneficiaries. DMHC is responsible for regulating and licensing managed care health plans in California and ensuring their compliance with managed care laws as set forth in the Knox-Keene Act (KKA) of 1975. The KKA contains provisions regarding consumer protections access to care, specific services coverage, prescriptions drugs, grievances, licensing of health plans, and reporting by health plans. Under its authority, DMHC has promulgated regulations specific to network

Waiver: http://www.dhcs.ca.gov/provgovpart/Pages/Standard-Terms-and-Conditions.aspx

[6] DHCS to MCP Boilerplate Contracts: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

adequacy including time and distance and timely access[7].

DHCS has responsibility for oversight and monitoring of health plans with respect to network adequacy requirements already imposed under DHCS contracts and will continue to be responsible for monitoring of future network adequacy requirements as set forth in this document.

The DHCS to MCP contract generally mirror the KKA standards for timely access and exceeds time and distance for primary care providers (e.g. 15 miles in KKA as compared to 10 miles in the DHCS to MCP contract). DHCS has adopted these KKA standards, unless otherwise specified, as requirements for its MCPs and DMCs. It is important to note that DHCS-specific network standards already exist in addition to time and distance and timely access, for example, physician to provider ratios; these additional requirements are not further noted in this document.

Table 2: Current Network Adequacy Standards

Category	Time and Distance	Timely Access for Non-Urgent Appointments
Physical health	*Primary Care* KKA: 15 miles or 30 minutes DHCS to MCP contract: 10 miles or 30 minutes *Hospital* KKA and DHCS to MCP contract: 15 miles or 30 minutes	KKA and DHCS to MCP contract: *Non-urgent appointments for primary care*: within 10 business days of the request for appointment *Non-urgent appointments with specialist physicians*: within 15 business days of the request for appointment
Dental health	DHCS to DMC contract: 10 miles or 30 minutes	KKA and DHCS to DMC contract: *Routine appointment (non-emergency)*: within 4 weeks *Specialist appointment*: within 30 business days from request
Mental health *Non-specialty*	Reasonable access[8]	KKA: within 10 business days of request DHCS to MCP contract: within 10 business days of request
Mental health *Specialty*	There are currently no network adequacy standards for specialty mental health in Medi-Cal.	

[7] COHS are not required to be KKA licensed in the State of California. Nonetheless, COHS plans are held to the same network adequacy standards as KKA plans per the DHCS to MCP contract.

[8] Reasonable access as defined in Health and Safety Code § 1367, subdivision (d), (e), and (i).

Table 2: Current Network Adequacy Standards		
Category	**Time and Distance**	**Timely Access for Non-Urgent Appointments**
Drug Medi-Cal	There are currently no network adequacy standards for DMC-ODS.	

4. FINAL NETWORK ADEQUACY STANDARDS

Though the KKA and DHCS contracts set forth standards for network adequacy (as described in Section 3, Current Network Adequacy Requirements), the Final Rule requires that additional standards be established for specified provider categories and applies these requirements to other systems within the Medi-Cal delivery system (i.e., MHPs and DMC-ODS plans).

Moreover, the Final Rule requires states to take into account a number of factors when setting their time and distance standards, including:

- Anticipated Medicaid enrollment
- Expected utilization of services
- The characteristics and health care needs of specific Medicaid populations covered by the plans
- The number and types (in terms of specialization, training and experience) of network providers
- The number of network providers who are not accepting new patients
- The geographic location of network providers
- The ability of network providers to communicate in non-English languages
- The ability of network providers to ensure accessible, culturally competent care to people with disabilities
- Use of telemedicine or similar technologies

Described within this section are the current requirements for each of the required provider categories, final standards, and reasoning for each final standard. DHCS utilized a methodical approach to determine the proposals. The aforementioned nine factors were considered as well as internal and external discussions held at the local, state and national levels. A review of other states and lines of business standards was conducted. Considerations for current requirements and structures were made including the efficacy of them. Utilization, geographic, and provider data were used to identify both service utilization needs and a clear picture of provider availability. California's uniqueness was also considered including beneficiary demographics, geographic differences (e.g. rural and urban), and provider availability, among others. Current contractual requirements require plans to provide culturally competent health care to meet the needs of California's diverse population.

The Final Rule requires states to develop time and distance standards for both adult and pediatric services for primary care, behavioral health, and specialist services. For these service categories, the standards will apply to both adult and pediatric services. However, each MCO (MCPs and DMC plans) and PIHP (MHPs and DMC-ODS plans) must demonstrate it maintains an adequate network of providers to meet the needs of both adult and child/youth beneficiaries in the Plan's service area. Plans are required to comply with timely access requirements and meet time OR distance standards when a beneficiary travels to the provider to access care. DHCS will develop network adequacy

standards other than time and distance for LTSS provider types, and other providers, that travel to the beneficiary to deliver services as part of its alternate access process. The standards described in this document only apply to the specified provider types and do not extend to ancillary services.

4.1 PRIMARY CARE

Primary care network adequacy standards are currently set forth under KKA and the DHCS to MCP contract, as described below. DHCS proposes to align primary care network adequacy requirements with current standards, applying them to both adult and pediatric services, respectively. Primary care providers (PCPs) are defined as those that are responsible for supervising, coordinating, and providing initial and primary care to patients and serve as the medical home for beneficiaries. PCPs for adults include those that practice internal medicine, family medicine, geriatrics and preventive medicine. PCPs for children include those that are general practitioners or that practice pediatrics, adolescent medicine, family medicine and preventive medicine.

Obstetrician/gynecologists also function as PCPs for both adults and children but are addressed elsewhere in this document. As such, the aforementioned providers with the exception of obstetrician/gynecologists are included under the primary care network adequacy standards and not specialist standards as included below.

The same time and distance and timely access standards will be established for both adults and pediatric primary care providers. Nonetheless, DHCS intends to monitor the adult and pediatric primary care services separately to assure compliance.

Table 3. Primary Care Network Adequacy Standards

Standard	Current Requirement	Final Standard
Time and Distance	KKA: 15 miles or 30 minutes from beneficiary's residence DHCS to MCP contract: 10 miles or 30 minutes from beneficiary's residence	Same as current DHCS to MCP contract requirement for both adults and pediatric services: 10 miles or 30 minutes from beneficiary's residence
Timely Access (Non-Urgent)	KKA: Within 10 business days of request DHCS to MCP contract: Within 10 business days of request	Same as current requirement for both adults and pediatric services: Within 10 business days of request

4.2 SPECIALISTS

Per the Final Rule, the state must develop network adequacy standards for specialists. Furthermore, CMS allows states to establish what constitutes a specialist for which network adequacy standards must apply.

Timely access requirements for specialists are currently required under KKA and the DHCS to MCP contract – the next appointment must be within 15 business days of request unless an alternative access standard is approved. DHCS will maintain this same standard for all specialists, not only the core specialties listed in Table 4 below.

While establishing standard time and distance requirements is reasonable for many specialists, there are specialists for whom a standardized time and distance requirement need not apply because either the specialist is accessed primarily through a hospital or hospital-associated clinic setting, or because the specialist does not need a face-to-face patient encounter to perform the service (e.g., pathology or radiology). In addition, other unique specialties were excluded from the list, as these types of standards would not reasonably apply.

The following table lists the specialists for which network adequacy standards must apply:

Table 4. DHCS Core Specialists	
Cardiology/Interventional Cardiology	Nephrology
Dermatology	Neurology
Endocrinology	Oncology
ENT/Otolaryngology	Ophthalmology
Gastroenterology	Orthopedic Surgery
General Surgery	Physical Medicine and Rehabilitation
Hematology	Psychiatry
HIV/AIDS Specialists/Infectious Diseases	Pulmonology

Time and distance requirements for specialists are applicable to this list of specialists. These specialists are included in the DHCS core specialist list because they are most critically utilized by Medi-Cal beneficiaries.

It is important to note, however, that not all specialties may be included in network; this follows current requirements under which health plans must provide access to out-of-network providers in a timely manner when services are not available in network[9]. In these instances, the same timely access requirements apply as when access occurs in-network.

California's diversity provides for a need to establish categories of counties depending on population density. In the initial version of this document, published in July 2017, DHCS categorized counties based on the California Department of Finance (DOF) county size categories. In this amended document, as specified in AB 205, the counties included in each category were adjusted to reflect population density groupings rather than population size.

[9] DHCS to MCP Boilerplate Contract, Exhibit A, Attachment 9, Provision 16, Out-of-Network Providers: http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf

Table 5. County Size Categories by Population[10]		
Size Category	**Population**	**Counties**
Rural	50 people per square mile	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.
Small	51- 200 people per square mile	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
Medium	201-600 people per square mile	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
Large	≥ 600 people per square mile	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

Time and distance standards in these categorical areas may vary for differing reasons including no providers to inability for a health plan to contract with a sole specialty provider, among others. Given this, DHCS requires different specialist time and distance standards for the different geographic areas. Based on geo-access mapping of these areas and a survey of available providers within the core specialist group, DHCS requires the following specialist standards:

[10] California Department of Finance, Demographic Research Unit, Report E1 – County Population Data to Determine County Size Categories: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/

Table 6. Specialist Network Adequacy Standards *(For specialties listed in Table 4)*		
Standard	**Current Requirement**	**Final Standard**
Time and Distance	Reasonable access	Based on county population density as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties*: 45 miles or 75 minutes from the beneficiary's residence *Medium Counties:* 30 miles or 60 minutes from the beneficiary's residence *Large Counties*: 15 miles or 30 minutes from the beneficiary's residence
Timely Access (Non-Urgent)	KKA: 15 business days to appointment from request	Same as current requirement: 15 business days to appointment from request

4.3 OBSTETRICS/GYNECOLOGY

Obstetrics/Gynecology (OB/GYN) providers are treated as both primary care and specialist providers in network depending on the beneficiary and their need for services. As such, DHCS proposes to align standards with the type of service accessed by the beneficiary.

Table 7. OB/GYN Network Adequacy Standards

Standard	Current Requirement	Final Standard
Primary Care or Specialty Care standards as determined by beneficiary access to the OB/GYN provider as primary care provider or specialist:		
Time and Distance	*Primary Care*: KKA: 15 miles or 30 minutes from beneficiary's residence DHCS to MCP contract: 10 miles or 30 minutes from beneficiary's residence *Specialty Care*: None	*Primary Care*: 10 miles or 30 minutes from beneficiary's residence Specialty Care is based on county population density as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties*: 45 miles or 75 minutes from the beneficiary's residence *Medium Counties:* 30 miles or 60 minutes from the beneficiary's residence *Large Counties*: 15 miles or 30 minutes from the beneficiary's residence
Timely Access (Non-Urgent)	*Primary Care*: KKA: Within 15 business days of request DHCS to MCP contract: Within 10 business days of request *Specialty Care*: KKA and DHCS to MCP contract: Within 15 business days of request	*Primary Care*: Within 10 business days appointment from request *Specialty Care*: Within 15 business days to appointment from request

4.4 HOSPITALS

Hospital network adequacy standards are currently set forth under KKA and the DHCS to MCP contract, as described below. DHCS will align hospital network adequacy requirements with current standards.

Table 8. Hospital Network Adequacy Standards

Standard	Current Requirement	Final Standard
Time and Distance	KKA: 15 miles or 30 minutes from beneficiary's residence	Same as current requirement: 15 miles or 30 minutes from beneficiary's residence

4.5 MENTAL HEALTH SERVICES

In March 2016, CMS issued the Medicaid mental health parity final rule[11]. The rule stipulates that treatment limitation, including non-quantitative treatment limitations like network adequacy, and financial requirements applicable to mental health/substance use disorder Medicaid benefits cannot be more restrictive than those limitations applicable to medical/surgical Medicaid benefits. To demonstrate compliance with the rule, plans must apply comparable processes, strategies, evidentiary standards or other factors to non-quantitative treatment limitations for mental health/substance use disorder and medical/surgical benefits across the delivery system. Therefore, when developing network adequacy standards, such as time and distance and timely access requirements, the Department proposes to use a comparable process, strategy, evidentiary standard and/or other factors in the development of the standards. As such, the network adequacy standards for time and distance and timely access will equally be applied to mental health providers (specialty and non-specialty) and specialists providing medical/surgical benefits. In addition, DHCS will align mental health network adequacy requirements with current standards for timely access for MCPs as further described below. The identified standards will be applied to both adult and pediatric providers of outpatient specialty and non-specialty mental health services[12]. Similar to MCPs, MHPs required to demonstrate compliance with network adequacy standards for outpatient services provided to both adults and children/youth.

Please note that standards for psychiatry services are covered in Section 4.2[13]. DHCS' mental health provider time and distance standards are as follows:

[11] Federal Register, Vol. 81, No. 61, Mental Health Parity Final Rule: https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf

[12] For purposes of the Final Rule network adequacy standards, outpatient Specialty Mental Health Services include Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support Services; all non-specialty mental health services provided by MCPs are also included.

[13] Access to psychiatry services is covered in section 4.2; however, Medication Support Services are included in this section. Medication Support Services may be delivered by any provider acting within his/her scope of practice under California State law.

Table 9. MCP & MHP Mental Health Network Adequacy Standards		
Standard	**Current Requirement**	**Final Standard**
Time and Distance	Reasonable access	Based on county population density as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties*: 45 miles or 75 minutes from the beneficiary's residence *Medium Counties:* 30 miles or 60 minutes from the beneficiary's residence *Large Counties*: 15 miles or 30 minutes from the beneficiary's residence
Timely Access	KKA for MCPs: within 10 business days of request DHCS to MCP contract: within 10 business days of request	Same as current requirements for both adults and pediatric: Within 10 business days of request

4.6 DMC-ODS WAIVER SERVICES

Counties opting in to the DMC-ODS pilot program will be required to demonstrate compliance with the network adequacy standards set forth in this document.

When proposing these standards, treatment services have been separated into outpatient and specialty categories, similar to mental health, and further broken down in consideration of the counties' population density. Time and distance and timely access standards differ between these services due to the need for beneficiaries in an OTP to receive their medication daily since imminent withdrawal will occur without medication.

As stated above, the parity rule applies to substance use disorder services also and stipulates that treatment limitations, including non-quantitative treatment limitations like network adequacy cannot be more restrictive than those limitations applicable to medical/surgical Medicaid benefits.

Table 10. Substance Use Disorder Network Adequacy Standards		
Standard	**Current Requirement**	**Final Standard**
Time and Distance: Outpatient Services	None	Based on county population density as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties*: 60 miles or 90 minutes from the beneficiary's residence *Medium Counties*: 30 miles or 60 minutes from the beneficiary's residence *Large Counties*: 15 miles or 30 minutes from the beneficiary's residence
Timely Access: Outpatient Services	None	Within 10 business days of request
Time and Distance: Opioid Treatment Programs[14]	None	Based on county population density as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties:* 45 miles or 75 minutes from the beneficiary's residence *Medium Counties*: 30 miles or 60 minutes from the beneficiary's residence *Large Counties*: 15 miles or 30 minutes from the beneficiary's residence
Timely Access: Opioid Treatment Programs[14]	None	Within 3 business days of request

[14] For OTP patients, the OTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations so we default to the federal regulations. For example, with take home medication, time in treatment requirements are not applicable to buprenorphine patients.

4.7 LONG-TERM SERVICES AND SUPPORTS

The Final Rule distinguishes requirements pertaining to network adequacy time and distance for LTSS providers into two categories – if the beneficiary is traveling to the provider, or the provider is traveling to the beneficiary. This includes if a beneficiary is residing at the place of the provider. Standards must only be required if the beneficiary is traveling to the provider to receive services.

In California, time and distance standards do not need to be established for Multipurpose Senior Services Program (MSSP), SNF, or ICF providers as these providers either travel to the beneficiary to provide services or the beneficiary resides at the facility for care. However, timely access requirements would apply.

In addition, while MSSP is a service in some counties, the services are limited by slots and service requirements set forth in the Section 1115 Medi-Cal 2020 Special Terms and Conditions (STCs)[15] and 1915(c) waiver[16] and as such timely access requirements are not applicable. Similarly, CBAS requirements are set forth in the STCs and indicate that the requirements disallow decreased access from prior to April 1, 2012.

Table 11. LTSS Network Adequacy Standards

Standard	Current Requirement	Final Standard
Timely Access: Skilled Nursing Facility (SNF)	None	Based on county population density as follows: *Rural Counties*: Within 14 calendar days of request *Small Counties:* Within 14 calendar days of request *Medium Counties*: Within 7 business days of request *Large Counties*: Within 5 business days of request

[15] Medi-Cal 2020 Waiver Special Terms and Conditions: http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCs12-8-16.pdf

[16] MSSP Waiver Approval: http://www.dhcs.ca.gov/services/ltc/Pages/MSSP.aspx

Table 11. LTSS Network Adequacy Standards		
Standard	**Current Requirement**	**Final Standard**
Timely Access: Intermediate Care Facility/ Developmentally Disabled (ICF-DD)	None	Based on county population density as follows: *Rural Counties*: Within 14 calendar days of request *Small Counties:* Within 14 calendar days of request *Medium Counties*: Within 7 business days of request *Large Counties*: Within 5 business days of request
Network Adequacy: Community Based Adult Services (CBAS)	1115 Waiver requirement: Capacity cannot decrease in aggregate statewide	Same as current 1115 Waiver requirement: Capacity cannot decrease in aggregate statewide below April 2012 level

4.8 PHARMACY

Pharmacy time and distance network adequacy standards are currently not set forth in Medi-Cal regulation or contract. DHCS proposes to align pharmacy network adequacy requirements with primary care time and distance standards. Timely access to care standards would follow Welfare and Institutions Code Section (W&I) 14185[17] pertaining to access to prescriptions.

Table 12. Pharmacy Network Adequacy Standards		
Standard	**Current Requirement**	**Final Standard**
Time and Distance	Reasonable distance from the primary care provider	10 miles or 30 minutes from beneficiary's residence
Timely Access: Authorization Requests	Request for prior authorization made via telecommunication: 24 hours or one business day response	Request for prior authorization made via telecommunication: 24 hours
Timely Access: Covered outpatient drugs	Dispensing of at least a 72-hour supply of a covered outpatient drug in an emergency situation	Same as current requirement: Dispensing of at least a 72-hour supply of a covered outpatient drug in an emergency situation

[17] WIC §14185: http://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14185.html

4.9 PEDIATRIC DENTAL

Primary care network adequacy standards applicable to pediatric dental are currently set forth under KKA, as described below. DHCS proposes to maintain access standards at the current contract requirement and KKA requirement for pediatric dentistry. Pediatric dentistry is defined as a primary care dentist who engages in the practice of dentistry for pediatric patients.

Table 13. Pediatric Dental Network Adequacy Standards

Standard	Current Requirement	Final Standard
Time and Distance	10 miles or 30 minutes from beneficiary's residence	Same as current requirement: 10 miles or 30 minutes from beneficiary's residence
Timely Access (Non-Urgent)	DHCS to DMC contract: *Routine appointment (non-emergency)*: within 4 weeks *Specialist appointment:* within 30 business days from authorized request	*Routine appointment:* Within 4 weeks to appointment from the request *Specialist appointment:* Within 30 calendar days to appointment from the authorized request

4.10 ALTERNATIVE ACCESS STANDARDS

The Final Rule provides for exceptions to the standards in recognition of special situations. DHCS will develop an alternative access standards process for application by MCPs, MHPs, DMC-ODS, and DMC plans. Alternative access standards will only be approved in circumstances where the applying entity has exhausted all other reasonable options to obtain providers to meet time and distance standards. Other modalities such as telemedicine and pharmacy mail order will be considered for purposes of meeting requirements when reviewing these applications. In addition, seasonal considerations (e.g. winter road conditions) to time and distance standards will be made when necessary.

5. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement

DHCS sought stakeholder input from the Medi-Cal Managed Care Advisory Group, Stakeholder Advisory Committee, California Association of Health Plans, Local Health Plans of California, County Behavioral Health Directors Association of California, Medi-Cal Dental Advisory Committee, Los Angeles Dental Stakeholders group, and other interested stakeholders, on the proposal.

Additionally, DHCS will engage with stakeholders should changes to these standards be deemed necessary for reasons such as a new benefit with a type of provider is implemented, a significant change to the program, or a health epidemic. When a new benefit is implemented, timely access will be required until such time that data are available to analyze if the provider should be added to the specialist list. At a minimum of every five years, a review of the standards will occur.

In accordance with the Final Rule network adequacy requirements, DHCS will publish network adequacy standards on its website and will make available, upon request, standards in alternative formats for beneficiaries with disabilities.

Plan Guidance

The Department will work closely with the plans to ensure they have clear direction and guidance to meet the network standards. DHCS will seek feedback on the draft All Plan Letter (APL), which serves as policy guidance to the MCPs. DHCS will also work with the MCPs on readiness requirements that serves to demonstrate compliance with the policy requirements. Examples of deliverables requested include policies and procedures for referrals and out-of-network access.

DHCS will also issue guidance to the DMCs through an APL. In a parallel process, DHCS will seek feedback and offer guidance to MHPs via a County Information Notice. Through this avenue, DHCS will provide policy direction to the MHPs that will reflect the network standards and DHCS expectations.

6. MONITORING

DHCS Monitoring

DHCS currently is, and will continue to be, responsible for monitoring its contracted managed care health plans to determine compliance with the Final Rule network adequacy standards described in this document, as well as existing contractual requirements. DMHC will continue to monitor requirements pertaining to Knox-Keene. CMS requires that states have mechanisms in place to ensure that plan networks meet network adequacy standards. DHCS will align its monitoring processes across the impacted delivery systems for consistency with the Final Rule network adequacy monitoring requirements. Besides the Final Rule requirements, DHCS will also engage a myriad of monitoring methods that are program-specific.

To measure time and distance, DHCS will utilize geo-mapping software to determine the

beneficiaries' residential addresses to given provider types and validate data submissions from plans and providers. Other indicators will also be reviewed to identify performance trends, such as grievances and appeals reports, Medi- Cal Office of the Ombudsman call statistics, State Fair Hearing data, DMHC health center data, and other reports. DHCS looks at these data at the individual plan level, by plan model, and on a statewide aggregate level. These varied monitoring activities occur at various frequencies throughout the year ranging from real time, to quarterly, to annually.

To ensure that all MCP beneficiaries are able to access timely, medically necessary covered services, DHCS will maintain a comprehensive monitoring plan to monitor compliance with contractual requirements. The monitoring plan itself will include a number of different methods relating to network adequacy. For example, for MCPs, DHCS will conduct a telephonic timely access survey through its External Quality Review Organization (EQRO).

DHCS will provide the EQRO with provider network data and the EQRO will randomly select a statistically significant sample of providers, by plan operating area, to survey wait times for beneficiaries to next appointment. These surveys will be conducted quarterly. DHCS also conducts compliance audits and reviews of plans both annually and triannually, depending on plan type, to determine the plans' compliance with state and Federal requirements, including, but not limited to: network adequacy, provider monitoring, provider directories, and access standards.

In order to ensure network adequacy standards are meaningful, DHCS will hold plans to the standards and enforce corrective action if they fail to meet them. DHCS has established processes to work with the MCPs on monitoring and oversight issues. If DHCS identifies that a plan is struggling to meet network adequacy requirements, DHCS will provide technical assistance to the MCP. When necessary, a corrective action plan may be imposed. Moreover, if a plan does not come into compliance with the corrective action plan, DHCS may impose a financial penalty or sanction.

Finally, the Department continually seeks improvement in its monitoring program to further drive quality. There are currently efforts underway to enhance the provider network data collected. For example, DHCS is spearheading a provider network data project that will include a more robust file layout for managed care provider networks. DHCS will use this monthly provider network data for a variety of purposes including, but not limited to, review and approval of alternate access standards, network analysis and certification, and program integrity efforts. DHCS will use the provider network data to conduct trends analyses to develop strategies for addressing network shortages. Besides the review of provider network data, DHCS will review provider network directories on a monthly basis as required by the Final Rule. DHCS is committed to complying with network adequacy standards as described in the Final Rule and providing for timely access and appropriate care for our Medi-Cal beneficiaries.

Final Rule Network Adequacy Monitoring

A new requirement to strengthen DHCS' existing monitoring processes is completion of a network certification to CMS. The network certification requirements are prescribed in Title 42, Part 438, of the

Code of Federal Regulations[18]. These requirements include verification of the following: network's ability to meet medically necessary services needed for the projected enrollment and utilization, number and types of network providers, geographic location of providers relating to time and distance and timely access, hours of operation, service availability, physical accessibility, out of network access, right to a second opinion, provider credentialing, and policy and procedure requirements such as continuity of care and provider compliance. DHCS will certify the networks with CMS annually and is required to make this documentation available to CMS upon request.

The Final Rule added a new mandatory requirement for the ERQO, an independent entity, to review the new network adequacy standards and validate the health plan networks on an annual basis. The evaluations must include assessments of how a plan is meeting access standards. DHCS is anticipating further details from CMS in a forthcoming EQR protocol.

DHCS will include updates on monitoring in its annual program report to CMS, a separate and new requirement under the Final Rule[19]. The report will contain any areas of concern related to network adequacy in addition to other required elements, such as: financial performance; encounter data reporting; enrollment and service area expansion; any benefit changes; grievances, appeals, and State fair hearings; evaluation of quality measures performance; corrective action plans and sanctions; and the beneficiary support system activities and performance.

7. APPENDICES

[18] 42 CFR Part 438, Subpart H – Certifications and Program Integrity: https://www.law.cornell.edu/cfr/text/42/part- 438/subpart-H

[19] Medicaid Managed Care Final Rule Section 438.66: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf

ATTACHMENT A
Glossary of Terms

Term	Definition
CBAS	Community-Based Adult Services – an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries. CBAS is a Medi-Cal managed care benefit in counties where CBAS existed on April 1, 2012.
DMC	Dental Managed Care – A dental services delivery system carried out through contracts established between DHCS and dental plans licensed with the Department of Managed Health Care. DMC is offered only in Los Angeles County and Sacramento County.
DMC – ODS	The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a Pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with Substance Use Disorder (SUD).
DMHC	Department of Managed Health Care – The State agency responsible for regulating the Knox-Keene Act licensed managed care health plans. DHCS works in partnership with DMHC on monitoring Medi-Cal managed care plans that are Knox-Keene licensed.
FFS	Fee-for-Service – A payment model where services are unbundled and paid for separately. FFS occurs when doctors and other health care providers receive a fee for each service, such as an office visit, test or procedure. Payments are issued retrospectively, after the services are provided.
KKA	Knox-Keene Act – The governing laws that regulate Health Maintenance Organizations (HMOs) and managed care plans within California.
MCP	Managed Care Plan – An established network of organized systems of care that emphasize primary and preventive care. DHCS pays the MCP a capitated payment per member each month to provide care. The MCP helps beneficiaries find doctors, pharmacies, and other providers in the MCP's network.
MHP	Mental Health Plan – Prepaid inpatient health plans that have primary funding and programmatic responsibilities for the majority of Medi-Cal mental health programs. MHPs authorize specialty mental health services for Medi-Cal beneficiaries. There are 56 county- operated MHPs contracted with DHCS.

ATTACHMENT B
Medicaid Managed Care Final Rule Network Adequacy Provisions

§438.68 Network Adequacy Standards

(a) General rule. A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section.

(b) Provider-specific network adequacy standards. (1) At a minimum, a State must develop time and distance standards for the following provider types, if covered under the contract:

(i) Primary care, adult and pediatric.

(ii) OB/GYN.

(iii) Behavioral health (mental health and substance use disorder), adult and pediatric.

(iv) Specialist, adult and pediatric.

(v) Hospital.

(vi) Pharmacy.

(vii) Pediatric dental (not MCQMD scope)

(viii) Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards.

(2) LTSS. States with MCO, PIHP or PAHP contracts which cover LTSS must develop:

(i) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and

(ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.

(3) Scope of network adequacy standards. Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.

(c) Development of network adequacy standards. (1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:

(i) The anticipated Medicaid enrollment.

(ii) The expected utilization of services.

(iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract.

(iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.

(v) The numbers of network providers who are not accepting new Medicaid patients.

(vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees.

(vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language.

(viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

(ix) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

ATTACHMENT B
Medicaid Managed Care Final Rule Network Adequacy Provisions

(2) States developing standards consistent with paragraph (b)(2) of this section must consider the following:
(i) All elements in paragraphs (c)(1)(i) through (ix) of this section.
(ii) Elements that would support an enrollee's choice of provider.
(iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee.
(iv) Other considerations that are in the best interest of the enrollees that need LTSS.
(d) Exceptions process. (1) To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be:
(i) Specified in the MCO, PIHP or PAHP contract.
(ii) Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area.
(2) States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under §438.66.
(e) Publication of network adequacy standards. States must publish the standards developed in accordance with paragraphs (b)(1) and (2) of this section on the Web site required by §438.10. Upon request, network adequacy standards must also be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.

§ 438.206 Availability of Services
(a) Basic rule. Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68.
(b) Delivery network. The State must ensure, through its contracts, that each MCO, PIHP and PAHP, consistent with the scope of its contracted services, meets the following requirements:
(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.
(2) Provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.
(3) Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
(4) If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP's provider network is unable to provide them.

ATTACHMENT B
Medicaid Managed Care Final Rule Network Adequacy Provisions

(5) Requires out-of-network providers to coordinate with the MCO, PIHP, or PAHP for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.
(6) Demonstrates that its network providers are credentialed as required by §438.214.
(7) Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.
(c) Furnishing of services. The State must ensure that each contract with a MCO, PIHP, and PAHP complies with the following requirements.
(1) Timely access. Each MCO, PIHP, and PAHP must do the following:
(i) Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.
(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.
(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.
(iv) Establish mechanisms to ensure compliance by network providers.
(v) Monitor network providers regularly to determine compliance.
(vi) Take corrective action if there is a failure to comply by a network provider.
(2) Access and cultural considerations. Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
(3) Accessibility considerations. Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
(d) Applicability date. This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2018. Until that applicability date, states are required to continue to comply with
§438.206 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

ATTACHMENT B
Medicaid Managed Care Final Rule Network Adequacy Provisions

§438.207 - Assurances of Adequate Capacity and Services

(a) *Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at §438.68 and §438.206(c) (1)

(b) *Nature of supporting documentation.* Each MCO, PIHP, and PAHP must submit documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:

(1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area.

(2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(c) *Timing of documentation.* Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following:

(1) At the time it enters into a contract with the State.

(2) On an annual basis.

(3) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect the adequacy of capacity and services, including—

(i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider network; or

(ii) Enrollment of a new population in the MCO, PIHP, or PAHP.

(d) *State review and certification to CMS.* After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must submit an assurance of compliance to CMS that the MCO, PIHP, or PAHP meets the State's requirements for availability of services, as set forth in §438.68 and §438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP or PAHP related to its provider network.

(e) *CMS' right to inspect documentation.* The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.

(f) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2018. Until that applicability date, states are required to continue to comply with

§438.207 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

ATTACHMENT C
Knox-Keene and Other Network Adequacy Requirements

Basic health care services that managed care health plans must provide (Health and Safety Code § 1345): http://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1345.html

Ready referral and reasonable access to all basic health care services (Health and Safety Code § 1367, subdivision (d), (e), and (i)): http://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1367.html

Defines presumptively reasonable geographic access standards and illustrates the provider types that must be included in a health plan network (28 CCR 1300.51(d)(H) and (I)): https://govt.westlaw.com/calregs/Document/IBCF3D0D0D44911DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

Accessibility of services, including ready referral and access to specialists (28 CCR § 1300.67.2): https://govt.westlaw.com/calregs/Document/IA926F8C0101711DFBF14F83A306F765F?originationContext=Search+Result&listSource=Search&viewType=FullText&navigationPath=Search%2fv3%2fsearch%2fresults%2fnavigation%2fi0ad6005600000159f670f00daa5cba69%3fstartIndex%3d61%26Nav%3dREGULATION_PUBLICVIEW%26contextData%3d(sc.Default)&rank=79&list=REGULATION_PUBLICVIEW&transitionType=SearchIte m&contextData=(sc.Search)&t_T1=28&t_S1=CA+ADC+s

Time and distance standards (1300.51(d)(I): https://govt.westlaw.com/calregs/Document/IBCF3D0D0D44911DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

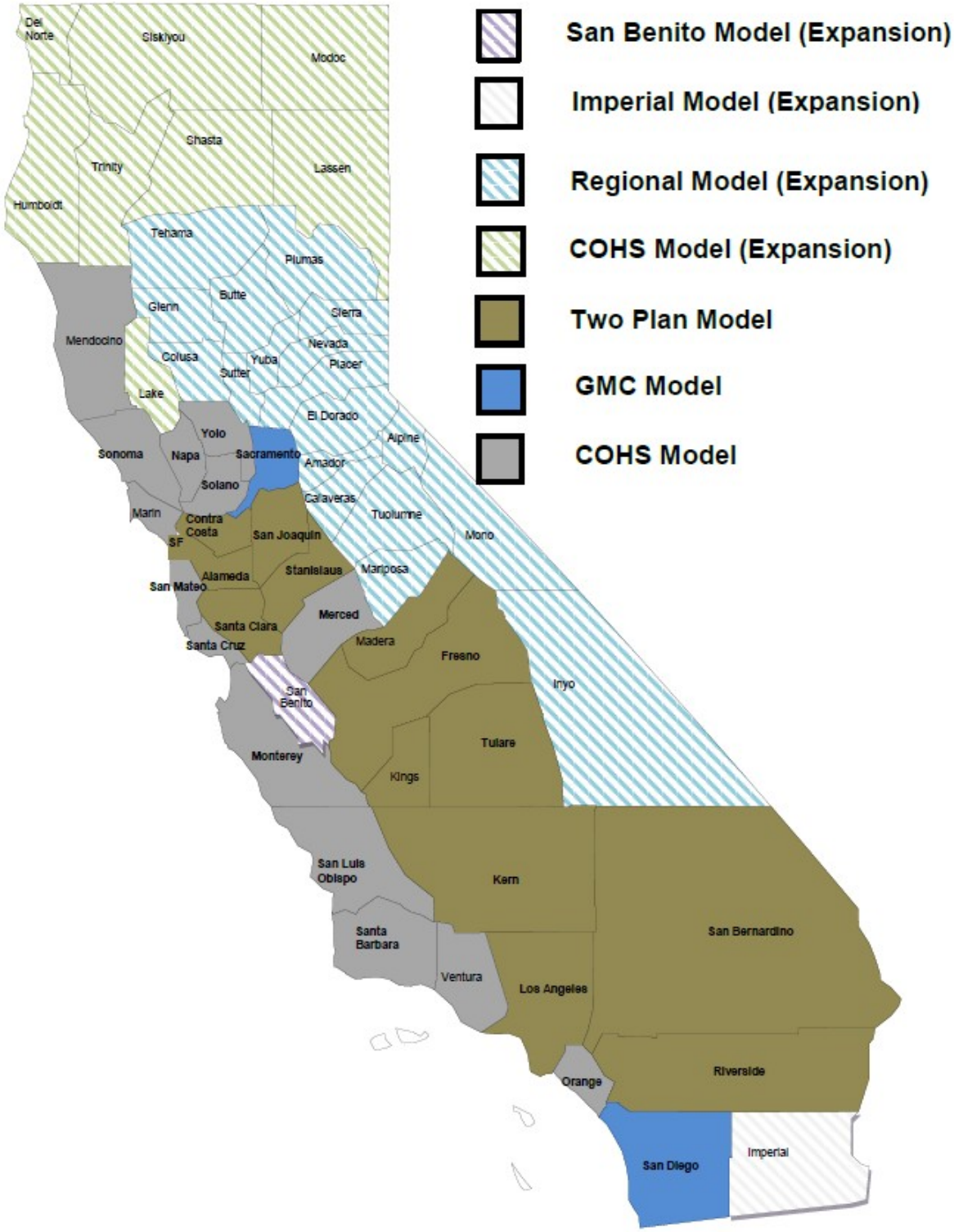
Timely access standards (1300.67.2.2): https://govt.westlaw.com/calregs/Document/IAEB5B380101711DFBF14F83A306F765F?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

Geographic accessibility standards (28 CCR § 1300.67.2.1): https://govt.westlaw.com/calregs/Document/ICA826D60D44911DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

Provider to member ratios (22 CCR §53853): https://govt.westlaw.com/calregs/Document/I6DC649B05F7811DFBF84F211BF18441D?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

ATTACHMENT D

MEDI-CAL MANAGED CARE MODELS



ATTACHMENT E
California Counties Map by Mental Health and DMC-ODS Region

ATTACHMENT F
Summary of March 26, 2018 Amendments

This appendix summarizes the changes in the updated Medicaid Managed Care Final Rule Network Adequacy Standards document that was published on March 26, 2018. The Network Adequacy Standards document was initially published in July 2017, and has been subsequently amended as a result of AB 205.

"Current standards" as referenced in the document refer to the network adequacy standards that California had in place prior to the implementation of the Final Rule requirements and AB 205. In all, these standards were clarified to be referred to as "final" standards, rather than "proposed."

The amendments that occurred as a result of AB 205 are as follows:

- Time and distance standards that were previously determined based on county population size now reflect county population density.
- County categorization, "rural," "small," "medium," and "large" are maintained, however the counties that were grouped in each category now reflect population density groupings rather than population size.
- Dental pediatric timely access standards for specialist appointments are adjusted from 30 business days to 30 calendar days.
- Timely access standards for Skilled Nursing Facilities and Intermediate Care Facilities for small and rural counties are adjusted from 14 business days to 14 calendar days.
- "Proposed Standards" were renamed as Final Standards, which were codified as a result of AB 205.

Table 5 on page 17 was edited to reflect the shifts that occurred in county groupings as follows:

- Amador, El Dorado, Kings, Lake, Madera, Napa, Nevada, Sutter, and Yuba counties were moved from the rural grouping to small grouping.
- Marin, Placer, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura counties were moved from the small grouping to the medium grouping.
- San Francisco, and San Mateo counties were moved from the small grouping to the large grouping.
- San Bernardino County was moved from the medium grouping to the small grouping.
- Alameda, Contra Costa, Orange, Sacramento, San Diego, and Santa Clara counties were moved from the medium grouping to the large grouping.

Pharmacy standards' request for prior authorization was amended to 24 hours, rather than "the greater of 24 hours or one business day response" originally.

Alternative Access Standards was adjusted to communicate that alternative access standards will only be accepted for time and distance standards, not timely access. The language regarding alternate access standards for Medical Service Study Areas was also removed.

Attachment E, which was previously a table of the county groupings, was removed from the Appendix. This table was transferred into the main report section on page 17.