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DATE: February 16, 2018

ALL PLAN LETTER 18-005

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS¹

SUBJECT: NETWORK CERTIFICATION REQUIREMENTS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding new Annual Network Certification, other network reporting requirements, and associated network adequacy standards. The requirement to certify MCP networks annually was issued on May 6, 2016 by the federal Centers for Medicare & Medicaid Services (CMS) in rulemaking CMS-2390-F (Final Rule).² This APL also provides clarifying guidance regarding federal and state provider network requirements.

BACKGROUND:

Historically, the Department of Health Care Services (DHCS) has conducted network certification when a new MCP enters into a contract with DHCS or when a significant change occurs (e.g., change in services or benefits, change in geographic service area, or enrollment of a new beneficiary group) in the MCP's operations that would affect the adequacy of the MCP's network and provision of services.³

MCP's will still be required to submit documentation to DHCS when a significant change occurs that affects network adequacy. However, pursuant to the Final Rule, DHCS will be required, beginning July 1, 2018, to certify each MCP's provider network on an annual basis.⁴

The Annual Network Certification includes verification of the following:⁵

- The network's ability to provide medically necessary services needed for the anticipated enrollment and utilization;

¹ This APL applies to all MCPs and SCAN.

² CMS-2390-F is available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See Title 42 of the Code of Federal Regulations (C.F.R.), sections 438.207(c)(1), 438.207(c)(3), and 438.207(c)(3)(i) and (ii). Part 438 Managed Care Regulations can be found at:

<https://www.ecfr.gov/cgi-bin/text-idx?SID=fd4e77a29e6327c6ff8475948c57df7&mc=true&node=pt42.4.438&rgn=div5>

⁴ 42 C.F.R. section 438.207(c)(2)

⁵ 42 C.F.R. section 438.207(b)

- The number and types of network providers;
- The geographic location of providers to ensure compliance with time and distance standards;
- MCP internal operations analysis and review of service availability, physical accessibility, out-of-network access, timely access, continuity of care, and 24/7 language assistance.

The Final Rule also requires MCPs to submit documentation to DHCS any time there is a significant change in the MCP's network that impacts its adequacy or capacity to deliver services, or that affects payments to the MCP's provider network.^{6,7}

POLICY:

MCPs are required to annually submit network certification documentation to DHCS.⁸ The Annual Network Certification provides a prospective look at the MCP's upcoming contract year (CY).⁹ Each MCP must provide DHCS with supporting documentation that demonstrates the MCP's capacity to serve the anticipated enrollment in its service area in accordance with federal regulations.^{10,11} DHCS is required to review all MCP network submissions and provide an assurance of compliance to CMS before the CY begins.¹²

ANNUAL NETWORK CERTIFICATION STANDARDS AND COMPONENTS:

MCPs must submit a complete and accurate Annual Network Certification report/template that reflects the MCP's entire contracted provider network for each service area at the time of submission. MCPs must submit the Annual Network Certification and all supporting documentation to DHCS no later than 105 days before the CY begins (or the next business day if the due date occurs on a weekend or holiday). Each MCP must complete and submit all required reporting attachments of this APL to DHCS. The documentation must confirm the MCP's network will meet the anticipated needs of its service area(s) and show that the MCP's network includes an appropriate range of providers.¹³ Documentation must be submitted through the DHCS Secure File Transfer Protocol (SFTP) site and labeled based on the instructions provided in Attachment B.

⁶ 42 C.F.R. section 438.207(c)(3)

⁷ For additional information on significant changes, refer to APL 16-001.

⁸ 42 C.F.R. section 438.207(c)(2)

⁹ For purposes of this APL, the CY is the MCP's fiscal year of July 1- June 30, with the exception of Family Mosaic, AIDS Healthcare Foundation and SCAN Health Plan, for which the CY is the calendar year.

¹⁰ For purposes of this APL, service area and reporting unit have the same meaning. Reporting units are outlined in Attachment C.

¹¹ 42 C.F.R. sections 438.207, 438.68, and 438.206(c)(1)

¹² 42 C.F.R. section 438.207(d)

¹³ 42 C.F.R. section 438.207(b)

Network Capacity and Ratios

MCPs must maintain a provider network adequate to serve their service area. MCPs must meet or exceed network capacity requirements, as defined in the MCP contract, and proportionately adjust the number of network providers to support any anticipated changes in enrollment.¹⁴ The MCP must maintain a network capacity adequate to serve the following percentages of all eligible beneficiaries, including SPD beneficiaries within its service area: County/Two-Plan plan models - 60%; Geographic Managed Care plan model - 60%; and County Organized Health Systems (COHS) plan model - 100%. In the event that an MCP's membership in a service area exceeds the above-mentioned network capacity percentages, the MCP must increase its network capacity to accommodate enrollment beyond these percentages.

Additionally, MCPs must meet full-time equivalent (FTE) provider-to-beneficiary ratios for Primary Care Physicians (PCPs) of one FTE PCP to every 2,000 beneficiaries and total network physicians of one FTE physician to every 1,200 beneficiaries.¹⁵ MCPs are permitted to use non-physician medical practitioners, such as physician assistants, nurse practitioners, and certified nurse midwives, to meet required beneficiary-to-provider ratios.¹⁶ DHCS calculates full time equivalency based on the MCP's network capacity percentage by plan model, or their allotted beneficiary assignment, whichever is greater; however, per the MCP contract, MCPs can renegotiate their network capacity requirement in limited circumstances.¹⁷ The MCP must complete Attachment C, Exhibit A-1 to meet the federal requirement for providing supporting documentation to demonstrate compliance with network capacity standards and provider-to-beneficiary ratios. DHCS will review each submission to confirm compliance with network adequacy standards and contractual requirements.

Network Composition

MCPs must maintain and monitor an appropriate provider network which includes FTE adult and pediatric PCPs, FTE adult and pediatric core specialists,¹⁸ mental health providers,¹⁹ hospitals, pharmacies, and ancillary services.²⁰ MCP provider networks must also have the capacity to provide all medically necessary services not covered by

¹⁴ MCP Contract, Exhibit A, Attachment 6, Network Capacity. DHCS Boilerplate Managed Care Contracts are available at: <http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

¹⁵ MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.

¹⁶ Ibid.

¹⁷ MCP Contract, Exhibit A, Attachment 6, Network Capacity.

¹⁸ Core specialists are outlined in Attachment A of this APL.

¹⁹ State Plan Amendment (SPA) 14-012 is available at:

<http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CASPA14-012ApprovedPackageOriginalADA.pdf>

²⁰ MCP Contract, Exhibit A, Attachment 6, Network Composition.

the core specialists. In addition, MCPs operating in COHS or Coordinated Care Initiative (CCI) counties must provide Managed Long-Term Services and Supports (MLTSS)²¹ provider counts in accordance with the applicable MCP contract.

DHCS will utilize data sources including, but not limited to, MCP enrollment and encounter data in order to project CY utilization levels and MCP enrollment. DHCS will then project the number of providers needed to meet the anticipated enrollment and utilization. Data submitted by MCPs will be validated and verified by DHCS by comparing it with the MCPs' 274 provider network file submissions. MCPs must complete Attachment C, Exhibit A-1 to meet the federal requirement for providing supporting documentation to demonstrate that the provider network is appropriate to serve anticipated enrollment and utilization. DHCS will review the submitted documentation to determine compliance with requirements.

Mandatory Provider Types

MCPs must include at least one federally qualified health center (FQHC), one rural health clinic (RHC), and one freestanding birth center (FBC), where available, in their contracted service area, per CMS State Health Official letter (SHO) #16-006.²² MCPs must also include Indian Health Facilities (IHF) in their provider network.

Additionally, MCPs must meet federal and contractual requirements for access to midwifery services, as outlined in APL 16-017 or any superseding letter.²³ MCPs must utilize Attachment C, Exhibit A-2 to document efforts to include midwifery service providers in the MCP's provider network.

California state regulations provide protections for American Indians and American Indian Health Services, as they are not required to contract with managed care plans. IHFs are not required to contract with MCPs; however, they retain the option to contract with an MCP at any time. MCPs are required to offer to contract with an IHF in each of their reporting units and must utilize Attachment C, Exhibit A-2 to document any and all efforts to contract with IHFs, especially in cases where the MCP is unable to contract with an IHF.²⁴

²¹ MCP Contract, Exhibit A, Attachment 21, Managed Long-Term Services and Supports.

²² SHO #16-006 is available at:

<https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf>

²³ APL 16-017 can be found, along with other APLs, at:

<http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

²⁴ Title 22 of the California Code of Regulations (CCR), section 55120. The CCR can be found at:

[https://govt.westlaw.com/calregs/Index?transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Index?transitionType=Default&contextData=(sc.Default))

MCPs must complete Attachment C, Exhibit A-2 of this APL to demonstrate compliance with provider network requirements regarding FQHCs, RHCs, FBCs, IHFs and midwifery services. If the MCP does not have a contract with any of the mandatory provider types, the MCP must submit an explanation and supporting documentation to justify the absence of the provider type to DHCS. DHCS will review the submitted documentation to determine compliance with requirements.

Behavioral Health Treatment

On July 7, 2014, in response to CMS guidance,²⁵ DHCS included Behavioral Health Treatment (BHT) services as a covered Medi-Cal benefit for beneficiaries under 21 years of age when medically necessary, based upon recommendation from a licensed physician and surgeon, or licensed psychologist, after a diagnosis of Autism Spectrum Disorder (ASD). BHT services for children diagnosed with ASD are provided by MCP-credentialed qualified autism service providers as defined in the California State Plan.

To conform to the federal Early Period Screening, Diagnosis and Treatment (EPSDT) requirements, effective July 1, 2018, DHCS will include BHT services as a Medi-Cal managed care benefit for all beneficiaries under 21 years of age when medically necessary, based upon recommendation from a licensed physician and surgeon or a licensed psychologist. Each MCP must demonstrate an adequate provider network of State Plan-approved BHT providers²⁶ sufficient to serve the anticipated BHT-eligible beneficiaries, using Attachment C, Exhibit A-3.

Time and Distance Standards

To ensure adequate availability and accessibility of services to beneficiaries, the Final Rule requires DHCS to establish network adequacy standards that will be effective July 1, 2018. Assembly Bill (AB) 205 (Wood, Chapter 738, Statutes of 2017),²⁷ outlines California's state-specific standards.

These standards, set forth in Attachment A, include time and distance standards based on county population density, and are applicable to the following provider types: pediatric and adult PCPs, pediatric and adult core specialists, OB/GYN primary care and specialty care services, hospitals, mental health providers, and pharmacies. MCPs

²⁵ CMS Informational Bulletin, July 7, 2014 can be found at:

<http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf>.

²⁶ See APL 15-025, regarding BHT coverage. APL 15-025 can be found, along with other APLs, at:

<http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

²⁷ AB 205 (Wood, Chapter 738, Statutes of 2017) can be found at:

https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB205

may use time or distance requirements to demonstrate compliance. Additionally, DHCS will allow MCPs to use telehealth as a means of determining compliance with time and distance standards.²⁸

For each service area, MCPs must create and submit geographic access maps or accessibility analyses that cover the entire service area, following the instructions provided in Attachment B, to confirm compliance with time or distance standards. The MCP's analysis must either illustrate that it complies with applicable time or distance standards or demonstrate that it has requested approval of an alternative access standard by submitting Attachment F to DHCS for review and approval.

Whole Child Model

Each Whole Child Model (WCM) MCP²⁹ will be required, per Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016),³⁰ to demonstrate an adequate provider network that includes: pediatricians, pediatric specialists, and pediatric subspecialties; professional, allied, and medical supportive personnel; as well as licensed acute care hospitals and special care centers. Each WCM MCP must also show that its network contains adequate provider overlap with California Children's Services (CCS) paneled providers. WCM MCPs must submit documentation to DHCS by utilizing the checklist located in Attachment D and the reporting template located in Attachment E, to demonstrate compliance with both SB 586 and CCS requirements.

ALTERNATIVE ACCESS REQUESTS:

MCPs unable to meet time and distance standards for assigned beneficiaries must submit an Alternative Access Standard (AAS) request to DHCS.³¹ DHCS will allow AAS requests when the MCP has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting MCP has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.³² AAS requests must be received by DHCS no later than 105 days prior to the beginning of every CY (or the next business day if the due date occurs on a weekend or holiday) to be considered for the Annual Network Certification.

²⁸ Welfare and Institutions Code (WIC) section 14197(e)(4). WIC 14197 can be found at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14197.&lawCode=WIC

²⁹ A listing of the WCM MCPs can be found at: <http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx>

³⁰ SB 586, (Hernandez, Chapter 625, Statutes of 2016) can be found at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586

³¹ WIC 14197(e)(2)

³² WIC 14197(e)(1)

DHCS will attempt to expedite any AAS requests received after the deadline but will not guarantee a decision prior to submission to CMS. The requirement to comply with the Annual Network Certification does not relieve MCPs of the ongoing requirement to submit an AAS request to DHCS when a significant change to their provider network occurs that affects the MCP's ability to meet all network adequacy standards, components set forth in this APL and state and federal law. Requests for AAS will be approved or denied on a zip code and provider type basis. All AAS requests must be submitted in Excel format, in accordance with Attachment F, and, if required, must include documentation of Department of Managed Health Care (DMHC) approval and/or pending AAS requests. Likewise, if an MCP requests approval of AAS from DMHC, the MCP must include the DHCS approval and/or pending AAS request with its DMHC request. Upon DHCS approval of an AAS request, the request will be valid for one contract year and must be renewed every year thereafter.

Telehealth and Mail Order Pharmacy

DHCS will allow MCPs to use telehealth to determine compliance with time and distance standards, and MCPs will be authorized to begin using telehealth as an alternative access to care for contractual provider-to-beneficiary ratios and/or time and distance standards, beginning July 1, 2018,³³ if the services provided via telehealth align with the telehealth policy in the Medi-Cal Provider Manual³⁴ and if the telehealth providers meet the following criteria:

- Licensed to practice medicine in the State of California
- Certified and enrolled as providers in the Medi-Cal program³⁵
- Trained per contractual requirements³⁶

In order to utilize telehealth to fulfill network adequacy requirements for time and distance standards in a defined service area, the MCP must make reasonable attempts to acquire an in-person provider.³⁷ The telehealth provider must be available to provide telehealth services to assigned beneficiaries in the defined service area regardless of beneficiary assignment in any Individual Physician Association (IPA) or physician group.

³³ WIC 14197(e)(4)

³⁴ Medi-Cal Provider Manual. "Medicine: Telehealth."

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc.

³⁵ For information on provider enrollment and certification, see All Plan Letter 17-019, available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf>

³⁶ DHCS Boilerplate Managed Care Contracts are available at:

<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

³⁷ WIC 14197(e)(1)(A)

MCPs may also utilize telehealth providers to meet physician and provider-to-beneficiary ratios. Current provider-to-beneficiary ratios for PCPs and Total Network Physicians can be found in the MCP contracts.³⁸ Network providers who provide both in-person and telehealth services can only be factored in once when calculating the MCP's available providers in any given specialty. Providers who are not otherwise a network provider for the purposes of providing in-person care can be counted as an additional provider to meet provider-to-beneficiary ratio requirements.

If using telehealth to meet either network adequacy standards or provider-to-beneficiary ratios, MCPs must submit information to DHCS about their telehealth providers using Attachment C, Exhibit A-4. The information must indicate the provider type and specialty, whether the provider is available for in-person services as well as telehealth services, and the service area the telehealth provider serves.

MCPs may also utilize mail order pharmacy to fulfill network adequacy requirements for time and distance standards as an alternative access to care in a defined service area. The MCP must make all reasonable attempts to acquire a pharmacy with a physical location within time and distance standards. MCPs must submit information to DHCS about their mail order pharmacy providers using Attachment C, Exhibit A-4. The MCP must have a procedure to ensure that any medications that cannot be sent through the mail are delivered to beneficiaries in a timely manner consistent with the beneficiary's medical need.

Though MCPs may utilize telehealth or mail order pharmacies to meet network adequacy standards, this does not authorize the MCP to require beneficiaries to utilize telehealth or pharmacy services in place of in-person services.

MCP INTERNAL OPERATIONS ANALYSIS:

DHCS' Audits and Investigations Division (A&I) routinely performs full medical audits of each MCP, including a review of the MCP's infrastructure to assess MCP compliance with timely access and availability of care requirements. A&I will communicate audit findings to the Network Certification team for coordination purposes if the medical audit contains findings of non-compliance, including findings in Category 3 (Access and Availability). Under these circumstances, the Medi-Cal Managed Care Quality and Monitoring Division (MCQMD) will monitor the progress of the corrective action plan (CAP) that has been assessed by A&I as a part of the Annual Network Certification process.

³⁸ DHCS Boilerplate Managed Care Contracts are available at:
<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>

SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION:

MCPs are permitted to use subcontractors to fulfill their obligations under the MCP contract. If an MCP delegates the responsibility to deliver services covered by the MCP contract, whether under a capitated or fee-for-service payment arrangement, to a subcontractor, including, but not limited to, a health plan partner, IPA or clinic, the subcontractor must have an adequate provider network. If the subcontractor does not have an adequate provider network, it must allow assigned beneficiaries to access services out-of-network for any deficient network component(s), as required by state and federal law, the MCP contract, and DHCS guidance, including any applicable APLs.

The delegated subcontractor is not permitted to restrict an assigned beneficiary to only access Medi-Cal managed care services in its own provider network if network adequacy deficiencies exist. In these cases the MCP must authorize services through out-of-network providers. DHCS prohibits the use of an administrative subcontractor, including, but not limited to, an Administrative Services Organization, to restrict an assigned beneficiary to a subcontractor's network if that network does not meet network adequacy standards. DHCS will certify the aggregated MCP provider network.

MCPs must have policies and procedures for monitoring subcontractor network adequacy, including the use of administrative subcontractors that facilitate the referral and/or utilization management process. MCP policies and procedures must include an annual process to assess the network adequacy of all subcontractors that are delegated for the provision of Medi-Cal managed care covered services.

MCPs must also have policies and procedures in place for imposing CAPs and financial sanctions on subcontractors when there is non-compliance with the subcontract or other Medi-Cal requirements. Within three business days, MCPs must report to their contract manager any significant instances of non-compliance³⁹ or the imposition of CAPs or financial sanctions on a subcontractor when it results in the MCP's non-compliance with contractual requirements.

CERTIFICATION OF DOCUMENTS AND DATA CERTIFICATION:

MCPs are required to submit complete, accurate, reasonable, and timely Annual Network Certification attachments in compliance with this APL and 42 C.F.R. 438.207, 42 C.F.R. 438.68, and 42 C.F.R. 438.206 (c)(1). The Annual Network Certification falls within the scope of APL 17-005.⁴⁰

³⁹ DHCS APL 16-001 is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-001.pdf>

⁴⁰ APL 17-005 is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-005.pdf>

NETWORK CERTIFICATION NON-COMPLIANCE:

MCPs who fail to meet the Annual Network Certification reporting requirements or have submitted inaccurate or incomplete data, information or documentation may be placed under a CAP and may be subject to sanctions⁴¹ or penalties for non-compliance. DHCS also reserves the right to halt a beneficiary transition, such as the WCM, if the MCP does not meet network certification requirements.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct all provider network deficiencies. During the CAP process, MCPs must allow Medi-Cal beneficiaries to access Medi-Cal services out-of-network if the services are not available in-network until DHCS finds that the deficiency(ies) has been corrected. If an MCP requests AAS due to a rate dispute with a provider, the MCP must continue to allow the beneficiary to see the provider during the CAP process. DHCS reserves the right to issue escalating measures for ongoing deficiencies for patterns of non-compliance with all network adequacy requirements.

POST NETWORK CERTIFICATION MONITORING ACTIVITIES:

MCPs will be subject to a quarterly monitoring process that includes, but is not limited to, timely access surveys; investigation of complaints, grievances, appeals and issues of non-compliance;⁴² a random sample of MCP subcontractor annual network assessments; provider-to-beneficiary ratios; and out-of-network access requests. In addition, MCPs are subject to a mandatory network adequacy validation performed by the External Quality Review Organization (EQRO). The validation will evaluate the previous 12 months captured by the Annual Network Certification in accordance with 42 C.F.R. section 438.358 (b)(iv).

In conjunction with the quarterly monitoring processes, DHCS will continue its existing data quality review processes. Encounter and provider data quality will continue to be evaluated and verified by MCQMD. Encounter and provider data quality metrics may include, but are not limited to, primary source verification that is conducted by DHCS' EQRO through encounter data validation studies and provider surveys, respectively.

DHCS reserves the right to perform an ad hoc network certification if there is a significant change⁴³ in the MCP's provider network that would affect the adequacy and capacity of services. These significant changes include, but are not limited to, changes

⁴¹ See APL 18-003, which is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-003.pdf>

⁴² WIC 14197(f)(2)

⁴³ See APL 16-001, available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-001.pdf>

in services, benefits, or geographic service area, or an enrollment of a new beneficiary group.

DHCS will post all approved alternative access standards on its website.⁴⁴ Additionally, DHCS will post a report that includes the findings of its evaluation and identify any MCPs that are subject to a CAP due to non-compliance with network adequacy standards, along with the MCPs response to the CAP.⁴⁵ In addition, DHCS will post an annual report in accordance with 42 C.F.R. section 438.66(e)(1)(i).

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

⁴⁴ WIC 14197(e)(3)

⁴⁵ WIC 14197(f)(3)