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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

COMPLIANCE ASSURANCE REPORT: FEBRUARY 2019 SIGNIFICANT CHANGE NETWORK CERTIFICATION FOR MOLINA & HEALTH NET

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1. Background

Overview of Network Certification Requirements

The Department of Health Care Services (DHCS) is responsible for certifying Medi-Cal managed care health plan (MCP) networks and submitting assurances to the Center for Medicare and Medicaid Services (CMS). In accordance with Title 42 Code of Federal Regulations (C.F.R.) section 438.207(c)(3), DHCS must conduct network certifications when there is significant change to the MCP's network that would affect the adequacy of capacity and services that is defined by DHCS.

DHCS defines a significant change as a change in the composition of the MCP's network, services, benefits, geographic service area, or enrollment of a new population. The significant change may occur as a result of a termination, suspension or decertification of an MCP network provider or subcontractor. A termination resulting in a transfer or redirection of 2,000 or more members by the MCP to one or more network providers is considered to be a Block Transfer.[1]

In accordance with California Code of Regulations, title 28, section 1300.67.1.3, subdivision (b), a Block Transfer filing must be submitted to the California Department of Managed Health Care (DMHC) by Knox-Keene licensed Plans. [2] The MCP is also required to notify DHCS of the Block Transfer with a narrative of how the MCP intends to continue to provide covered services to affected Medi-Cal members. The Block Transfer filing and DHCS narrative includes the impacted geographic service area, location of impacted providers, number of members impacted, and their Primary Care Physician (PCP) retention percentage. DHCS reviews the number of members impacted and their PCP retention to determine if a significant change has occurred and a network certification must be conducted.

Upon completion of this Significant Change Network Certification, DHCS submits this Compliance Assurance Report as demonstration of compliance and includes the evaluation components used to certify the MCPs' networks in the impacted service areas. As required by the Final Rule, DHCS will make available to CMS, upon request, all documentation collected by the State from each affected MCP.[3]

Description of Significant Change

Molina and Golden Shore Medical Group (Golden Shore) were unable to reach an agreement to extend the provider contract, which resulted in a contract termination. Subsequently, on November 16, 2018, Molina filed a Block Transfer filing notifying DMHC about the contract termination and submitted to DHCS the required narrative and member notices for review and approval.[4]

[1] California Code of Regulations (CCR), title 28, section 1300.67.1.3, subdivision (a)(3)
[2] CCR, title 28, section 1300.67.1.3, subdivision (b)
[3] 42 C.F.R. section 438.207(e)
[4] CCR, title 22, sections 53852 and 5391

Molina Healthcare Partnership Plan (Molina)

The Golden Shores termination impacted Molina's 67,351 members in Sacramento, Riverside, and San Bernardino Counties. Molina attested that no specialists were impacted by Golden Shore's termination. To confirm this attestation, DHCS required Molina to submit report detailing each member's PCP retention. The report required Molina to list of each affected member's provider include the provider type. With the reported information, DHCS determined that no specialists were impacted by the termination and approximately 8% of impacted members assigned to Molina would retain their current PCP post the effective date of termination.

Health Net Community Solutions

The Golden Shores termination impacted Health Net's 10,938 members in Los Angeles County. The impacted members are assigned to Health Net, but are managed by Molina through a subcontract. Since Health Net contracts directly with DHCS, it is required to meet its contractual obligations and thus is held responsible for submitting the Block Transfer Filing and narrative. Health Net attested that no specialists were impacted by Golden Shore's termination. To confirm this attestation, DHCS required Health Net to submit report detailing each member's PCP retention. The report required Health Net to list of each affected member's provider include the provider type. With the reported information, DHCS determined that no specialists were impacted by the termination and approximately 4% of the impacted members assigned in Los Angeles County would retain their current PCP post the effective date of termination.

Due to the combination of a large number of impacted members and low PCP retention, DHCS determined that the changes to Molina's and Health Net's impacted counties were significant enough to warrant a further review of their networks. DHCS conducted a Significant Change Network Certification as described in the section below to ensure that both Molina and Health Net continue to be compliant with network certification standards in the impacted counties.

2. Significant Change Network Certification Components

The evaluation of the affected MCP's networks consisted of assessing each MCP's compliance with the same network components as required for the Annual Network Certification to meet contractual, State, and federal requirements. The network certification components included network provider to member ratios, mandatory provider types, time and distance standards, and timely access. For each component, DHCS details the requirements and approach used to determine an adequate network in the following subsections.

2.1. Network Provider to Member Ratios

Requirement

Per the MCP's contractual requirements, MCPs must meet current full-time equivalency (FTE) network provider to member ratios for PCPs of 1 PCP to every 2,000 members

and total network physicians of 1 physician to every 1,200 members. The PCP may be a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). Further, an OB/GYN functioning as a PCP must be assignable to members.

Review Approach

DHCS requested MCPs submit PCP and physician network provider information in their monthly provider file submission, the274, taking FTE into account for its reporting units.

DHCS calculated the network provider to member ratio using the total number of MCP network providers divided by the projected enrollment until June 30, 2019, by which time the next Annual Network Certification will have been effective. The projected enrollment is based on each reporting unit's monthly enrollment of the 18-month period prior to the contract year. The monthly enrollments are divided into four (4) categories based on the combination of utilization of the Seniors and Persons with Disabilities (SPD) population and the non-SPD population and age groups (0-18 and 18+). Enrollment to the next Annual Network Certification was forecasted by combining each of the four projections to calculate a total projected enrollment per reporting unit. MCPs are required to cover a percentage of their projected enrollment as specified in its contract, which varies by plan model type.

2.2. Mandatory Provider Types

Requirement

MCPs must have contracts with the following provider types or facilities based on federal and State requirements:

- At least one Federally Qualified Health Center, one Rural Health Clinic and one Freestanding Birthing Center, where available in the contracted service area,[5]
- Offer contracts with each Indian Health Service Facility (IHF) in the contracted service area where available,[6] and
- At a minimum one Certified Nurse Midwives and at a minimum one Licensed Midwives in the contracted service area.[7]

Review Approach

MCPs may either have an executed contract or have submitted documentation to DHCS that demonstrates the MCP has conducted good faith contracting efforts in order to contract with the mandatory provider type. DHCS requested MCPs enter the mandatory network providers in its 274 file submission or submit documentation justifying the absence of the required provider.

[5] CMS State Health Official Letter (SHO) #16-006
[6] 42 C.F.R., section 438.14(b)(1)
[7] WIC, sections 14132.39 and 14132.4.

DHCS assessed the MCP's submissions and validated the information by verifying reported differences in the same contracted service area were allowable, ensuring that all MCPs had attempted to contract with a facility or each IHF in their service area, or provide supporting documentation detailing any contracts that were unable to be executed.

2.3. Time and Distance Standards

Requirement

Welfare and Institutions Code (WIC) section 14197 outlines California's state-specific time and distance standards as set forth in **Attachment A**. The time and distance standards are based on county population density and are applicable to the following provider types: pediatric and adult PCPs, pediatric and adult core specialists[8], OB/GYN PCPs and specialists, hospitals, pediatric and adult mental health providers[9], and pharmacies.

Additionally, DHCS allowed MCPs to utilize telehealth or mail order pharmacy services as a means of meeting time and distance standards in cases where the MCP can demonstrate it has been unable to contract with an in-person provider or if they can demonstrate that its delivery structure is capable of delivering the appropriate level of care.

Review Approach

DHCS requested MCPs submit geographic access maps and accessibility analyses that demonstrated compliance with applicable time or distance standards or demonstrated that they had requested DHCS approval of an Alternative Access Standard (AAS) for the entire service area.[10,11,12] **Attachment B** in the Appendix outlines zip codes that MCPs are not required to meet time and distance standards due to those zip codes being carved out to fee-for-service or another MCP.

DHCS assessed and certified the MCPs using geographic access maps and accessibility analysis for time and distance standards based on county population density for each of the required provider types. The geographic access maps and accessibility analysis looked at total distance and travel time between the providers and the member's residence. Additionally, DHCS assessed and ensured there was entire

[8] Core Specialists are outlined in Attachment A.
[9] Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapists (LMFT) LCSW and LMFT Interns.
[10] DHCS confirmed that no specialists were impacted due to the Golden Shores termination. As such, time and distance standards were only assessed for PCPs.
[11] The Golden Shores website confirmed that only primary care was available at the Golden Shores Federally Qualified Health Centers: https://www.goldenshoremedical.com/citrus-heights
[12] DHCS attests that the networks of Molina and Health Net post the Golden Shores termination have sufficient family planning providers.

service area coverage for time and distance standards. DHCS verified that the MCP submitted an AAS request if they were unable to meet time and distance standards based on the geographic access analysis.

2.4. Alternative Access Standard Requests

Requirement

MCPs are permitted to submit AAS requests for time and distance standards for the following provider types: adult and pediatric PCPs, OB/GYN PCPs (only for assigned members), OB/GYN specialists, hospitals, pharmacies, adult and pediatric core specialists and adult and pediatric mental health outpatient providers.[13] AAS requests may only be submitted when the MCP has exhausted all other reasonable options for contracting with network 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.

Review Approach

DHCS requested that MCPs unable to meet time and distance standards for assigned members submit AAS requests on a reporting template. MCP AAS requests were organized by zip code and county and included:

- Driving time and/or the distance, in miles, between the nearest in-network provider(s) and the most remote members;
- Proposed AAS standard in minutes and miles from the most remote members; and
- Detailed the MCP's contracting efforts including documentation of all the providers with whom the MCP attempted to contract and an explanation of why the contract was not executed.

DHCS assessed the requests for AAS and either approved or denied each request on a zip code and provider type basis using the following review criteria:

- Driving times to the nearest in-network provider request exceeds the time standard or distance to the nearest in-network provider exceeds the distance standard;
- Name and address of closest in-network provider;
- Narrative explaining why the plan was unable to execute contract with located provider, including whether there was a rate dispute between the provider and MCP; and
- Determined whether the proposed alternative standard is a reasonable request based on:
    - Health Care Options website;
    - Medicare.gov;

[13] WIC section 14197(e)(1)

- Office of Statewide Health Planning and Development;
- California Health and Human Services Open Data/Fee-for-Service;
- Any additional web based sites; and
- Consider the geographic region, size, and total members affected when assessing the request. If the standard is within 5 miles of the nearest provider, DHCS does not require additional substantiation.

DHCS-approved AAS requests are valid for one contract year and must be resubmitted to DHCS for approval annually. DHCS posts all approved alternative access standards on its website.[14]

AAS for Significant Change

Molina and Health Net did not require AAS requests for PCPs due to the MCPs meeting time and distance standards. During this process, DHCS received AAS requests for other provider types unrelated to the significant change and thus, will review those based on the provision of WIC section 14197.

2.5. Timely Access

Requirement

Final Rule timely access requirements are outlined in **Attachment A**. In addition to timely access, DHCS is required to monitor access and availability.[15]

Review Approach

To monitor access and availability, DHCS' Audits and Investigations (A&I) Division conducts verification studies of MCP timely access compliance during the annual medical audit and looks at the following:

- The MCP and its network providers meet state mandated standards for timely access to care and services;
- That network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee-for-Service if the provider services only Medicaid members;
- That services are available 24 hours a day, 7 days a week when medically necessary;
- There are mechanisms to ensure compliance from network providers;
- There is monitoring of network providers regularly to determine compliance; and
- Corrective action is taken if there is failure to comply by a network provider.

DHCS' Managed Care Quality and Monitoring Division (MCQMD) reviews audit findings, and where deficiencies are identified, requires MCPs to submit a CAP addressing all

[14] WIC section 14197(e)(3)
[15] 42 C.F.R. section 438.206(c)(1)

areas of non-compliance, including those identified in Category 3 (Access and Availability) of the medical audit. In order to reinforce DHCS' MCP monitoring efforts, MCQMD incorporates A&I's corrective action plans (CAPs) concerning access and availability findings into the Annual Network Certification process.

3. Significant Change Network Evaluation Determinations

After reviewing each of the Significant Change Network Certification components, each MCP was given a final determination: Pass or Pass with Conditions.

- A **Pass** or **AAS Pass** designation means the standard was met and/or deemed to be met due to AAS being approved; no further action is needed from the MCP.
- A **Pass with Conditions** designation means the MCP did not fully meet the standard, and as such, DHCS imposed a Corrective Action Plan (CAP) and temporary standards[16].

4. Significant Change Network Certification Overall Results

The following charts indicate the overall results of each affected MCP by reporting unit. MCP-specific results are noted in **Attachment C**.

Significant Network Certification Key

Pass with Conditions: Standard is not met and/or standard is not met due to AAS Denial; temporary standard in place with CAP.
AAS Pass: Standard is met due to AAS approval.
Pass: Standard is met.
Not Applicable (N/A): Not applicable to MCP[17].

MCP Name	Reporting Unit	Results
Health Net Community Solutions, Inc.	Los Angeles County	Pass
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino Counties	Pass
	Sacramento County	Pass

5. Enhanced Monitoring Post Transition

DHCS will monitor the impacted members and service areas monthly for six months post the effective date of termination. MCPs must submit Continuity of Care, Authorizations, Call Center, Grievances and Appeals, and Timely Access reporting as part of the enhanced monitoring of the transition.

[16] Please refer to **Section 6** for the temporary standards and requirements placed on MCPs under a CAP.
[17] MCPs are not contractually at risk for certain benefits.

- Continuity of Care (COC) reports capture the number of members who have requested COC with a provider with whom they have a pre-existing relationship; the status of the request; and denial reason, if applicable.
- Authorization reports capture the number of requests for previously approved services and medications in the last 12 months; and the number of requests for previously approved services and medications in the last 12 months not resulting from the transfers.
- Call Center reports capture the number of calls that were received, abandoned, and answered during the reporting periods; and the outcome of the calls.
- Grievances and Appeals reports capture member grievances regarding accessibility and quality of care.
- Timely Access reports captures number and percentage of providers meeting wait time standard based on first appointment time for urgent and non-urgent appointments.

Submission deadlines for all reports are as follows:

Submission Deadline	
April 1, 2019	February 1, 2019 through February 28, 2019
May 1, 2019	March 1, 2019 through March 31, 2019
June 3, 2019	April 1, 2019 through April 30, 2019
July 1, 2019	May 1, 2019 through May 31, 2019
August 1, 2019	June 1, 2019 through June 30, 2019
September 3, 2019	July 1, 2019 through July 31, 2019

In an effort to ensure a smooth transition of the members affected by the Golden Shores closure, DHCS has also requested daily updates from the MCPs for the month of February to monitor any issues or concerns.
In addition to enhanced monitoring requirements, Molina and Health Net must continue to submit existing quarterly MCP network monitoring processes that include, but are not limited to:

- Timely access results;
- Grievances, appeals and issues of non-compliance;
- A random sample of MCP subcontractor annual network assessments;
- Continuity of Care requests;
- Network composition;
- Provider-to-member ratios; and
- Out-of-Network access requests.

In addition to the monitoring mechanisms outlined above, DHCS has a standard practice of performing monitoring activities daily for a month after transition. MCPs are required to report on grievances and appeals, continuity of care, and any other areas of concern that the MCP and/or DHCS has identified as part of the transition. DHCS works

closely with the MCPs to track the beneficiary-specific cases and ensure proper authorizations and claims payments, as well as pending continuity of care requests.

6. Corrective Action Plan (CAP)

CAP Process

MCPs that are unable demonstrate compliance with the Significant Change Network Certification components are subject to a CAP. DHCS will impose temporary standards for the MCP to meet immediately and impose a CAP for any network certification deficiencies. The temporary standard requires the MCP to authorize out-of-network services which allows the MCP to correct all deficiencies during the CAP process, while at the same time ensuring that members have access to medically necessary services within timely access standards. MCPs may not deny access to out-of-network services on the basis of payment or rate disputes with a provider. The temporary standard remains in full effect until all network certification deficiencies have been corrected and DHCS approves closure of the CAP.

MCPs under a CAP are required to submit a response to the CAP and include the following items:

- Proposed solution;
- Specific deliverables to be met and completed;
- Timeline for each deliverable;
- Attestation that the MCP will approve out-of-network services for the members affected by the deficiencies for the duration of the CAP;
- Timeline for progress updates; and
- CEO signature.

Network Adequacy CAPs will remain effective until all deficiencies are resolved. MCPs will have up to six (6) months or two quarterly reporting periods to resolve all deficiencies. If the significant change occurs within three (3) to six (6) months of the next Annual Network Certification the Network Adequacy CAP would be folded into the Annual Network Certification.

If the MCP fails to comply with CAP requirements, DHCS may initiate additional corrective action measures, including sanctions in accordance with the MCP contract, State and federal law.

CAP Resulting from Significant Change

Due to Molina and Health Net meeting all the network certification components as described in **Section 2** , DHCS has not imposed a CAP on either MCP for the 2019 Significant Change Network Certification.

7. Appendices

7.1. Attachment A: Network Adequacy Standards

Provider Type	Timely Access Standard	Time and Distance[18] Rural	Time and Distance[18] Small	Time and Distance[18] Medium	Time and Distance[18] Dense
Primary Care (Adult and Pediatric)	Within 10 business days to appt. from request	10 miles or 30 minutes from the member's residence	10 miles or 30 minutes from the member's residence	10 miles or 30 minutes from the member's residence	10 miles or 30 minutes from the member's residence
Specialty Care[19] (Adult and Pediatric)	Within 15 business days to appt. from request[20]	60 miles or 90 minutes from the member's residence	45 miles or 75 minutes from the member's residence	30 miles or 60 minutes from the member's residence	15 miles or 30 minutes from the member's residence
Obstetrics/Gynecology (OB/GYN) Primary Care	Within 10 business days to appt. from request	10 miles or 30 minutes from the member's residence	10 miles or 30 minutes from the member's residence	10 miles or 30 minutes from the member's residence	10 miles or 30 minutes from the member's residence
Obstetrics/Gynecology (OB/GYN) Specialty Care	Within 15 business days to appt. from request	60 miles or 90 minutes from the member's residence	45 miles or 75 minutes from the member's residence	30 miles or 60 minutes from the member's residence	15 miles or 30 minutes from the member's residence
Hospitals	N/A	15 miles or 30 minutes from the member's residence	15 miles or 30 minutes from the member's residence	15 miles or 30 minutes from the member's residence	15 miles or 30 minutes from the member's residence
Pharmacy	Dispensing of at least a 72-hour supply of covered outpatient drug in an emergency situation	10 miles or 30 minutes from the member's residence	10 miles or 30 minutes from the member's residence	10 miles or 30 minutes from the member's residence	10 miles or 30 minutes from the member's residence

[18] County Size Category by Population defined in Table 1
[19] Time and Distance Standards apply to the core specialists outlined in Table 2
[20] Timely Access standards apply to all specialists, not only core specialists

Provider Type	**Timely Access Standard**	**Time and Distance[18]** Rural	**Time and Distance[18]** Small	**Time and Distance[18]** Medium	**Time and Distance[18]** Dense
Mental Health (non-psychiatry) Outpatient Services[21] (Adult and Pediatric)	Within 10 business days to apt. from request	60 miles or 90 minutes from the member's residence	45 miles or 75 minutes from the member's residence	30 miles or 60 minutes from the member's residence	15 miles or 30 minutes from the member's residence
Ancillary	Within 15 business days to appt. from request	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Long Term Services and Supports	If applicable[22]	Time and distance standards are not established for Multipurpose Senior Services Program (MSSP), Skilled Nursing Facilities (SNF), or Intermediate Care Facilities (ICF) providers as these providers either travel to the member to provide services or the member resides at	Time and distance standards are not established for Multipurpose Senior Services Program (MSSP), Skilled Nursing Facilities (SNF), or Intermediate Care Facilities (ICF) providers as these providers either travel to the member to provide services or the member resides at	Time and distance standards are not established for Multipurpose Senior Services Program (MSSP), Skilled Nursing Facilities (SNF), or Intermediate Care Facilities (ICF) providers as these providers either travel to the member to provide services or the member resides at	Time and distance standards are not established for Multipurpose Senior Services Program (MSSP), Skilled Nursing Facilities (SNF), or Intermediate Care Facilities (ICF) providers as these providers either travel to the member to provide services or the member resides at

[21] Non-specialty mental health services for beneficiaries with mild to moderate impairments
[22] LTSS Timely Access Network Standards defined in See Table 3

Provider Type	Timely Access Standard	Time and Distance[18] Rural	Time and Distance[18] Small	Time and Distance[18] Medium	Time and Distance[18] Dense
		the facility for care.	the facility for care.	the facility for care.	the facility for care.

Table 1: County Size Categories by Population

Size Category	Population Density	# of Counties	Counties
Rural	<50 people per square mile	21	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Tuolumne, Trinity
Small	51 to 200 people per square mile	19	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba
Medium	201 to 600 people per square mile	9	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura
Dense	≥600 people per square mile	9	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara

Table 2: DHCS Adult and Pediatric 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

7.2. Attachment B: Carved Out Zip Codes

County	Carved-Out to Fee for Service	Zip Codes
Los Angeles	Carve-Out	90704
Riverside	Carve-Out	92225, 92226, 92239
San Bernardino	Carve-Out	92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 93592

7.3. Attachment C: Significant Change Network Certification Results

MCP Name - Health Net
Reporting Unit – Los Angeles County

Provider to Member Ratios	Results
PCP Ratio (1: 1,200)	Pass
Total Physician Ratio (1: 2,000)	Pass

Time and Distance	Results
Adult PCPs	Pass
Pediatric PCPs	Pass
OB/GYN Primary Care	AAS Pass

Mandatory Provider Types	Results
FQHC, FBC, RHC, IHF, CNM, and LM (1 of each in the Network)	Pass

Alternative Access Standards Requests	AAS Pass

Overall Results	Pass

MCP Name – Molina Healthcare
Reporting Unit – Riverside/San Bernardino County

Provider to Member Ratios	
PCP Ratio (1: 1,200)	Pass
Total Physician Ratio (1: 2,000)	Pass

Time and Distance	Results
Adult PCPs	Pass
Pediatric PCPs	Pass
OB/GYN Primary Care	AAS Pass

Mandatory Provider Types	Results
FQHC, FBC, RHC, IHF, CNM, and LM (1 of each in the Network)	Pass

Alternative Access Standards Requests	AAS Pass

Overall Results	Pass

MCP Name –Molina Healthcare
Reporting Unit – Sacramento County

Provider to Member Ratios	
PCP Ratio (1: 1,200)	Pass
Total Physician Ratio (1: 2,000)	Pass

Time and Distance	
Adult PCPs	Pass
Pediatric PCPs	Pass
OB/GYN Primary Care	Pass

Mandatory Provider Types	
FQHC, FBC, RHC, IHF, CNM, and LM (1 of each in the Network)	Pass

Alternative Access Standards Requests	N/A

Overall Results	Pass