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

2022 MEDI-CAL MANAGED CARE HEALTH PLANS NETWORK ADEQUACY AND ACCESS ASSURANCES ANALYSIS METHODS

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1. Overview

The Department of Health Care Services (DHCS) submits its Network Adequacy and Access Assurances Analysis Methods Report to the federal Centers for Medicaid & Medicaid Services (CMS) to demonstrate network adequacy of Medi-Cal managed care health plans (MCP) for the 2022 contract year.

DHCS assesses network adequacy standards compliance in accordance with Part 438 of the Code of Federal Regulations (CFR) sections 438.68, 438.206 and 438.207 and corresponding state law and policy guidance.[1] DHCS will provide all Annual Network Certification (ANC) documentation collected by DHCS from each MCP to CMS, upon request.[2] DHCS' policy and compliance guidance for MCPs regarding ANC components and submission requirements are published in All Plan Letter (APL) 23-001.[3]

2. Annual Network Certification Components

During the ANC process, DHCS evaluates each MCP's compliance with contractual, State, and Federal requirements related to network adequacy standards. This evaluation includes reviewing all MCP reported data through DHCS' monthly 274 provider file and additional MCP submissions for compliance with provider to member ratios, mandatory provider types, and Time or Distance standard requirements. The findings of DHCS' evaluation of all MCPs are detailed in the "2022 ANC MCP-Specific Findings" Excel file.

2.1 Provider-to-Member Ratios

Physician Ratios

MCPs are contractually required to meet provider-to-member ratios for full-time equivalent (FTE) primary care physicians (PCPs) of one PCP to every 2,000 members, and for total network physicians of one FTE physician to every 1,200 members. Non-physician medical practitioners may be used to demonstrate a sufficient network of PCPs; however, non-physician medical practitioners are not included in the assessment of provider-to-member ratios.

DHCS calculates provider-to-member ratios by dividing each MCP's total number of network providers by the MCP's current member enrollment for the current contract year. Monthly enrollments are reported in four member populations: Seniors and Persons with Disabilities (SPDs), non-SPDs, age groups 0–17, and 18+.

DHCS calculates the total enrollment per the Healthcare Effectiveness Data and Information Set (HEDIS) reporting unit by combining the four member populations. MCPs are required to have the capacity to cover a percentage of enrollment as specified in the MCP contract, which varies by Medi-Cal managed care model type. The

[1] Managed Care Final Rule, Federal Register, Vol. 81, No. 88; Welfare & Institutions Code section 14197.7, All Plan Letter 19-001 and any subsequent revisions.
[2] Title 42 Code of Federal Regulation (C.F.R.) section 438.207(e).
[3] APL available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

FTE provider count is based on the sum of FTEs divided by 100 for all distinct providers at the primary MCP level. Each provider has a maximum FTE of 100% for each MCP.

Outpatient Mild-to-Moderate Mental Health Services
MCPs must meet adult and pediatric provider-to-member ratios to ensure access to medically necessary mild-to-moderate outpatient mental health services for State Plan approved providers including: psychologists, licensed clinical social workers, and licensed marriage and family therapists. DHCS calculates provider-to-member ratios annually by taking into account current service utilization, dedicated provider time for providing mental health services, and anticipated utilization of mild-to-moderate mental health services.

2.2 Mandatory Provider Types

The Social Security Act set forth that Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birth Center (FBC) services are mandatory Medicaid benefits.[4] As outlined in CMS SHO Letter #16-006, CMS has determined that, in order for an MCP's provider network to be sufficient, the MCP must include access to FQHC, RHC, and FBC services, if available, from FQHCs, RHCs, and FBCs. Federal law requires MCPs to contract with at least one FQHC, RHC, and FBC in each of the MCPs' service area(s), where available.[5] SHO Letter #16-006 further allows States the flexibility to require MCPs to contract beyond this minimum standard. Pursuant to WIC Section 14087.325 MCPs that operate in a local initiative (LI) health plan model are required to offer to contract with all available FQHCs and RHCs in each of their service area(s)[6]. LI MCPs must provide supporting documentation of their contracting efforts with all FQHCs and RHCs, even if they have a minimum of one active contract with an FQHC and RHC in each service area. MCPs operating under Non-LI health plan models are required to only meet SHO Letter #16-006 requirements. Nonetheless, non-LI MCPs that do not meet this federal requirement must submit a justification or attestation detailing the reasons for not being able to establish a contract. Additionally, the MCP must provide supporting documentation of their contracting efforts.

MCPs must also contract with at least one certified nurse midwife (CNM) and one licensed midwife (LM) in each of their service areas, where available, per State and federal network adequacy requirements.[7,8,9] Indian Health Facilities (IHFs) are not required to contract with MCPs; however, MCPs are required to offer to contract with all

[4] Sections 1905(a)(2)(B) and (C) and 1905(a)(28) of the Act, as well as sections 1905(l)(1) through (3) of the Act
[5] State Health Official (SHO) Letter #16-006: https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf
[6] WIC section 14087.325 places the expanded obligation on LIs. Non-LIs are held to the SHO Letter #16-006 MPT contracting requirements.
[7] MCP Contract, Exhibit A, Attachment 9, Nurse Midwife and Nurse Practitioner Services.
[8] WIC section 14132.39; WIC section 14132.4
[9] 42 USC section 1396d(a)(17). The USC is available at: http://uscode.house.gov/.

IHFs in each of the MCP's service areas and maintain documentation of all contracting efforts.

2.3 Time or Distance Standards

DHCS established network adequacy standards in accordance with State and Federal law and regulations based on county population density for specific provider types.[10] If the MCP is unable to meet Time or Distance standards based upon the geographic accessibility analysis, it must request DHCS approval for an alternative access standard (AAS) as detailed in APL 23-001 and below in Section 3: Alternative Access Standards.

2.4 Timely Access

DHCS conducts an annual Timely Access Survey that measures compliance with appointment wait time standards and shares the results quarterly to each MCP. DHCS' contracted External Quality Review Organization (EQRO) conducts the survey using a statistically valid random sample of network providers to confirm the first three available times for urgent and non-urgent primary, specialty, mental health appointments for pediatric and adult members. Additionally, the survey confirms wait time standards for call centers and nurse triage/advice lines and the availability of interpreter services

MCPs must submit a response to any timely access deficiencies found in the quarterly survey results and identify any changes or corrections necessary to achieve compliance with timely access requirements.

As part of the ANC, DHCS also verifies timely access to Long Term Services and Supports (LTSS) based on county population density. MCPs must submit policies and procedures to ensure compliance with timely access standards for Skilled Nursing Facility (SNF) services, Intermediate Care Facility (ICF) services, and Community-Based Adult Services (CBAS). MCPs must confirm they have processes for verifying SNF, ICF and CBAS providers are meeting timely access standards within the MCP network. Additionally, for MCPs that do not have SNF, ICF or CBAS providers in their network, those MCPs' policies and procedures must demonstrate how the MCP provides access to SNF, ICF, or CBAS services and attest to the availability of services out-of-network.

3. Alternative Access Standards

3.1 Alternative Access Standard Requests

MCPs that are unable to meet Time or Distance standards and have exhausted all reasonable contracting efforts with closer providers must submit a request for an alternative access standard (AAS) to DHCS for review and approval. The AAS request is by ZIP code and provider type and must detail the specific reasons demonstrating the

[10] Pediatric and adult PCPs, pediatric and adult core specialists, OB/GYN specialist, pediatric and adult mental health providers, hospitals, and pharmacies.

need for the AAS.[11] DHCS will only approve an AAS request if an AAS request is being submitted for MCPs operating in challenging geographical areas for Provider types that may be difficult to contract with (i.e. Health Professional Shortage Areas for mental health providers) or if the MCP identified and DHCS confirmed there are no closer providers outside of their network. Before receiving an AAS approval, MCPs must make good faith efforts to exhaust reasonable contracting options with additional Providers within the time or distance standards.

An AAS request can include telehealth when appropriate for the member's health condition and supported by justification that in-person care is not available. DHCS approves or denies AAS requests by analyzing the information provided by the MCP, information from other MCPs operating in the same county and bordering counties, and DHCS' research of closer Providers to validate each request.[12] Approved AAS requests are contingent on the results of DHCS' AAS validation process as detailed below in 5.3 Alternative Access Standard Validations. All AAS findings are posted on the DHCS website.

When medically appropriate, if the MCP covers at least 85% of the population points in the ZIP code, DHCS permits MCPs to use the synchronous mode of Telehealth instead of submitting an AAS request.[13] If the MCP is using Telehealth to meet time or distance for 15% of the population points in the ZIP code, it must meet the required Telehealth Provider-to-Member ratio of 1:2,000 (or better) of "Telehealth Only" Providers to Medi-Cal members based on the number of the MCP's Members in that ZIP code that are not covered by in-person Providers.

Telehealth Providers can be utilized to meet time or distance standards for any ANC Provider types except for General Surgery, Orthopedic Surgery, Physical Medicine and Rehabilitation and Hospitals.[14] The MCP must submit documentation if using Telehealth as specified in Attachment B, and Exhibits B and C of APL 23-001.

3.2 Delivery System Alternative Access Standard

In cases where an MCP is unable to meet Time or Distance standards due to its unique delivery system, the MCP must demonstrate its capability to deliver the appropriate level of care and access to members. DHCS reviews the MCP's formal justification to determine if its unique delivery system can meet the needs of its members and ensure appropriate and timely access to care.[15] For this ANC submission, DHCS has approved delivery system AAS for AIDS Healthcare Foundation, Kaiser Permanente, and SCAN.

[11] Health Professional Shortage Areas (HPSAs) are designated by Health Resources and Services Administration (HRSA) as having shortages of health providers. See https://bhw.hrsa.gov/shortage-designation.
[12] WIC section 14197(f)(3).
[13] WIC section 14197(f)(1).
[14] The list of telehealth ANC provider types can be found in Attachment A Table 5 of APL 23-001.
[15] See WIC §14197(e)(1)(B)

4. Network Adequacy Determinations

DHCS evaluates MCP data submissions for each ANC component and makes the following ANC designations:

- A **Pass** designation means the required standards were met.
- An **AAS Pass** designation mean the required standard was not met but an AAS was approved for the MCP or a Delivery System Alternative Access Standard was granted.
- A **Pass with Conditions** designation means the MCP's submission did not fully meet the required submission standards, and DHCS imposed a temporary access compliance standard for the MCP to maintain until all ANC deficiencies are corrected. DHCS is actively working with the plan to ensure the AAS are properly submitted and meet DHCS' requirements for approval.

MCPs under the Pass with Conditions designation will face a Corrective Action Plan (CAP). Under the CAP, DHCS establishes temporary access standards with which each MCP must comply. These, include, but are not limited to, authorization of out-of-network referrals and provisions transportation services. DHCS also mandates CAPs for each deficient ANC component for specific MCPs. MCPs must comply with the CAP requirements until the MCP corrects all specified deficiencies and DHCS closes the CAP. DHCS publishes a report detailing each MCP's CAP on its website and the findings of DHCS' network adequacy determinations are detailed in the "2022 ANC MCP-Specific Findings Excel File."[16]

5. Network Validations

DHCS conducts validations of the providers and facilities by sampling and reviewing MCPs' monthly 274 network provider file submissions, Mandatory Provider Type (MPT) contracts and approved AAS compliance through various activities specific to each requirement set forth below. Specific validation findings are detailed in the "2022 ANC MCP-Specific Findings Excel File."

5.1 Provider and Facility Validations

DHCS validates that MCPs are contracted with network providers entered in the monthly 274 file submission through the Timely Access Survey. The Timely Access Survey question asks whether the provider is contracted with the MCP in order to validate the provider's response as compared to the MCP's monthly 274 file. Further, DHCS reviews supporting evidence such as contracts between MCPs and network providers to ensure there are valid contracts in place. Therefore, MCPs designated as a Pass with Conditions for Provider Validations in Exhibit A will be required to provide updates on provider training and outreach through the quarterly monitoring process.

[16] DHCS Reporting on Network Adequacy can be found at: https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx

5.2 Mandatory Provider Type Validations

DHCS validates each MCP contracts with the required MPTs including FQHCs, RHCs, IHFs, FBCs, CNMs and LMs.[17] As part of the validation process, DHCS reviews that MCPs have an active contract with an MPT, if there is one in the service area. MCPs with no contract are required to submit additional documentation demonstrating that either they attempted to contract and the MPT refused, or that no active MPTs operate in the service area. DHCS reviews all documentation submitted to ensure compliance with the MPT requirement. DHCS' validation findings are detailed in the "2022 ANC MCP-Specific Findings Excel File."

5.3 Alternative Access Standard Validations

DHCS validates MCP approved AAS requests through review of contracting efforts, verification of contract signature pages, and other evidence and supporting documentation that validates the MCP's compliance with its approved AAS. MCPs that fail to provide necessary documentation or provide inaccurate information may have their approval rescinded, a CAP may be imposed, and may face sanctions for failures to provide necessary or accurate documentation or data. Since MCPs are required to demonstrate good faith contracting efforts before requesting an AAS, the number of AAS requests are minimized.

5.4 Out-of-Network Access Validations

DHCS validates out-of-network member access for MCPs with provider types identified as Pass with Conditions. The validation process includes a review of access and transportation services policies and procedures, member services call scripts, and training materials, and a call campaign. A call campaign entails DHCS calling the member services lines of the MCPs under a corrective action plan to ensure they member services representatives are using the approved call scripts and providing members with accurate information. MCPs that fail to provide accurate information during the call campaign receive technical assistance and additional call rounds as needed until compliance is achieved. MCPs who fail the out-of-network validation process may face additional CAPs and/or sanctions.

6. **Compliance Mechanisms and Actions**

6.1 Corrective Action Plans

MCPs unable to meet ANC requirements are designated as Pass with Conditions and face CAPs. DHCS monitors MCPs to assess whether they are making progress and meeting the requirements under the CAPs. MCPs must correct all MCP specific ANC deficiencies within six months of the CAP start date. MCPs that fail to comply with CAP requirements, or fail to correct all ANC deficiencies within the six month timeframe, may face additional CAP and/or sanctions.[18] DHCS will close a CAP after confirming that the MCP has corrected all ANC deficiencies.

[17] SHO Letter #16-006
[18] See WIC section 14197.7.

6.2 Quarterly Monitoring

In addition to the ANC process, DHCS monitors compliance for access and member protection requirements, including provider-to-member ratios, timely access, MPTs, grievances, State Fair Hearings, and out-of-network access through its quarterly monitoring process. MCPs are required to review and provide responses to additional inquiries from DHCS when they are out of compliance and/or do not sufficiently demonstrate improvements in any identified deficiencies.

7. Next Steps for Improvement

The State's varied county population densities and geographical attributes pose challenges to meeting time or distance standards and MCPs continue to utilize AAS requests in geographically remote regions, which lack specialists, especially pediatric specialists. Additionally, three dense counties (e.g., Los Angeles, Sacramento, and San Diego) continue to submit AAS requests given rural zip codes within those dense counties.

In an effort to improve member access to care, DHCS will work continue to work directly with the MCPs to identify the barriers the MCPs are facing in these regions and will explore creative solutions to reduce the number of AAS requests. DHCS will also institute additional documentation requirements, including increasing the minimum level of evidence required to gain AAS approval. For example, DHCS will require the MCPs to provide more detail regarding MCP's outreach and contract negotiations activity to assess the drivers of the failed negotiations and associated AAS requests.

DHCS acknowledges the lack of providers within these regions are driven by a complex suite of circumstances and may require resources and multi-year initiatives from multiple state agencies to drive increases in the pipeline and workforce to ultimately address provider shortages. However, DHCS believes the steps noted above will assist in improving gaps in the MCPs' provider network and ultimately improve access to care.

DHCS will provide technical assistance to its MCPs prior to the next ANC submission to ensure that MCPs understand the requirements and conduct appropriate activities to improve access. DHCS will continue to undertake appropriate enforcement activities, including but not limited to, Corrective Action Plans and sanctions.