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

COMPLIANCE ASSURANCE REPORT: JANUARY 2019 ANNUAL NETWORK CERTIFICATION

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1. Synopsis

The Department of Health Care Services (DHCS) is responsible for certifying Medi-Cal managed care health plan (MCP) provider networks and submitting assurances to CMS on an annual basis prior to the start of each contract year. DHCS published guidance for MCPs that prescribed the MCP network certification process and submission requirements. MCPs are required to submit documentation to DHCS that demonstrates the capacity to serve the expected enrollment in each service area in accordance with DHCS' standards for access to care established under the authority of CMS Medicaid and CHIP Final Rule, CMS-2390-F (Final Rule) sections 438.68, 438.206 and 438.207.[1]

After completing a comprehensive assessment of each MCP's provider networks, DHCS had determined that each MCP is in full compliance with the Annual Network Certification requirements set forth in 42 C.F.R. section 438.207.

Each MCP's Annual Network Certification was given a final determination: Pass or Pass with Conditions.

- A Pass or AAS Pass designation means the standard was met and/or an alternative access standard was approved for the MCP. 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 temporary standard requiring the MCP to authorize access to out-of-network providers and/or services if services are not available in-network within the timely access standards. Further, MCPs may not deny access to out-of-network services on the basis of payment or rate disputes with the provider. The temporary standard was communicated through a CAP. MCPs are required to authorize out-of-network providers and services until all CAP items have been corrected and the CAP is closed.

DHCS submits this Compliance Assurance Report for January 2019 as demonstration of compliance and includes the evaluation components used to certify the MCPs' provider networks included in this report. As required by the Final Rule, DHCS will make available to CMS, upon request, all documentation collected by the State from each MCP.[2]

[1] Managed Care Final Rule, Federal Register, Vol. 81, No. 88
[2] Title 42 Code of Federal Regulation (C.F.R.) section 438.207(e)

2. Background and Overview

2.1. Medicaid Managed Care Final Rule Requirements

The Final Rule required DHCS to codify its network adequacy standards and certification requirements, which in California expanded on previous provider network requirements. Furthermore, it required that states not only meet the federal requirements of 42 C.F.R. sections 438.68, 438.206(c) and 428.207, but also establish state specific network adequacy standards to ensure that MCPs are meeting the current needs of the members and expected members during the next contract year.

To assure compliance with established federal and State standards, the Final Rule requires DHCS to submit to CMS an annual network certification of the MCPs' conformance of the requirements. In addition to the Final Rule annual network certification requirements, DHCS must also submit a network certification when a MCP enters into a contract with the State; there has been a significant change in the MCP's operations that would affect the adequacy of capacity and services as defined by DHCS, including changes in MCP services, benefits, geographic service area, composition of, or payments to its provider network; or enrollment of a new population in the MCP occurs.[3]

2.2. Compliance Assurance Report Overview

This Compliance Assurance Report describes the network certification process and validation activities that DHCS has conducted to meet the requirements specified in the Final Rule. The report is organized by the following sections:

- Section 1: Overview: Describes the purpose of the Compliance Assurance Report
- Section 2: Background and Overview: Describes the Medicaid Managed Care Final Rule requirements specific to network adequacy standards and certification requirements, the State Medicaid Program, and the State network adequacy standards and MCP contractual requirements
- Section 3: Annual Network Certification Components: Details the requirements, approach and methodology used to determine an adequate network
- Section 4: Specialty Managed Care Plan Components: Describes the specialty plans that require analysis and certification of the provider network
- Section 5: Significant State Initiatives: Describes major State initiatives that require analysis and certification of the provider network
- Section 6: Provider Network Evaluation Determinations: Designates the results of the certifications
- Section 7: MCP Network Certification Results: Displays the results of the Annual Network Certification and the Significant State Initiatives Certifications

[3] 42 C.F.R. section 438.207(c)

2.3. Managed Care Delivery System in California

DHCS administers the Medi-Cal program through a combination of delivery systems that are either managed care of fee-for-service (FFS) systems. For most services, approximately 82 percent of Medi-Cal members receive Medi-Cal services through an MCP[4]. In California, there are six (6) Medi-Cal managed care models:

- County Organized Health Systems (COHS) – 22 counties, one MCP operates in each county
- Two-Plan – 14 counties, two MCPs operate in each of these counties
- Geographic Managed Care (GMC) – 2 counties, six or more MCPs in the county
- Regional – 18 counties, two MCPs operate in all of these counties
- Imperial – 1 county, two MCPs operate in this county
- San Benito – 1 county, one MCP operates in this county

Attachment E in the Appendix illustrates the Medi-Cal Managed Care plan models by county.

In addition to the six (6) Medi-Cal managed care models, DHCS contracts with specialty MCPs to serve specific populations and provide necessary care as covered by Medicaid. Enrollment into specialty plans is optional due to other MCPs existing in the same service area and being available to Medi-Cal beneficiaries. Specialty plans contracted with DHCS that are included in this network certification include Family Mosaic Project (FMP) and Senior Care Action Network Health Plan (SCAN).

Family Mosaic Project (FMP)

FMP is a specialty MCP which provides intensive case management and wraparound services for Medi-Cal managed care children and adolescents in San Francisco County who are at risk of out-of-home placement. FMP is part of the Child, Youth, and Family System of Care operated by the City and County of San Francisco Department of Public Health, Community Behavioral Health Services. To receive services from FMP, a member must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of (or currently in) out-of-home placement.

Senior Care Action Network (SCAN) Health Plan

SCAN contracts with DHCS to provide services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties.

SCAN provides all Medi-Cal covered services, including home- and community-based services, to members assessed at the nursing facility-level of care and in nursing home custodial care. SCAN members must be at least 65 years of age, live in the service

[4] Medi-Cal Managed Care Performance Dashboard

area, have Medicare Parts A and B, and have full-scope Medi-Cal with no share of cost. SCAN does not enroll individuals with end-stage renal disease. SCAN's health care delivery model is conducted through a delegated model that contracts with medical groups who in turn contract with individual providers, physician groups, and hospitals.

2.4. Statewide Network Adequacy Standards Development

In February 2017, DHCS released a Network Adequacy Proposal[5] that included the Final Rule's required factors for consideration when time and distance standards were developed:

- Anticipated Medicaid enrollment;
- Expected utilization of services;
- The characteristics and health care needs of specific Medicaid populations covered by the MCPs;
- 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; and
- Use of telemedicine or similar technologies.

DHCS requested 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, LA Stakeholders group, and other interested stakeholders, on this proposal.

In July 2017, DHCS issued the Network Adequacy proposal and published guidance establishing statewide network adequacy standards in compliance with the network adequacy provisions of the Final Rule. These adequacy standards were subsequently amended as a result of Assembly Bill (AB) 205 (Chapter 738, Statutes of 2018), which codified California's network adequacy standards in Welfare and Institutions Code (WIC) 14197. The network adequacy standards are outlined in **Attachment A** and include time and distance and timely access standards for:

- Adult and pediatric primary care physicians (PCP);
- OB/GYNs;
- Adult and pediatric core specialists;
- Hospitals;
- Pharmacies;
- Outpatient mental health providers;

[5] Final Rule Network Adequacy Proposal

- Long term services and supports.[6]

The Final Rule permits states to grant exceptions to network adequacy standards under certain circumstances.[7] Per WIC 14197, if an MCP cannot meet time and distance standards, it may submit a request for alternative access which, if approved, allows for an alternative time and distance standard.[8] DHCS may grant requests for alternative access standards if the MCP has exhausted all other reasonable attempts to contract with providers to meet the applicable network adequacy standard or if DHCS determines that the MCP has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access with the current provider network.[9]

2.5. Annual Network Certification Development

In order to evaluate whether MCPs meet the state's network adequacy requirements, DHCS assessed all of the network requirements as required under the MCP contract, State, and federal laws. As described within this Report, the Annual Network Certification evaluated all of the following network requirements:

- MCP Contractual Requirements
  - Provider to member ratios ensure that the MCPs have an adequate ratio of PCPs and total physicians as determined by the MCP's contractual network capacity requirement.
- Federal Requirements
  - Mandatory provider types which ensure that the MCPs contract with Freestanding Birthing Centers, Federally Qualified Health Centers and Rural Health Clinics to ensure that Members have greater access to comprehensive primary and preventative care services.
  - An adequate Indian Health Facility (IHF) network that ensures MCPs contract with as many IHFs as possible.
    Access to midwifery services to ensure an appropriate provider network to provide access to perinatal services.
- Network Changes in Capacity and Services
  - DHCS is also required to certify the provider network in the following situations:
    - When a new population is enrolled;
    - There is a change in services or benefits;[10] or

[6] Time and distance standards did not need to be 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 the facility for care.
[7] 42 C.F.R. section 438.68(d)(1)
[8] Welfare and Institutions Code (WIC), section 14197(e)(2)
[9] WIC 14197(e)(1)(A) and (B)
[10] 42 C.F.R. section 438.207(c)(3)

        - When a MCP enters into a new contract with DHCS.[11]
    - Based on these provisions, the following statewide initiative with an implementation date of January 1, 2019 are also included within this Compliance Assurance Report and January 2019 Annual Network Certification submission:
        - Whole Child Model: Incorporating the California Children Services (CCS) Program into managed care

The approach used to determine network adequacy for these services is further described in **Section 3.**

Technical Assistance

To prepare the MCPs for the network requirements, DHCS provided guidance to the MCPs by issuing reporting templates and accompanying instructions. Throughout the Annual Network Certification submission and collection process, DHCS provided MCPs with technical assistance via email and telephone and worked closely with the MCPs on any identified or potential issues with access. DHCS assigned a coordinator for each MCP to assist with specific questions relating to the process.

After the MCPs' submissions, DHCS continued to provide technical assistance to the MCPs by providing a Pre-CAP worksheet. The Pre-CAP contained findings from DHCS' initial assessment of the MCP submissions and was intended to allow the MCPs to rectify any findings. The Pre-CAP process helped DHCS determine the MCPs that were unable to meet the standards rather than what was considered to be reporting errors.

Throughout the Pre-CAP process, DHCS continued to work closely with the MCPs and emphasized the importance of ensuring that all data reported in the Annual Network Certification should also be contained in the monthly provider reporting submitted to the Department.

3. Annual Network Certification Assessment Components

Evaluation of the provider networks consisted of assessing the MCPs' compliance with contractual and federal requirements for the Annual Network Certification, which included provider to member ratios, mandatory provider types, and time and distance standards. For each component, DHCS details the requirements and approach used to determine an adequate network in the following subsections.

[11] 42 C.F.R. section 438.207(c)(1)

3.1. Contractual Provider to Member Ratios

Requirement

Per the MCP's contractual requirements, MCPs must meet current FTE provider to member ratios for Primary Care Physicians (PCPs) of 1 PCP to every 2,000 members and Total Network Physicians of 1 physician to every 1,200 members. The MCPs are allowed to use physician extenders to increase their PCP network if necessary as long as they meet the requirements outlined in the MCP's contract.

Approach

DHCS requested MCPs submit aggregate provider counts of the total PCPs and total network physicians taking FTE into account for their reporting units on **Attachment B**. The PCP providers reported were required to only be assignable providers.

DHCS calculated the provider to member ratio using the total number of providers contracted with the MCP divided by the projected enrollment for the following contract year. The projected enrollment is based on each reporting unit's monthly enrollment of the 18-month period prior to the contract year. Enrollment for the following contract year was forecasted by the total projected enrollment per reporting unit.

DHCS validated a sample of each MCP's provider network to ensure there is an executed contract between the provider and MCP. DHCS contacted (through email or phone) a random sample of the MCP's contracted network providers from each MCP's provider network monthly submission.

3.2. Mandatory Provider Types

Requirement

MCPs must contract with the following provider types or facilities based on federal requirements:

- At least one federally qualified health center (FQHC), one rural health clinic (RHC) and one freestanding birth center (FBC), where available in the contracted service area,[12]
- Offer contracts with each Indian Health Facility (IHF) in the contracted service area where available,[13] and
- Midwifery services in the contracted service area.

[12] CMS State Health Official letter (SHO) #16-006
[13] 42 C.F.R. section 438.14(b)(1)

Approach

DHCS requested that MCPs submit on the Annual Network Certification Reporting Template (see **Attachment C**):

- Name of the provider or facility;
- Location of the provider or facility; and
- MCP's contract status with the provider or facility.

MCPs may either have an executed contract or submitted documentation to DHCS that demonstrates the MCP has conducted good faith contracting efforts in order to contract with the mandatory provider type.

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.

3.3. Time and Distance Standards

Requirement

WIC 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:

- Adult and Pediatric PCPs
  - 10 miles or 30 minutes from the member's residence
- Adult and Pediatric Core Specialists
  - Rural Counties: 60 miles or 90 minutes from the member's residence
  - Small Counties: 45 miles or 75 minutes from the member's residence
  - Medium Counties: 30 miles or 60 minutes from the member's residence
  - Dense Counties: 15 miles or 30 minutes from the member's residence
- OB/GYN Primary Care
  - 10 miles or 30 minutes from member's residence
- OB/GYN Specialty Care
  - Rural Counties: 60 miles or 90 minutes from the member's residence
  - Small Counties: 45 miles or 75 minutes from the member's residence
  - Medium Counties: 30 miles or 60 minutes from the member's residence
  - Dense Counties: 15 miles or 30 minutes from the member's residence
- Hospitals
  - 15 miles or 30 minutes from the member's residence
- Mental Health Providers
  - Rural Counties: 60 miles or 90 minutes from the member's residence
  - Small Counties: 45 miles or 75 minutes from the member's residence

  - Medium Counties: 30 miles or 60 minutes from the member's residence
  - Dense Counties: 15 miles or 30 minutes from the member's residence
- Pharmacies
  - 10 miles or 30 minutes from the member's residence

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.

Approach

DHCS requested MCPs submit geographic access maps or 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. **Attachment D** 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 the following provider types: pediatric and adult PCPs, pediatric and adult core specialists, OB/GYN PCP and specialist, hospitals, mental health providers, and pharmacies. 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 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.

DHCS requested MCPs submit required provider types for time and distance standards. Those providers included:

- Adult and Pediatric PCPs
  - General Practice
  - Geriatrician
  - Family Medicine
  - Internal Medicine
  - Pediatrician
  - Other PCPs as indicated
- OB/GYNs
  - Primary Care Providers
  - Specialty Care Providers
- Adult and Pediatric Core Specialists
  - Cardiology/Interventional Cardiology
  - Dermatology
  - Endocrinology
  - ENT/Otolaryngology
  - Gastroenterology
  - General Surgery
  - Hematology

  - HIV/AIDS Specialists/Infectious Diseases
  - Nephrology
  - Neurology
  - Oncology
  - Ophthalmology
  - Orthopedic Surgery
  - Physical Medicine and Rehabilitation
  - Psychiatry
  - Pulmonology
- Facilities
  - Hospitals
  - Pharmacies
- Outpatient Mental Health Providers
  - Psychologist
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Marriage and Family Therapists (LMFT)
  - LCSW and LMFT Interns

Telehealth and Mail Order Pharmacy

Requirement

Pursuant to WIC 14197, DHCS may allow MCPs to use telehealth to demonstrate compliance with time and distance standards. MCPs will be authorized to begin using telehealth as an alternative access to care for contractual provider-to-member ratios and/or time and distance standards[14] if they meet the contractual and State requirements. Additionally, MCPs may utilize mail order pharmacy to fulfill network adequacy requirements for time and distance standards as an alternative access to care.

Approach

DHCS requested MCPs that utilize telehealth to meet either network adequacy standards or provider-to-member ratios to submit the Annual Network Certification Reporting Template to DHCS (see **Attachment C**). The MCP indicated 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. In addition, the MCPs submitted AAS requests for any members that may want to opt out of telehealth services.

DHCS requested MCPs that utilize mail order pharmacy to meet network adequacy standards to submit the Annual Network Certification Reporting Template to DHCS (see **Attachment C**). The MCP indicated the mail order pharmacy company and the service area of the mail order pharmacy. In addition, the MCPs submitted pharmacy AAS requests for any member that may want to opt out of mail order pharmacy services or needs prescriptions that are unable to be processed through a mail order service.

[14] WIC 14197(e)(4)

DHCS assessed and certified the provider information provided by the MCPs to ensure that utilizing telehealth or mail order pharmacy was appropriate. DHCS validated that the MCP had exhausted all other reasonable options to obtain in-person providers for telehealth providers to meet the applicable standard, and for mail order pharmacy, the MCP had made reasonable attempts to obtain a pharmacy with a physical location. Additionally, DHCS assessed the AAS requests to ensure the MCP also had the services available to the members in person or a physical location if needed to supplement the approved telehealth or mail order pharmacy alternative access to care.

Alternative Access Requests

Requirement

Pursuant to WIC 14197, MCPs 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 outpatient mental health providers. AAS requests can only be submitted when the MCP has exhausted all other reasonable options for contracting with 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.

WIC 14197 authorizes DHCS, upon request of an MCP to allow alternative access standards for time and distance standards.[15] It permits DHCS to determine if the requesting MCP has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.[16]

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;
- Three nearest out-of-network providers;
- 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.

[15] Welfare and Institutions Code (WIC) 14197(e)(1)
[16] WIC 14197(e)(1)(B)

MCPs were required to submit a letter of request to DHCS for an alternative to the time and distance standards. In response, DHCS sent an Alternative Access Standards Request Template, **Attachment F**, to the MCP. The MCP was required to provide written responses on the template to demonstrate that their MCP's delivery structure is capable of delivering the appropriate level of care and access.

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;
- Names and addresses of three closest provider;
- Narrative explaining why the MCP was unable to execute contract with located provider, to include if there was a rate dispute between the provider and MCP; and
- Determine whether the proposed alternative standard is a reasonable request based on:
    - Health Care Options website;
    - Medicare.gov;
    - 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.

MCPs may request DHCS to consider the WIC 14197(e)(1)(B) alternative to the time and distance standards. This process allows for the MCP to provide justification that their delivery structure is capable of delivering the appropriate level of care so that they are not required to meet the network adequacy time and distance standards.

DHCS reviewed each MCP's alternative access request and determined that the requesting MCP has adequately described its delivery structure to exhibit a clinically integrated health care model/network, consisting of either a:

- **Medical Home**: A team-based health care delivery model led by a health care team in a centralized facility to provide comprehensive and continuous medical care to patients with a goal to obtain maximal health outcomes.

  OR

- **Specialty Services for Specialty Population:** A limited but comprehensive provider network that renders services specific to the diagnoses of the members and ensures there is care coordination and support services across the continuum of care regardless of location.

This alternative to the time and distance standards does not preclude MCPs from meeting the other Annual Network Certification requirements. DHCS reserves the right to revoke this alternative standard should concerns regarding quality of care are discovered through avenues such as grievances and appeals reporting and/or timely access survey results.

DHCS will post all approved alternative access standards on its website.[17]

3.4. Access and Availability

Requirement

Final Rule timely access requirements are outlined in **Attachment A**. In addition to timely access, DHCS is required to monitor access and availability.[18]

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 FFS 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

[17] WIC 14197(e)(3)
[18] 42 C.F.R. section 438.206(c)(1)

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

In addition to A&I's timely access verification studies, DHCS' External Quality Review Organization (EQRO) also currently conducts a Timely Access Survey. The EQRO will call providers on behalf of DHCS to collect appointment times for non-urgent and urgent services, if applicable. The Timely Access Survey sample size is statistically significant and will be stratified and equally distributed by each reporting unit into five (5) provider categories:

- PCPs,
- Specialists,
- Non-Physician Mental Health Providers,
- OB/GYN, and
- Ancillary Providers.

The EQRO will also collect responses to additional survey questions which will gather information regarding:

- Acceptance of new patients;
- Difference between adult and pediatric appointment times; and
- Quality of DHCS' provider data.

The EQRO will submit quarterly results to DHCS including the five (5) provider categories mentioned above.

The EQRO's Timely Access Survey is in addition to existing MCP network adequacy requirements. MCPs are subject to a mandatory network adequacy validation performed by the EQRO. The validation will evaluate the previous 12 months of network adequacy data captured by the Annual Network Certification in accordance with 42 C.F.R. section 438.358 (b)(iv).

4. Specialty Managed Care Plan Alternative Access Approval Process

As part of the ANC, MCPs are required to demonstrate that they contract with required providers and facilities identified in section 3. However, because of the unique delivery

structure of FMP and SCAN, and the unique population they serve, these specialty MCPs requested DHCS approval of proposed Alternative Access Standards for time and distance network providers.

Family Mosaic Project

FMP provides outpatient mental health services only for children and youth under the age of 18 living in City and County of San Francisco. FMP's beneficiary population have been identified as having severe emotional and behavioral difficulties that place them at risk for out-of-home placement. Based on their diagnosis and needs, FMP provides intensive care management for the provision of outpatient mental health services and wraparound services. All services are community based and provided within San Francisco County. Furthermore, all of the FMP's staff and providers conduct their services in the member's home, school and/or community.

Because of the unique population served and the specialized array of covered services, FMP was required to demonstrate an adequate provider network which includes:

- Pediatric Core Specialists;
- Outpatient Mental Health Providers; and
- Mandatory provider types as described in Section 3.2.

FMP submitted for review and approval the alternative access standards for time and distance requirements for the provider types as described in Section 3.3. Upon reviewing the request, DHCS has approved the AAS request for FMP pediatric core specialists and outpatient mental health providers due to its provision of specialty services for an age specific population within the geographic region of San Francisco County. Consequently, since they only provide specialized services to members under the age of 18, DHCS has confirmed that that FMP has demonstrated its delivery structure, which includes the provision of in-home, school-based and community-based services, is capable of delivering the appropriate level of care and access to its members within a time and distance standard. Therefore, because of its limited geographic service area, FMP meets time and distance standards.

SCAN Health Plan

SCAN members must be 65 years of age or older and have both Medicare and Medi-Cal eligibility. SCAN's membership requires the full range of medical services from primary care to advanced specialty care. SCAN also provides facility-based care including acute inpatient hospitals, skilled nursing facilities, laboratories, and outpatient rehabilitation and surgery centers. SCAN's health care delivery model is conducted through a delegated model that contracts with medical groups who in turn contract with individual providers, physician groups, and hospitals.

Because of its unique and limited population and services, SCAN submitted an AAS request to DHCS for approval. SCAN submitted documentation demonstrating it is contracted directly or indirectly with the following providers:

- Primary Care Providers;
- Adult Core Specialists;
- Outpatient Mental Health Specialists;
- OB/GYNs;
- Licensed Acute Care Hospitals;
- Pharmacies; and
- Mandatory provider types as described in Section 3.2.

SCAN submitted Network Certification documentation, which included aggregate provider counts of the total PCPs and total network physicians, mandatory provider types, and mental health specialists. SCAN also submitted for review and approval AAS standards for time and distance requirements for the certain provider types described in Section 3.3.

Upon reviewing the request, DHCS has approved the AAS requests for SCAN. DHCS has determined that SCAN has demonstrated its delivery structure is capable of providing the appropriate level of care through its delegated service delivery model and ensures access to its unique population of members who are 65 years and over.

5. Significant State Initiatives

As part of the Annual Network Certification submission, DHCS is required to also conduct network certifications when an MCP enters into a contract with the State[19] or there are significant state initiatives that would affect the adequacy of capacity and services.[20]

Based on these provisions, the following network certification with an implementation date of January 1, 2019 is also included within this Compliance Assurance Report and January 2019 Annual Network Certification:

- Whole Child Model (WCM): Incorporating the California Children Services (CCS) Program into managed care

5.1. Whole Child Model

Whole Child Model Background
Senate Bill (SB) 586[21] authorized DHCS to establish the Whole Child Model (WCM) program in designated County Organized Health System (COHS) or Regional Health Authority counties.

[19] 42 C.F.R. section 438.207(c)(1)
[20] 42 C.F.R. section 438.207(c)(3)
[21] Hernandez, Chapter 625, Statutes of 2016[22] Children and youth under 21 years of age who meet the eligibility requirements of section 123805 of the Health and Safety Code.

WCM will incorporate the California Children's Services (CCS) Program[22] into Medi-Cal managed care. MCPs operating in WCM counties will integrate Medi-Cal managed care and CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty and behavioral health for CCS-eligible and non-CCS conditions.

Due to the complexities of the CCS Program and the various components of the WCM implementation, DHCS determined that a phased in approach would allow for a more streamlined execution. DHCS assessed the network overlap between existing CCS Program and health plan providers, the number of counties in which each health plan operates, whether counties already had a single health plan rate across them, whether CCS Program services are currently carved-in to the health plan, and whether the county in which the CCS Program operates is an independent or dependent county.[23] Phase 1 was successfully implemented on July 1, 2018 and is currently operational in San Mateo, Santa Cruz, Monterey, Merced, San Luis Obispo and Santa Barbara.

The chart below shows the MCPs and counties participating in WCM:

Phase 1 – Implemented July 1, 2018*

WCM MCP	COHS County
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan San Mateo	San Mateo

Phase 2 – No sooner than January 1, 2019

WCM MCP	COHS County
Partnership Health Plan of California	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

***** Submitted to CMS in the Compliance Assurance Report: 2018 Annual Network Certification

[22] Children and youth under 21 years of age who meet the eligibility requirements of section 123805 of the Health and Safety Code.

[23] In counties with populations greater than 200,000 (independent counties), county staff perform all case management activities for CCS-eligible children residing within their county. This includes determining all phases of program eligibility, evaluating needs for specific services, determining the appropriate provider(s), and authorizing for medically necessary care. For counties with populations under 200,000 (dependent counties), DHCS provides medical case management and eligibility and benefits determination.

MCP Background

Partnership Health Plan

Partnership Health Plan (PHP) of California is a COHS MCP established in 1994 and has been contracted with DHCS to provide Medi-Cal services since 2013. PHP provides full scope Medi-Cal services to over 560,000 members in 14 Northern California counties, several of which are rural counties.

WCM Provider Network Assessment

Requirement

Per SB 586, each MCP participating in the WCM program are required to demonstrate an adequate provider network that includes:

- Primary care;
- Specialists and subspecialties;
- Professional, allied, and medical supportive personnel;
- Licensed acute care hospitals;
- Special Care Centers (SCCs);
- Home health agencies; and
- Durable and customizable medical equipment providers (DME).

Approach

MCPs submitted documentation to demonstrate compliance with both SB 586 and DHCS network requirements for the WCM program. DHCS created and issued a WCM submission overview checklist, a WCM Paneled Provider Report Template, and submission instructions. The WCM Provider Network Certification Template required submissions that included CCS-paneled providers, facility type, and geographic location. MCPs provided additional information documenting contracting inquiries and the outcome of contracting efforts for each provider. Network Certification requirements extend to the MCPs' subcontractors.

Methodology

CCS is currently a fee-for-service benefit, in the vast majority of counties, which is provided through a statewide network; therefore, MCPs shall contract with providers statewide. In order to ensure adequate coverage, MCPs were required to meet provider overlap thresholds in-county, regionally, and statewide.

Each required provider type or facility was first assessed for in-county overlap. If the MCP did not meet the in-county overlap requirement, the MCP was required to meet the regional overlap, which looks at the available CCS-paneled providers within the service area (bordering

counties). If the regional overlap was not met, the MCP was required to meet the statewide overlap. If there were no providers in-county or regionally, the MCP was required to contract with a minimum of one (1) provider in that provider type or facility.

The WCM Provider Network Certification assessed the following components of the WCM provider network, which included:

- Primary Care;
- Specialists and subspecialties;
- Professional, allied, and medical supportive personnel;
- Licensed acute care hospitals;
- SCCs;
- Home health agencies; and
- DME providers.

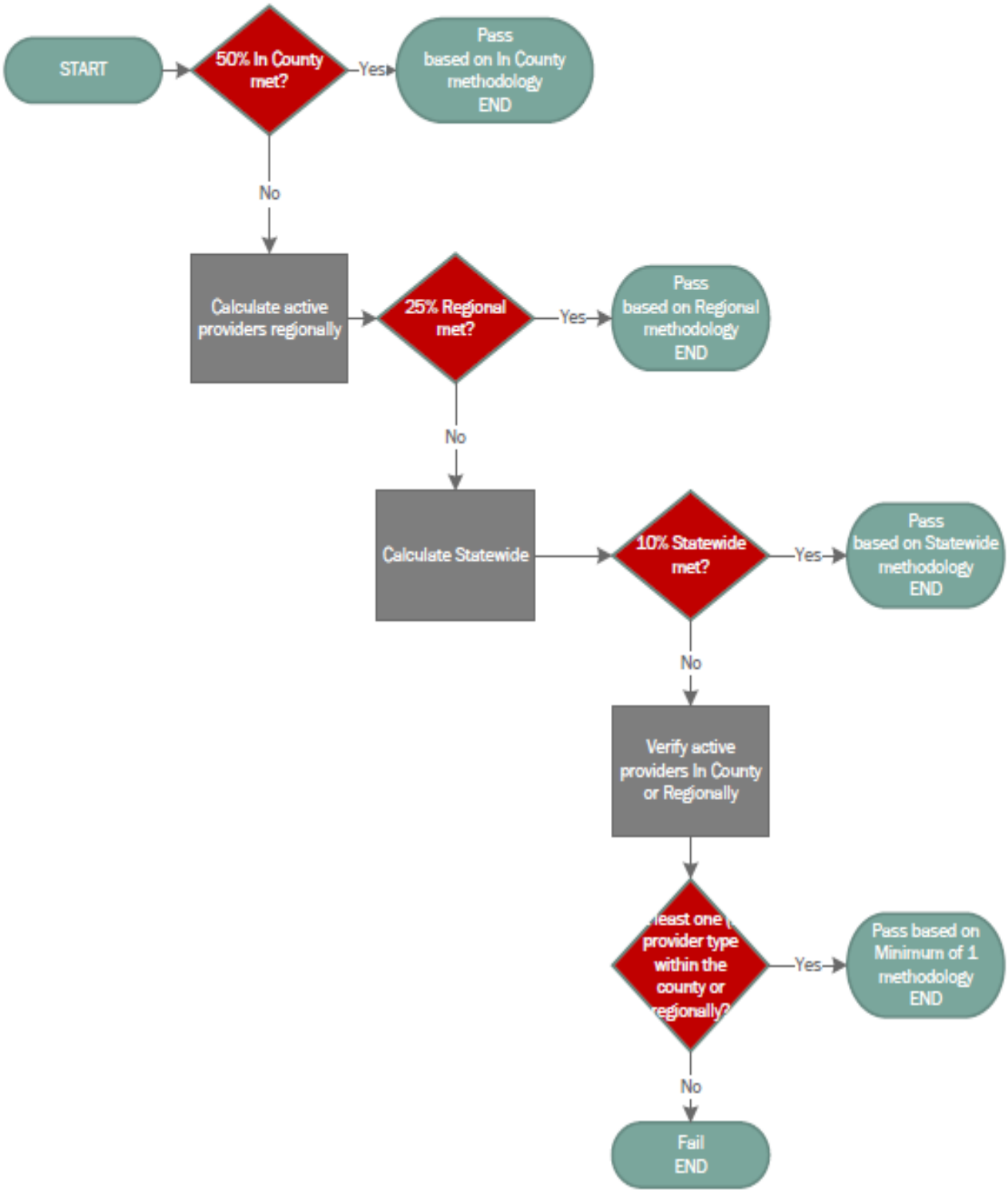
The MCPs' WCM Provider Network Certification was based on the core set of 24 specialists/subspecialists encompassing both adult and pediatric specialties and CCS approved hospitals.

The overlap thresholds were:

1. 50% in-county; or
2. 25%[24] regionally; or
3. 10% statewide; or
4. If there are no active providers in-county or regionally, the MCP must contract with at least one (1) provider statewide and is exempt from the 10% statewide requirement.

[24] The recommended 25% is based on the number of regional (bordering) counties that each WCM county touches as a percentage.

WCM Network Certification Review Process



Provider Validations

DHCS validated a sample of Partnership Health Plan's CCS-paneled provider network to ensure there is an executed contract between the provider and MCP. DHCS contacted (through email or phone) a random sample of PCPs and core specialists, indicated by the MCP to have an executed contract in the WCM Paneled Provider Report Template. DHCS ensured that each provider listed as being contracted with the associated MCP had an active and executed contract.

Physician Core Specialty

The core set of specialists and subspecialists is based on CCS-paneled providers with a focus on CCS qualifying conditions and is consistent with the pediatric core specialist list developed as part of the Final Rule network adequacy standards.

The core CCS-paneled specialists and subspecialists include the following:

- Allergy and Immunology
- Cardiology
- Clinical Genetics
- Critical Care Medicine/Intensivist
- Dermatology
- Developmental and Behavioral Medicine
- Endocrinology
- Gastroenterology
- Hematology-Oncology
- Infectious Disease
- Nephrology
- Neurology
- Neurological Surgery
- Ophthalmology
- Oral and Maxillofacial Surgery
- Orthopedics
- Otolaryngology
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Pulmonology
- Rheumatology
- Surgery
- Transplant Hepatology
- Urology

Each MCP was required to meet the overlap requirements for the core set of specialists within the provider network.

CCS-Approved Hospitals

In order to be a CCS-approved hospital, the hospital must apply to DHCS to treat CCS conditions. The hospital must demonstrate they have all the required specialists/subspecialists to treat the CCS conditions for which they are applying to treat. There are different types of required CCS-approved hospitals, all of which must meet different requirements before being approved.
CCS-approved hospitals include the following:

- Tertiary: Comprehensive, multidisciplinary, regionalized pediatric care for children from birth to 21 years of age. Tertiary hospitals provide a full range of medical and surgical care for severely ill children.
- Pediatric Community: Community based hospital with licensed pediatric beds that provides services for children from birth to 21 years of age. The length of stay shall not exceed 21 days.

Each MCP was required to meet the overlap requirements for tertiary hospitals and pediatric community hospitals within the provider network.

Special Care Centers

In order to be a SCC, the SCC must apply to DHCS to treat CCS conditions. The SCC must demonstrate they have all the required specialists/subspecialists to treat the CCS conditions for which they are applying to treat. There are different types of required CCS-approved SCCs, all of which must meet different requirements before being approved. CCS-approved SCCs include the following:

- Bone Marrow Transplant Centers
- Cardiac Center
- Cochlear Implant Centers
- Communication Disorder Centers
- Craniofacial Centers
- Cystic Fibrosis and Pulmonary Disease Centers
- Extracorporeal Membrane Oxygenation (ECMO) Centers
- Gastroenterology and Nutrition Centers
- Hematology/Oncology Centers
- Hemophilia Centers
- High Risk Infant Follow-up
- Infectious Disease and Immunologic Disorders Centers
- Metabolic and Endocrine Centers
- Neonatal Intensive Care Unit
- Pediatric Intensive Care Unit
- Prosthetics and Orthotics Centers
- Rehabilitation Centers
- Renal Dialysis and Transplant Centers
- Selective Posterior Rhizotomy Centers
- Sickle Cell Disease Centers
- Spina Bifida Centers

Each MCP was required to meet the overlap requirements for SCCs within the provider network.

Continuity of Care (COC) Rights

MCPs shall provide for the completion of covered services from a non-contracted, treating provider for specified conditions up to 12-months if the member has an existing relationship with the provider and has seen the out-of-network primary care provider or

specialist at least once during the 12 months prior to the transition. COC is also required for DME and must be extended beyond the 12-months for DME that is currently under warranty by the manufacturer and is deemed medically necessary.

Transitional Monitoring

DHCS will monitor and provide oversight during and following the WCM transition until such time that it is determined that it is no longer needed. Transitional monitoring includes regular collection and analysis of MCP data and will be specific to communication of member eligibility information and coordination of services across the delivery systems. The transitional monitoring template is collected monthly for the first six months following the transition and then quarterly thereafter.

DHCS will review various monitoring indicators to determine MCP compliance with network adequacy standards and assess if there are access to care concerns.

DHCS will also conduct a WCM Program Evaluation to compare CCS services in WCM counties before and after implementation. DHCS will evaluate whether the inclusion of CCS services in a managed care delivery system improves access to care, quality of care, and the patient experience. The evaluation will be conducted by an external entity who will produce a final evaluation report for public distribution.

6. Provider Network Evaluation Determinations

Each component of the MCP's Annual Network Certification was given a final determination: Pass or Pass with Conditions.

- A Pass or AAS Pass designation means the standard was met and 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 temporary standard requiring the MCP to authorize access to out-of-network providers and/or services if services are not available in-network within the timely access standards. Further, MCPs may not deny access to out-of-network services on the basis of payment or rate disputes with the provider. The temporary standard was communicated through a CAP. MCPs are required to authorize out-of-network providers and services until all CAP items have been corrected and the CAP is closed.

Network Adequacy findings for time and distance standards and provider to member ratios determined to require a CAP will be required to follow the guidelines outlined in **Section 7.1**. MCPs determined to be out of compliance with the State Official Health Letter 16-006 or 42 C.F.R. 438.14(b)(1) for Mandatory Provider and Facility types are also subject to the CAP guidelines noted in **Section 7.1**.

7. MCP Network Certification Overall Results

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

Annual 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[25].

Annual Network Certification Overall Results

MCP Name	Reporting Unit	Results
Family Mosaic	**San Francisco County**	**Pass**
SCAN Health Plan	**Los Angeles County**	**Pass**
	Riverside County	**Pass**
	San Bernardino County	**Pass**

Whole Child Model Key

Met:	Required overlap or contract is met.
Not Met:	Overlap requirement not met.
Not Applicable (N/A):	Category not required for MCP

Whole Child Model Network Certification Overall Results

MCP Name	Reporting Unit	Results
Partnership Health Plan	**Del Norte**	**Met**
	Humboldt	**Met**
	Lake	**Met**
	Lassen	**Met**
	Marin	**Met**
	Mendocino	**Met**
	Modoc	**Met**
	Napa	**Met**
	Shasta	**Met**
	Siskiyou	**Met**
	Solano	**Met**
	Sonoma	**Met**
	Trinity	**Met**
	Yolo	**Met**

[25] MCPs are not contractually at risk for certain benefits.

7.1. Corrective Action Plans

MCPs that were unable to rectify the Pre-CAP findings for provider ratios, time and distance standards, and mandatory provider types are subject to a CAP. DHCS granted MCPs a pass with conditions on Annual Network Certifications if the MCP was unable to meet the network adequacy requirements. DHCS will impose temporary standards for the MCP to meet immediately and impose a CAP for any network certification deficiencies. The temporary standard requiring authorization of out-of-network services allows the MCP to correct all deficiencies during the CAP process, while at the same time ensuring that Medi-Cal members are allowed to access to out-of-network services within the 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.

DHCS issued CAPs to the MCPs with a description of each deficiency. The MCP will need 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.

In addition to CAPs, DHCS will continue to utilize existing quarterly MCP provider network monitoring processes that include, but are not limited to:

- Quarterly timely access results;
- Investigation of complaints, 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.

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.

8. Appendices

8.1 Attachment A: Network Adequacy Standards

Provider Type	Timely Access Standard	Time and Distance[26] Rural	Time and Distance[26] Small	Time and Distance[26] Medium	Time and Distance[26] 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[26] (Adult and Pediatric)	Within 15 business days to appt. from request[27]	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

[26] Time and Distance Standards apply to the core specialists outlined in Table 2
[27] Timely Access standards apply to all specialists, not only core specialists

Provider Type	Timely Access Standard	Time and Distance[26] Rural	Time and Distance[26] Small	Time and Distance[26] Medium	Time and Distance[26] Dense
Mental Health (non-psychiatry) Outpatient Services[29]	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
Long Term Services and Supports	If applicable[30]	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 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

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

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

Table 3: LTSS Timely Access Network Standards by County Size

Provider Type	**Rural**	**Small**	**Medium**	**Dense**
Skilled Nursing Facility (SNF)	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Community Based Adult Services (CBAS)	Capacity cannot decrease in aggregate statewide below April 2012 level			

8.2. Attachment B: Reporting Units

MCP Name	Reporting Unit
Aetna Better Health	**Sacramento County**
	San Diego County
AIDS Healthcare Foundation	**Los Angeles County**
Alameda Alliance for Health	**Alameda County**
Anthem Blue Cross Partnership Plan	**Alameda County**
	Contra Costa County
	Fresno County
	Kings County
	Madera County
	Region 1: Butte, Colusa, Glenn, Plumas, Sierra, Sutter and Tehama Counties
	Region 2: Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne and Yuba Counties
	Sacramento County
	San Benito County
	San Francisco County
	Santa Clara County
	Tulare County
CalOptima	**Orange County**
CalViva	**Fresno County**
	Kings County
	Madera County
California Health & Wellness Plan	**Imperial County**
	Region 1: Butte, Colusa, Glenn, Plumas, Sierra, Sutter and Tehama Counties
	Region 2: Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne and Yuba Counties
Care1st Partner Plan	**San Diego County**
CenCal Health	**San Luis Obispo County**
	Santa Barbara County
Central California Alliance for Health	**Merced County**
	Monterey/Santa Cruz Counties
Community Health Group Partnership Plan	**San Diego County**
Contra Costa Health Plan	**Contra Costa County**
Family Mosaic	**San Francisco County**

MCP Name	Reporting Unit
Gold Coast Health Plan	**Ventura County**
Health Net Community Solutions, Inc.	**Kern County**
	Los Angeles County
	Sacramento County
	San Diego County
	San Joaquin County
	Stanislaus County
	Tulare County
Health Plan of San Joaquin	**San Joaquin County**
	Stanislaus County
Health Plan of San Mateo	**San Mateo County**
Inland Empire Health Plan	**Riverside/San Bernardino Counties**
Kaiser NorCal (KP Cal LLC)	**KP North:** Amador, El Dorado, Placer and Sacramento Counties
Kaiser SoCal (KP Cal LLC)	**San Diego County**
Kern Family Health Care	**Kern County**
LA Care Health Plan	**Los Angeles County**
Molina Healthcare of California Partner Plan, Inc.	**Imperial County**
	Riverside/San Bernardino Counties
	Sacramento County
	San Diego County
Partnership Health Plan of California	**Northeast:** Lassen, Modoc, Shasta, Siskiyou and Trinity Counties
	Northwest: Del Norte and Humboldt Counties
	Southeast: Napa, Solano, Yolo Counties
	Southwest: Lake, Marin, Mendocino, and Sonoma Counties
San Francisco Health Plan	**San Francisco County**
Santa Clara Family Health Plan	**Santa Clara County**
SCAN Health Plan	**Los Angeles County**
	Riverside County
	San Bernardino County
United Healthcare	**Sacramento County**
	San Diego County

8.3. Attachment C: Annual Network Certification Reporting Template

Department of Health Care Services (DHCS)
Mandatory Provider Types Reporting Template
FQHC/RHC/FBC/IHF/Midwifery Service Providers
Exhibit A-2

A	B	C	D	E	F	G	H	I	J	K	L	M	N
Plan Code	Plan Name	County	Contract Date Reporting Month	Contract Date Reporting Year	Provider, Health Center, or Facility Type (FQHC, RHC, FBC, IHF or Midwifery Services Provider)	Provider, Health Center, or Facility Name. For Midwifery Services, please list Provider Type and name.	Address	City	Zip Code	Provider NPI (10 digits)	Does your plan have a current contract in place with this provider, health center, or facility?	Does your plan provide beneficiaries access to this provider, health center, or facility which does not contract with your MCP?	Outcome of the Efforts or Reason for Declining Request to Contract with MCP (use Comments Tab to add detailed documentation)

Department of Health Care Services (DHCS)
Telehealth and Mail Order Pharmacy Provider Reporting Template
Exhibit A-4

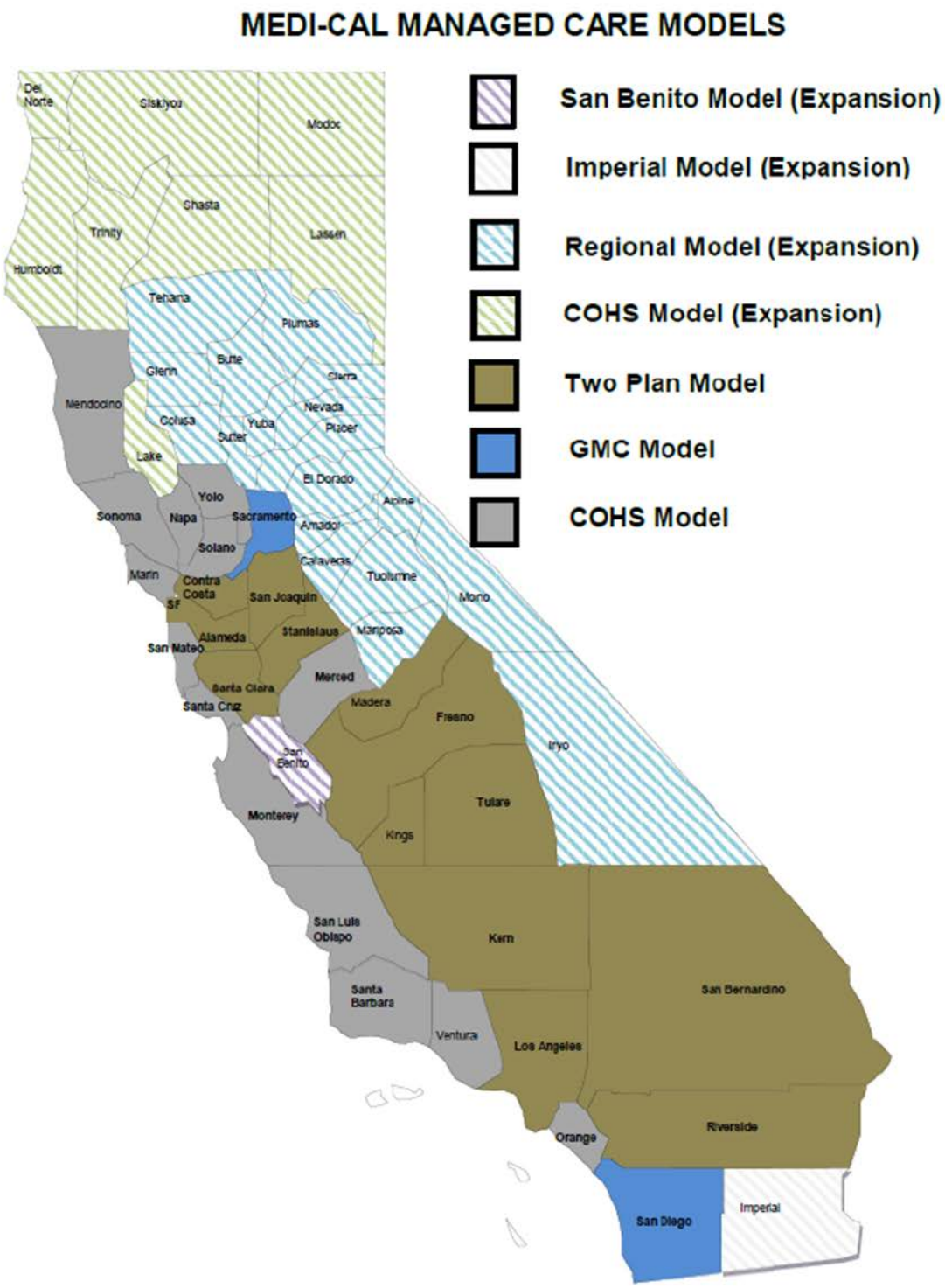
A	B	C	D	E	F	G	H	I	J	K
Provider Name	Provider NPI (10 Digits)	Provider Type	Provider Specialty	Telehealth or Mail Order Pharmacy Company	What Geographical Area will the Provider serve?	Is the Provider already a MCP contracted provider for in person visits?	Does the Provider see members in person?	Is the Provider being counted to meet the contractual provider to member ratio?	Is the Provider being used to meet time or distance standards?	Is the Provider entered into 274?

8.4. Attachment D: Carved Out Zip Codes

Carved Out Zip Codes

County	MCP Name or Fee-for-Service	Zip Code(s)
Amador	Kaiser	95642, 95685, 95629, 95689, 95665, 95666
El Dorado	Kaiser	95709, 95684, 95726, 95720, 95636, 95735, 95721, 96150, 96142
Kern	Fee-for-Service	93558
Los Angeles	Fee-for-Service	90704
Placer	Kaiser	95713, 95631, 95717, 95714, 95701, 95715, 95724, 96146, 96140, 96145, 96141, 96148, 96143
Riverside	Fee-for-Service	92225, 92226, 92239
San Bernardino	Fee-for-Service	92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 93592

8.5. Attachment E: California Counties by Medi-Cal Managed Care Plan Model



8.6. Attachment F: Alternative Access Standards Request Template

Alternative Access Standards Exemption Template

MCP Name:
MCP Service Area(s):
Date:

Purpose
Welfare and Institutions Code (WIC) 14197 authorizes DHCS, upon request of a Medi-Cal managed care plan (MCP), to allow alternative access standards for time and distance standards.[31] DHCS may determine if the requesting MCP has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.[32] MCPs may submit AAS requests at any point throughout the year; however, MCPs must reapply annually.

Instructions:
Answer the questions below with responses specific to your MCP and provide as much detail as possible.

Questions:

Delivery System
1. Why is your MCP not able to meet the time and distance standards outlined in Welfare and Institutions Code (WIC) 14197?
2. What is the MCP's delivery system? What makes this delivery system different?
3. Is the MCP's delivery system a Medical Home with a centralized facility?
4. Does the MCP delivery system provide care coordination?

Population Served
5. What population does the MCP serve? (Specific ages, medical needs, diagnoses etc.)
6. What are the specific needs of the population being served by the MCP?
7. How many members does the MCP serve?
8. In what geographical locations does the MCP have members?

Services Provided
9. What types of services do the MCP's members require?
10. What specialty services are required by the MCP's members?

Provider Types Needed
11. Do the MCP's members have a specialist assigned as their PCP? If yes, what specialists are utilized?
12. Does the provider for the MCP's members need a specific certification or license other than a MD/DO? If yes, list certifications or licenses.

Additional Factors for Consideration
13. How does the delivery structure meet the level of care and access needed by the MCP's members?
14. What efforts will be implemented to help assisting members that are affected? (i.e. notifying them of their closest provider)
15. Does the MCP have any other information to be added for consideration?

[31] Welfare and Institutions Code (WIC) 14197(e)(1)
[32] WIC 14197(e)(1)(B)

8.7. Attachment G: Annual Network Certification Results

MCP Name	Reporting Unit	Overall Result
Family Mosaic	***San Francisco County***	***Pass***

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

Time and Distance

Provider Type	Adult/Pediatric	Results
PCPs	Adult	N/A
PCPs	Pediatric	AAS Pass*
OB/GYN	Combined	AAS Pass*
Cardiology/ Interventional Cardiology	Adult	N/A
Dermatology	Adult	N/A
Endocrinology	Adult	N/A
ENT/ Otolaryngology	Adult	N/A
Gastroenterology	Adult	N/A
General Surgery	Adult	N/A
Hematology	Adult	N/A
HIV/AIDS Specialists/ Infectious Diseases	Adult	N/A
Nephrology	Adult	N/A
Neurology	Adult	N/A
Oncology	Adult	N/A
Ophthalmology	Adult	N/A
Orthopedic Surgery	Adult	N/A
Physical Medicine and Rehabilitation	Adult	N/A
Psychiatry	Adult	N/A
Pulmonology	Adult	N/A
Cardiology/ Interventional Cardiology	Pediatric	N/A
Dermatology	Pediatric	N/A
Endocrinology	Pediatric	N/A
ENT/ Otolaryngology	Pediatric	N/A
Gastroenterology	Pediatric	N/A
General Surgery	Pediatric	N/A
Hematology	Pediatric	N/A
HIV/AIDS Specialists/ Infectious Diseases	Pediatric	N/A
Nephrology	Pediatric	N/A
Neurology	Pediatric	N/A
Oncology	Pediatric	N/A

Provider Type	Adult/Pediatric	Results
Ophthalmology	Pediatric	N/A
Orthopedic Surgery	Pediatric	N/A
Physical Medicine and Rehabilitation	Pediatric	N/A
Psychiatry	Pediatric	AAS Pass*
Pulmonology	Pediatric	N/A
Mental Health Outpatient Services	Combined	AAS Pass*
Hospitals	N/A	N/A
Pharmacies	N/A	N/A

Mandatory Provider Types

Provider Type	Description	Result
FQHC, FBC, RHC, IHF	1 of each in the Provider Network	Pass
Midwifery Services	Available in the network	Pass

MCP Policy and Procedure Review

A&I Medical Audit Components	Result
Category 3.1 Appointment Procedures / Wait Times	N/A
Category 3.2 Urgent Care / Emergency Care	N/A
Category 3.3 Telephone Procedures / After Hours	N/A
Category 3.4 Specialist and Specialty Services	N/A

Provider Validation	Alternative Access Standards Requests
Pass	AAS Pass*

* Granted AAS per WIC 14197

MCP Name	Reporting Unit	Overall Result
SCAN Health Plan	***Los Angeles County***	***Pass***

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

Time and Distance

Provider Type	Adult/Pediatric	Results
PCPs	Adult	AAS Pass*
PCPs	Pediatric	N/A
OB/GYN	Combined	AAS Pass*
Cardiology/ Interventional Cardiology	Adult	AAS Pass*
Dermatology	Adult	AAS Pass*
Endocrinology	Adult	AAS Pass*
ENT/ Otolaryngology	Adult	AAS Pass*
Gastroenterology	Adult	AAS Pass*
General Surgery	Adult	AAS Pass*
Hematology	Adult	AAS Pass*
HIV/AIDS Specialists/ Infectious Diseases	Adult	AAS Pass*
Nephrology	Adult	AAS Pass*
Neurology	Adult	AAS Pass*
Oncology	Adult	AAS Pass*
Ophthalmology	Adult	AAS Pass*
Orthopedic Surgery	Adult	AAS Pass*
Physical Medicine and Rehabilitation	Adult	AAS Pass*
Psychiatry	Adult	AAS Pass*
Pulmonology	Adult	AAS Pass*
Cardiology/ Interventional Cardiology	Pediatric	N/A
Dermatology	Pediatric	N/A
Endocrinology	Pediatric	N/A
ENT/ Otolaryngology	Pediatric	N/A
Gastroenterology	Pediatric	N/A
General Surgery	Pediatric	N/A
Hematology	Pediatric	N/A
HIV/AIDS Specialists/ Infectious Diseases	Pediatric	N/A
Nephrology	Pediatric	N/A
Neurology	Pediatric	N/A
Oncology	Pediatric	N/A
Ophthalmology	Pediatric	N/A
Orthopedic Surgery	Pediatric	N/A
Physical Medicine and Rehabilitation	Pediatric	N/A
Psychiatry	Pediatric	N/A
Pulmonology	Pediatric	N/A
Mental Health Outpatient Services	Combined	AAS Pass*
Hospitals	N/A	AAS Pass*
Pharmacies	N/A	AAS Pass*

Mandatory Provider Types

Provider Type	Description	Result
FQHC, FBC, RHC, IHF	1 of each in the Provider Network	Pass
Midwifery Services	Available in the network	Pass

MCP Policy and Procedure Review

A&I Medical Audit Components	Result
Category 3.1 Appointment Procedures / Wait Times	Pass
Category 3.2 Urgent Care / Emergency Care	Pass
Category 3.3 Telephone Procedures / After Hours	Pass
Category 3.4 Specialist and Specialty Services	Pass

Provider Validation	Alternative Access Standards Requests
Pass	AAS Pass*

* Granted AAS per WIC 14197

MCP Name	Reporting Unit	Overall Result
SCAN Health Plan	***Riverside County***	***Pass***

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

Time and Distance

Provider Type	Adult/Pediatric	Results
PCPs	Adult	AAS Pass*
PCPs	Pediatric	N/A
OB/GYN	Combined	AAS Pass*
Cardiology/ Interventional Cardiology	Adult	AAS Pass*
Dermatology	Adult	AAS Pass*
Endocrinology	Adult	AAS Pass*
ENT/ Otolaryngology	Adult	AAS Pass*
Gastroenterology	Adult	AAS Pass*
General Surgery	Adult	AAS Pass*
Hematology	Adult	AAS Pass*

Provider Type	Adult/Pediatric	Results
HIV/AIDS Specialists/ Infectious Diseases	Adult	AAS Pass*
Nephrology	Adult	AAS Pass*
Neurology	Adult	AAS Pass*
Oncology	Adult	AAS Pass*
Ophthalmology	Adult	AAS Pass*
Orthopedic Surgery	Adult	AAS Pass*
Physical Medicine and Rehabilitation	Adult	AAS Pass*
Psychiatry	Adult	AAS Pass*
Pulmonology	Adult	AAS Pass*
Cardiology/ Interventional Cardiology	Pediatric	N/A
Dermatology	Pediatric	N/A
Endocrinology	Pediatric	N/A
ENT/ Otolaryngology	Pediatric	N/A
Gastroenterology	Pediatric	N/A
General Surgery	Pediatric	N/A
Hematology	Pediatric	N/A
HIV/AIDS Specialists/ Infectious Diseases	Pediatric	N/A
Nephrology	Pediatric	N/A
Neurology	Pediatric	N/A
Oncology	Pediatric	N/A
Ophthalmology	Pediatric	N/A
Orthopedic Surgery	Pediatric	N/A
Physical Medicine and Rehabilitation	Pediatric	N/A
Psychiatry	Pediatric	N/A
Pulmonology	Pediatric	N/A
Mental Health Outpatient Services	Combined	AAS Pass*
Hospitals	N/A	AAS Pass*
Pharmacies	N/A	AAS Pass*

Mandatory Provider Types

Provider Type	Description	Result
FQHC, FBC, RHC, IHF	1 of each in the Provider Network	Pass
Midwifery Services	Available in the network	Pass

MCP Policy and Procedure Review

A&I Medical Audit Components	Result
Category 3.1. Appointment Procedures / Wait Times	Pass
Category 3.2 Urgent Care / Emergency Care	Pass
Category 3.3 Telephone Procedures / After Hours	Pass
Category 3.4 Specialist and Specialty Services	Pass

Provider Validation	Alternative Access Standards Requests
Pass	AAS Pass*

* Granted AAS per WIC 14197

MCP Name	Reporting Unit	Overall Result
SCAN Health Plan	***San Bernardino County***	***Pass***

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

Time and Distance

Provider Type	Adult/Pediatric	Results
PCPs	Adult	AAS Pass*
PCPs	Pediatric	N/A
OB/GYN	Combined	AAS Pass*
Cardiology/ Interventional Cardiology	Adult	AAS Pass*
Dermatology	Adult	AAS Pass*
Endocrinology	Adult	AAS Pass*
ENT/ Otolaryngology	Adult	AAS Pass*
Gastroenterology	Adult	AAS Pass*
General Surgery	Adult	AAS Pass*
Hematology	Adult	AAS Pass*
HIV/AIDS Specialists/ Infectious Diseases	Adult	AAS Pass*
Nephrology	Adult	AAS Pass*
Neurology	Adult	AAS Pass*
Oncology	Adult	AAS Pass*
Ophthalmology	Adult	AAS Pass*
Orthopedic Surgery	Adult	AAS Pass*
Physical Medicine and Rehabilitation	Adult	AAS Pass*
Psychiatry	Adult	AAS Pass*
Pulmonology	Adult	AAS Pass*
Cardiology/ Interventional Cardiology	Pediatric	N/A
Dermatology	Pediatric	N/A
Endocrinology	Pediatric	N/A
ENT/ Otolaryngology	Pediatric	N/A
Gastroenterology	Pediatric	N/A
General Surgery	Pediatric	N/A

Provider Type	Adult/Pediatric	Results
Hematology	Pediatric	N/A
HIV/AIDS Specialists/ Infectious Diseases	Pediatric	N/A
Nephrology	Pediatric	N/A
Neurology	Pediatric	N/A
Oncology	Pediatric	N/A
Ophthalmology	Pediatric	N/A
Orthopedic Surgery	Pediatric	N/A
Physical Medicine and Rehabilitation	Pediatric	N/A
Psychiatry	Pediatric	N/A
Pulmonology	Pediatric	N/A
Mental Health Outpatient Services	Combined	AAS Pass*
Hospitals	N/A	AAS Pass*
Pharmacies	N/A	AAS Pass*

Mandatory Provider Types

Provider Type	Description	Result
FQHC, FBC, RHC, IHF	1 of each in the Provider Network	Pass
Midwifery Services	Available in the network	Pass

MCP Policy and Procedure Review

A&I Medical Audit Components	Result
Category 3.1 Appointment Procedures / Wait Times	Pass
Category 3.2 Urgent Care / Emergency Care	Pass
Category 3.3 Telephone Procedures / After Hours	Pass
Category 3.4 Specialist and Specialty Services	Pass

Provider Validation	Alternative Access Standards Requests
Pass	AAS Pass*

* Granted AAS per WIC 14197

8.8 Attachment H: Whole Child Model Network Certification Results

WCM Network Certification Results: Phase 2
Partnership Health Plan*

CCS Provider Types and Facilities	Northeast	Northwest	Southeast	Southwest
CCS Paneled Primary Care	Met	Met	Met	Met
Allergy and Immunology	Met	Met	Met	Met
Cardiology	Met	Met	Met	Met
Critical Care Medicine/Intensivist	Met	Met	Met	Met
Dermatology	Met	Met	Met	Met
Developmental and Behavioral Medicine: Pediatric	Met	Met	Met	Met
Endocrinology	Met	Met	Met	Met
Gastroenterology	Met	Met	Met	Met
Genetics	Met	Met	Met	Met
Hematology-Oncology	Met	Met	Met	Met
Infectious Disease	Met	Met	Met	Met
Nephrology	Met	Met	Met	Met
Neurology	Met	Met	Met	Met
Neurological Surgery	Met	Met	Met	Met
Ophthalmology	Met	Met	Met	Met
Oral and Maxillofacial Surgery	Met	Met	Met	Met
Orthopedics	Met	Met	Met	Met
Otolaryngology	Met	Met	Met	Met
Physical Medicine and Rehabilitation	Met	Met	Met	Met
Plastic Surgery	Met	Met	Met	Met
Pulmonology	Met	Met	Met	Met
Rheumatology	Met	Met	Met	Met
Surgery	Met	Met	Met	Met
Transplant Hepatology	Met	Met	Met	Met
Urology	Met	Met	Met	Met

Licensed Acute Care Hospitals	Northeast	Northwest	Southeast	Southwest
Tertiary	Met	Met	Met	Met
Pediatric Community	Met	Met	Met	Met

* Findings/CAP Requirements: There were a total of zero findings and 0% of requirements not being met.