Network Certification Checklist

Purpose

The Department of Health Care Services (DHCS) will review, validate and certify the provider network of each Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) County, herein referred to as Plans. DHCS must ensure adequate access to appropriate service providers in accordance with Title 42 of the Code of Federal Regulations parts 438.207, 438.68 and 438.206(c)(1). The information will be used in the assurance of compliance with network adequacy requirements DHCS must send to the Centers for Medicare and Medicaid Services (CMS). In order to demonstrate network adequacy, Plans must submit a completed Network Adequacy Certification Tool (NACT).

Submission Instructions

MHPs must upload electronic submissions* of the NACT and supporting documentation into their BHIS - CSI system account 'data exchange' folder, by the submission deadline established in the Information Notice. When submitting files, each plan must use the following naming convention:

NACT_(County Code)_Plan Type (MHP or DMC_ODS)_Plan Name_Fiscal Year and Quarter
• Example: NACT_05_MHP_Alameda_2018_Q1

DMC-ODS pilot counties must provide the NACT via [SECURE] email format* to NACTData@DHCS.ca.gov by the submission deadline established in the Information Notice. When submitting files, each plan must use the following naming convention:

NACT_(County Code)_Plan Type (MHP or DMC_ODS)_Plan Name_Fiscal Year and Quarter
• Example: NACT_05_ODS_Alameda_2018_Q1

*Please contact NACTData@DHCS.ca.gov with any questions or to troubleshoot technical errors regarding the submission of the NACT or supporting documentation.

The applicable time and distance, and timely access, requirements are detailed in the Information Notice.

Timing of Submissions

- Timing of initial submission: Submissions shall be submitted to DHCS **no later than March 30, 2018.**

Network Adequacy Certification Tool (NACT)

Each Plan shall submit the NACT, Enclosure 1, with the following exhibits:

- Exhibit A-1 Network Provider Data, Organizational/Legal Entity Level

  All Plans must complete and submit Exhibit A-1. For the purposes of network adequacy, Plans must complete Exhibit A-1 in reference to the county (Row #1) AND the Plan's subcontracted organizations. The term "Organization" refers to the parent organization and/or legal entity designation. Telehealth organizations must be included in this exhibit.

- Exhibit A-2 Network Provider Data, Provider Site Detail

  All Plans must complete and submit Exhibit A-2. The term "site" refers to the physical location (i.e., clinic sites) where services are rendered to Medi-Cal beneficiaries. The “site” information must include county-owned and operated facilities and contracted network provider sites.

- Exhibit A-3 Network Provider Data, Rendering Provider Detail

  All Plans must complete and submit Exhibit A-3. The term “rendering service provider” refers to the individual practitioner, acting within his or her scope of practice, who is rendering services directly to the beneficiaries. This includes individuals employed by the Plan, individuals employed by a contracted organization, individual members of a provider group, and individual practitioners rendering services through “fee-for-service” contracts with the Plan. Telehealth practitioners must be included in this exhibit.

- Exhibit B-1 Community Based Services

  All Plans must complete Exhibit B-1, if rendering provider routinely travels to a site different from the site listed in Exhibit A-2, and the Plan utilizes mobile and/or community-based services (e.g., mobile units, satellite sites, community centers) to deliver services to beneficiaries in community-based settings (including the beneficiary’s home).

- Exhibit B-2 American Indian Health Facilities

  All Plans must complete Exhibit B-2 to demonstrate compliance with Federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 CFR 438.14). American Indians and American Indian Health Facilities (IHF) are not required to maintain MHP or DMC-ODS affiliation; however, they retain the option to join a MHP or DMC-ODS at any time. In the exhibit, Plans must to document any and all efforts to contract with American Indian Health Facilities in the Plan’s service area.

  If the Plan does not have a contract with any IHFs, the Plan must submit an explanation to DHCS that includes supporting documentation, to justify the absence of the mandatory provider type in the Plan’s network. DHCS will review the Plan’s submission to determine compliance.

- Exhibit C-1 Provider Counts

  All Plans must complete and submit Exhibit C-1. In the table provided on Exhibit C-1, enter the number of providers within the existing network, separated by provider type and the age group(s) served.

  For MHPs, enter the number of providers for the following provider types: Licensed Psychiatrists, Licensed Physicians, Licensed Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Marriage and Family Therapists, Registered Nurses, Certified Nurse Specialists, Nurse Practitioners, Licensed Vocational Nurses, Psychiatric Technicians, Mental Health Rehabilitation Specialists, Physician Assistants, Pharmacists, Occupational Therapists, and Other Qualified Providers.

  For DMC-ODS, enter the number of providers for the following provider types: Licensed Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Eligible Practitioners working under the supervision of Licensed Clinicians, Registered

Substance Use Disorder Counselors, and Certified Substance Used Disorder Counselors.

- Exhibit C-2 Expected Service Utilization

  All Plans must complete and submit Exhibit C-2. In the tables provided on Exhibit C-2, enter the actual number of Medi-Cal beneficiaries served this fiscal year (year-to-date) and the expected number of Medi-Cal beneficiaries to be served next fiscal year (next certification year), separated by service type/modality and age group(s) served.

Additional reporting instructions are detailed in Enclosure 1, Network Adequacy Certification Tool.

Geographic Access – Time and Distance

Geographic Access maps, accessibility charts and access summaries will be used to ensure that the Plan has met time and/or distance standards in the Plan's service area. Plans must submit to DHCS a map of all network providers in the Plan's service area. If necessary, the Plan should include contracted network providers in neighboring service areas if needed to meet time and distance standards.

The map must plot time and distance for all network providers, stratified by service type, and geographic location. The Plan must also include a map of community based settings where services are regularly delivered. The Plan's analysis must illustrate that it complies with applicable time or distance standards or it must demonstrate that it has requested DHCS approval for an alternative access standard.

For both adult and children/youth[1] separately, the Plan must provide a map of its network providers to demonstrate compliance with each of the required standards. Note: Psychiatrists are considered core specialists and will need a specific geographic access map that reflects the time and distance standards for specialists. Plans shall submit the following:

- An overview map of the entire service area which delineates boundaries and zip codes.
- An overview map of all beneficiaries receiving services in the county.
- Two geographic access maps for each service type (i.e., psychiatry, outpatient mental health, outpatient DMC-ODS, and opioid treatment programs) within the geographic area. The two maps include the following:
  1. Provider Map with radius
  2. Map combing Service Area, Provider and Enrollee with radius

Submission of geographic access maps must meet the following requirements:

- The File Name includes the name of the Exhibit
- The File Name and Map Header includes the name of the Plan
- The map includes a key
- The map identifies the applicable distance standard (Miles)

Only if the Plan's geo-mapping software does not have that capability to indicate the locations of all the Plan's beneficiaries, may the Plan indicate network provider locations and use the radius field function (e.g. the ability to show by use of color a certain mile radius around a provider) to ensure that the distance standards are met.

[1] For geographic access maps, Medi-Cal beneficiaries under the age of 21 are classified as children/youth.

Each Plan shall also submit an accessibility chart and access summary to demonstrate if the time standards can be met. The accessibility chart and access summary submission must specify any zip codes and/or specific geographic locations within the county for which the Plan was not able meet the distance standards.

The Plan's report shall be submitted in PDF and Excel formats and shall address the following information:

Accessibility Charts	**Access Summaries**
Name of the Exhibit	Logic of the Measurement
Name of the Plan	How did the Plan measure their radius?
Access Standard (Minutes)	From the center of the zip code or service area?
Name of the Service Area	Center of most populated area of zip code or service area?
Name of the City	From Provider?
Zip Codes in which distance was not met	From Enrollee?
# of Enrollees	
# of Providers	
Specialty, if applicable	
# of Enrollees with Access	
% of Enrollees with Access	
Travel distance to 1 Provider	
Travel time to 1 Provider	
# of Enrollees without Access	
% of Enrollees without Access	
Travel distance to 1 Provider	
Travel time to 1 Provider	

Alternative Access Standards
If time and/or distance standards are not met, the Plan shall submit an Alternative Access Standards Request. Instructions about how to request Alternative Access Standards are detailed in Enclosure 3, Alternative Access Standards Requests.

Additional Supporting Documentation

On an annual basis, at the time of its April 1st (or the next business day) submission[2], each Plan must submit the following additional supporting documentation:

- Provider Subcontracts, including the Plan's subcontracts for interpreter, language line and telehealth services
- Grievances and Appeals
- Provider Directory (for MHPs only)
- Beneficiary Satisfaction Survey Results (for MHPs only)

Policies and Procedures

On annual basis, at the time of its April 1st (or the next business day) submission, each Plan must submit the following policies and procedures:

- Network adequacy monitoring
  - Submit policies and procedures related to the Plan's procedures for monitoring compliance with the network adequacy standards.

- Out of network access
  - Submit policies and procedures related to the provision of medically necessary services delivered out-of-network.

- Timely access
  - Submit policies and procedures addressing appointment time standards

- Service availability
  - Submit policies and procedures addressing requirements for:
    - Appointment scheduling
    - Routine specialty (i.e., psychiatry) referral
    - After-hours calls

- Physical accessibility
  - Submit policies and procedures regarding access for beneficiaries with disabilities pursuant to the Americans with Disabilities Act of 1990.

- Telehealth services
  - Submit policies and procedures regarding use of telehealth services to deliver covered services.

- 24/7 Access line requirements
  - Submit policies and procedures regarding requirements for the Plan's 24/7 Access Line

- 24/7 language assistance

[2] For the initial submission, the deadline is March 30, 2018

- Submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.

Language Line Utilization

With its required NACT submission, Plans must submit a language line utilization chart detailing monthly utilization of its language line. The analysis must include utilization of interpretation services through the Plan's 24/7 Access line and for beneficiaries' face-to-face encounters with network providers. The Plan's report shall be submitted in PDF and Excel formats and shall address the following information:

Language Line Utilization for 24/7 Access Line	**Language Line Utilization for Face-to-Face Service Encounters**	**Language Line Utilization for Telehealth or Telephonic Service Encounters**
Exhibit Name: Language Line Utilization	Exhibit Name: Language Line Utilization	Exhibit Name: Language Line Utilization
Plan Name	Plan Name	Plan Name
Reporting Period	Reporting Period	Reporting Period
Total # encounters requiring language line services	Total # encounters requiring language line services	Total # encounters requiring language line services
# of encounters requiring language line services, stratified by language	# of encounters requiring language line services, stratified by language	# of encounters requiring language line services, stratified by language
Reason services could not be provided by bilingual provider/staff or contracted interpreter	Reason services could not be provided by bilingual provider/staff or via face-to-face interpretation	Reason services could not be provided by bilingual provider/staff or via face-to-face interpretation