

C.9 Provider Network and Access Requirements

C.9.1 Introduction

C.9.1.1 Contractor shall comply with federal standards governing the adequacy of capacity and services found at 42 C.F.R. §§ 438.207-438.210. Contractor shall have the capacity to serve Enrollees in accordance with the standards of access to care set forth in this Section C.9. 42 C.F.R. § 438.12(a) may not be construed to:

C.9.1.1.1 Require Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees;

C.9.1.1.2 Preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

C.9.1.1.3 Preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to Enrollees.

C.9.1.2 Contractor shall have the capacity to successfully perform the required services set forth in Section C and have a sustainable Provider network that can furnish the effective care, in the appropriate setting, and in a timely fashion, to Enrollees as defined in Section C.9.2 and C.9.3. For purposes of Section C.9 adequate capacity and accessibility shall be defined as the Contractor's ability to comply with the network composition requirements of C.9.2 and the geographic, Travel Time, and appointment standards set forth in C.9.3.

C.9.1.3 Contractor shall submit encounter information, claims data, and other data documenting service utilization in electronic format (as specified by DHCF) to DHCF, regardless of how the information is obtained from its Providers.

C.9.1.4 Contractor shall offer an appropriate range of preventive, primary care and specialty care that is adequate for the anticipated number of Enrollees as defined in C.3.1.5

C.9.1.4.1 Contractor shall maintain a network of Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated enrollment. Contractor's network of physicians, hospitals, pharmacies, and specialized treatment programs for persons with chronic physical and mental disabilities and conditions must be sufficient, as documented by data on network composition, encounter data, and other data documenting service utilization as DHCF may require, to meet the needs of Enrollees. DHCF shall evaluate the sufficiency of Contractor's network based upon whether Contractor is in compliance with the standards and requirements of C.9.2 and C.9.3.

C.9.1.4.2 Contractor shall arrange and administer Covered Services in accordance with Section C.8 to Enrollees through its network. Where Contractor's network is not able to adequately furnish Covered Services, which shall be determined based upon whether Contractor's Network Providers are in compliance with the requirements set forth in C.9.3, Contractor shall arrange for Covered Services to be provided on an out-of-network basis in accordance with this Section.

C.9.1.4.3 In accordance with 42 C.F.R. § 438.210, Contractor shall provide medical care that is as accessible to Enrollees, in terms of timeliness, amount, duration, and scope, as those services are to non-Medicaid and Fee-for-Service beneficiaries served by the Contractor.

C.9.1.5 In establishing a network, Contractor shall include all classes of Providers necessary to furnish Covered Services, including but not limited to hospitals, physicians (specialists and primary care), nurse midwives, nurse practitioners, pediatric nurse practitioners, federally qualified health centers, medical specialists, dentists, mental health and substance abuse Providers, allied health professionals, ancillary Providers, DME Providers, home health Providers and transportation Providers as described in C.9.2. Contractor's network shall include adequate numbers of Providers with the training, experience, and skills necessary to furnish quality care to Enrollees and to do so in a manner that is accessible and Culturally Competent. All Providers must be appropriately licensed or registered in accordance with the District of Columbia Health Occupation Regulatory Act (D.C. Code § 3-1200 et seq.) and any regulations thereunder or, if located in a jurisdiction outside of the District, in accordance with the health occupations regulatory requirements in the jurisdiction in which the Provider practices.

C.9.1.6 All of Contractor's Providers shall be eligible (i.e., not excluded, suspended or debarred) to participate in any District and Federal health care benefit program. Individuals or organizations suspended, excluded or debarred from participation in a Federal, state, or District health care benefit program shall not provide services under the Contract.

C.9.1.7 Contractor shall, on a quarterly basis, provide written documentation (as described in C.9.2.1) that it has sufficient capacity to handle the maximum number of Enrollees specified under Section C.3.1.5. In the event that there is a Material Change (as defined in C.9.2.2.2) in the anticipated enrollment in Contractor's plan, Contractor shall submit new documentation of network adequacy in relation to anticipated enrollment, across all classes of Providers and services within thirty (30) days.

C.9.1.8 Contractor shall have in place written guidelines and procedures to ensure Enrollees are provided Covered Services without regard to race, color, gender, creed, religion, age, national origin, ancestry, marital status, sexual orientation, political affiliation, personal appearance, or physical or mental disability. In addition, Contractor shall require that all Network Providers are in compliance with the requirements of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 et seq., Section 504 of the Rehabilitation Act of 1974, 29 U.S.C. § 794 and other requirements set forth in Section I.7)

C.9.1.9 Contractor shall, on a quarterly basis, analyze the composition of its network and, based upon the health status and needs of its Enrollees, identify any gaps or areas requiring expansion, including the provision of primary care, specialty care, dental and mental health services, including but not limited to services on weekends and evenings. This information shall be provided to DHCF upon request.

C.9.1.10 Contractor shall establish mechanisms to ensure that Network Providers comply with the timely access requirements and monitor them regularly to determine compliance and take corrective action if there is a failure to comply.

C.9.1.11 Contractor shall have written policies and procedures for selection and retention of Providers.

C.9.2 Network Composition

C.9.2.1 Network Adequacy Requirements

Contractor shall ensure that its delivery network is sufficient in numbers and types of providers to ensure that all Covered Services are accessible without unreasonable delay. For purposes of this C.9.2, Contractor's delivery network shall be sufficient if Contractor is in compliance with the geographic, Travel Time requirements, Appointment Time standards, and other standards established in C.9.2 and C.9.3. In documenting the adequacy of its network Contractor shall demonstrate that it has taken into account:

C.9.2.1.1 DCHFP and Alliance enrollment;

C.9.2.1.2 The expected utilization of services, considering Enrollee characteristics and health care needs;

C.9.2.1.3 The number and types of Providers (in terms of training, experience, capacity, and specialization) required to furnish Covered Services;

C.9.2.1.4 The number of network Providers not accepting new patients; and

C.9.2.1.5 The geographic location of Providers and Enrollees, distance, Travel Time, normal means of transportation, including public transportation, used by Enrollees and whether Provider locations are accessible to Enrollees with disabilities; and

C.9.2.1.6 The average routine appointment waiting times (i.e., time routinely spent waiting to see the Provider once the Enrollee has arrived) and the average time it takes for an Enrollee to schedule an initial and follow-up appointment.

C.9.2.2 Sufficiency in number and type of provider is determined in accordance with the requirements of this section. Enrollees must have access to emergency care 24 hours a day, 7 days a week.

At a minimum, the Contractor must have at least one (1) full-time equivalent PCP, regardless of specialty type, for every 1500 enrollees, and there must be one (1) full-time equivalent PCP with pediatric training and/or experience for every 1,000 enrollees through the age of twenty (20). Failure to maintain the adequacy requirement shall result in penalties to the Contractor of up to \$50,000 per PCP needed to meet the adequate network requirement.

Contractor shall use reasonable criteria to determine sufficiency. The criteria shall include, but are not limited to:

C.9.2.2.1 A ratio of specialty care providers to Enrollees;

C.9.2.2.2 A ratio of primary care providers to Enrollees;

C.9.2.2.3 A ratio of dental providers to Enrollees

C.9.2.2.4 Geographic accessibility;

- C.9.2.2.5 Waiting times for appointments with participating providers;
- C.9.2.2.6 Hours of operation; or
- C.9.2.2.7 The volume of technological and specialty services available to serve the needs of Enrollees requiring technological advanced or specialty care.
- C.9.2.3 Whenever Contractor has an insufficient number or type of participating providers to provide a covered service, the Contractor shall ensure that the Enrollee obtains the covered service at no cost; as if the covered service was obtained from within the Contractor's network.
- C.9.2.4 Contractor shall provide an access plan to DHCF/CA quarterly or upon request and must describe or contain at least the following:
- C.9.2.4.1 A listing of the names and specialties of the Contractor's participating providers;
- C.9.2.4.2 Contractor's procedures for making referrals within and outside its network;
- C.9.2.4.3 Contractor's process for monitoring and ensuring on an ongoing basis, the sufficiency of the network to meet the health care needs of Enrollees;
- C.9.2.4.4 Contractor's methods for assessing the health care needs of Enrollees;
- C.9.2.5 Failure to maintain an adequate and sufficient network that ensures Enrollees have access to covered services without unreasonable delays, and as described in Section C.9, can result in corrective action, fines, penalties and/or sanctions imposed by the District, including but not limited to the amount listed in C.9.2.2.
- C.9.2.6 Contractor shall provide the documentation of its network adequacy described in C.9.2.1 and C.9.2.2 above on a quarterly basis, and upon DHCF's request throughout the term of the Contract. In addition, Contractor shall update the documentation and assurance to DHCF with respect to network adequacy whenever there has been a Material Change (as defined in Section C.9.2.2.2) in Contractor's operations or a change in the health status of its Enrolled population that would affect adequate capacity and services, including changes in Contractor benefits, geographic service areas, Provider Network, payments, or enrollment of a new population in the Contractor. Contractor must include a Corrective Action Plan with this update.
- C.9.2.6.1 Contractor shall recruit licensed, Board-certified or Board eligible Providers needed to provide comprehensive, accessible, and Culturally Competent care on an ongoing basis. Any Material Changes in Contractor's Provider network shall be reported in writing to DHCF immediately and be accompanied by a plan of correction.
- C.9.2.6.2 For purposes of this paragraph C.9.2.2 a "Material Change" shall mean any change in the size or composition of the Provider network that could be expected to affect Enrollees' access to care in a timely fashion or that would elevate the overall number of registered patients with any primary care Provider above professionally and industry accepted norms and community standards (as defined in H.1.4) for the primary care specialties.

C.9.2.7 Primary Care Providers

C.9.2.7.1 For all Enrollees, Contractor shall have at least two (2) Primary Care Providers (PCPs) both Geographically Available and able to demonstrate that they can accept patients while maintaining their overall patient load within professional and industry norms and community standards (as defined in H.10.7). Geographic Availability is defined as a location within five (5) miles of an Enrollee's residence or no more than thirty (30) minutes Travel Time. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN, pediatric physician (when appropriate to the Enrollee), osteopath, clinic or FQHC, nurse practitioner, or a subspecialty physician when appropriate in light of an Enrollee's Special Health Care Needs.

C.9.2.7.1.1 Clinics as Providers

Enrollees may designate a clinic as a PCP. Clinics must comply with the capacity standards defined in Section C.9.2.3. In addition, each Full-time Equivalent PCP in the clinic may have no more than 2,000 total patient load of Medicaid and Alliance Enrollees. The Appointment Standards in Section C.9.3.4 shall apply to clinics.

C.9.2.7.2 Contractor shall ensure that PCPs have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards (as defined in H.10.7), including any CMS or DHCF guidance on this issue. In evaluating the capacity of PCPs, Contractor shall take into consideration both a PCP's existing Contractor Enrollee load, overall Enrollee load, Medicaid patient load, as well as its total patient load and shall assess the overall patient load against community standards for any specialty involved. Contractor shall also consider whether the Provider is in compliance with the Appointment Time standards set forth in C.9.3.4. In no event shall Contractor assign additional Enrollees to a single PCP if the Contractor believes that the PCP has reached his/her capacity to provide high quality services to Enrollees. Contractor shall provide this information upon DHCF's request.

C.9.2.7.3 Contractor shall submit a monthly report on number of participating PCPs accepting new patients (i.e., PCPs with fully open panels), Providers with less than 80% availability, and specialists authorized to serve as PCPs.

C.9.2.7.4 Contractor shall submit a quarterly report of an updated GEOAccess Map showing participating PCPs by zip code of office locations and less than eighty percent (80%) panel availability.

C.9.2.8 Specialty Care Providers

C.9.2.8.1 Contractor shall have a network that includes sufficient numbers and classes of specialty Providers to furnish Covered Specialty Services. Contractor's network shall be sufficient if it is able to comply with the Section C.9.2.4.2 below and the Access Standards in Section C.9.3. Contractor's network shall include medical sub-specialists and pediatric specialists and sub-specialists.

C.9.2.8.2 At a minimum Contractor's network shall include but not be limited to:

C.9.2.8.2.1 Dermatologists

C.9.2.8.2.2 Orthopedic surgeons,

- C.9.2.8.2.3 Neurologists,
- C.9.2.8.2.4 Neurosurgeons,
- C.9.2.8.2.5 Neonatologists,
- C.9.2.8.2.6 Perinatologists,
- C.9.2.8.2.7 Oncologists,
- C.9.2.8.2.8 Allergists and Immunologists,
- C.9.2.8.2.9 Cardiologists,
- C.9.2.8.2.10 Endocrinologists,
- C.9.2.8.2.11 Gastroenterologists (Pediatric and Adult),
- C.9.2.8.2.12 Geneticists,
- C.9.2.8.2.13 Nephrologists,
- C.9.2.8.2.14 Obstetricians/Gynecologists,
- C.9.2.8.2.15 Ophthalmologists,
- C.9.2.8.2.16 Orthopedic Surgeons,
- C.9.2.8.2.17 Otolaryngologists,
- C.9.2.8.2.18 Podiatrists,
- C.9.2.8.2.19 Pulmonary Specialists,
- C.9.2.8.2.20 Rheumatologists,
- C.9.2.8.2.21 Surgeons,
- C.9.2.8.2.22 Urologists,
- C.9.2.8.2.23 Mental health Providers,
- C.9.2.8.2.24 Inpatient specialty facilities, and
- C.9.2.8.2.25 Rehabilitation Providers.

C.9.2.8.3 In the event that Contractor's network is insufficient to furnish a specialty service, Contractor shall pay for the cost of such services, including transportation, for as long as Contractor is unable to provide the services through a Network Provider.

C.9.2.9 Specialist as a Primary Care Provider

Contractor shall offer each Enrollee with Special Health Care Needs as defined in Section C.1.3.193, the option of choosing as the Enrollee's PCP a specialist participating in Contractor's network who has the experience and expertise in the treatment of the Enrollee's Special Health Care Needs and is willing and has the capacity (as defined by Section C.3) to accept the Enrollee. The need for a specialist to function as an Enrollee's PCP shall be determined on a case-by-case basis and in consultation with the Enrollee, the Enrollee's current PCP, and the specialty Provider that would serve as the Enrollee's PCP. If the Enrollee disagrees with Contractor's decision, Contractor shall inform the Enrollee of his or her right to file a Grievance with Contractor and/or to utilize the Fair Hearing process described in Section C.14.

C.9.2.10 Dental Providers

Contractor shall maintain a sufficient network of Dental Providers, including Dentists, Pediatric Dentists, Orthodontists and Oral Surgeons, to meet the needs of Enrollees. Contractor shall submit a monthly report on the number of participating dental Providers categorized as Dentists, Pediatric Dentists, Orthodontists, or Oral Surgeons by fully open patient panels and patient panels with less than 80% availability. Failure to maintain an adequate and sufficient network that ensures Enrollees have access to covered dental services without unreasonable delays, and as described in Section C.9, can result in corrective action, fines, penalties and/or sanctions imposed by the District. For Enrollees through the age of twenty (20), Contractor shall ensure there is at least one (1) active dentist for every 750 Enrollees. Failure to maintain the adequacy requirement shall result in penalties to the Contractor of up to \$50,000 per dentist needed to meet the adequate network requirement.

C.9.2.11 Hospitals

C.9.2.11.1 Contractor shall demonstrate that it maintains agreements to utilize or access hospitals, including comprehensive psychiatric emergency programs, sufficient to provide Emergency Services. Contractor shall demonstrate its hospital network in the District, capable of furnishing a full range of tertiary services to Enrollees. Contractor must demonstrate that Enrollees have access to at least two (2) general acute care hospitals located in the District. All hospital Providers shall be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Alternatively, Contractor shall demonstrate that the hospital complies with NCQA standard CR 11: Assessment of Organizational Providers and verifies from the state that the hospital has met all state licensing and certification requirements and conducts onsite quality assessment if not accredited. State certification may be substituted for the required site visit. Moreover, the Contractor must comply with the requirements of Section 1867 of the Social Security Act, 42 U.S.C. § 1395dd (Anti-Dumping Provisions).

C.9.2.11.2 Contractor shall also include Sheppard Pratt Health System, or a hospital providing comparable services approved by DHCF's Division of Managed Care, in its network.

C.9.2.11.3 In addition to the requirements above, Contractor shall include at least two (2) hospital that specializes in pediatric care in its network.

C.9.2.11.4 For Enrollees seen for emergency services rendered at an out-of-network hospital, the Contractor shall pay the hospital the District's FFS rates. If the Contractor has a contract with the hospital, the contracted rates are paid.

C.9.2.12 Mental Health Providers

Contractor shall have a sufficient number of appropriately skilled Providers to provide Covered Mental Health Services to Enrollees. Contractor's mental health services network shall include the Department of Mental Health's core service agencies (as this term is defined by DMH) (unless this requirement is waived, in writing, by DHCF), as well as a sufficient number of the following to meet the needs of the Contractor's enrolled beneficiaries:

C.9.2.12.1 Psychiatrists, both adult and pediatric;

C.9.2.12.2 Specialists in developmental/behavioral health medicine;

C.9.2.12.3 Psychologists, both adult and pediatric;

C.9.2.12.4 Social Workers, including those specializing in treatment of mental health and alcohol/drug abuse;

C.9.2.12.5 Inpatient psychiatric units for adults and pediatric Enrollees;

C.9.2.12.6 Residential treatment facilities;

C.9.2.12.7 Partial Hospitalization and Intensive Outpatient Programs;

C.9.2.12.8 Coordination and Case Management service Providers; and

C.9.2.12.9 Contractor shall have the capacity necessary to effectively diagnose, treat and manage individuals dually diagnosed with both mental health and alcohol/drug abuse disorders.

C.9.2.12.10 Contractor's Alliance Network does not need to include the Providers listed in Section C.9.2.12.1 through C.9.2.12.8 above.

C.9.2.12.11 Contractor shall submit a quarterly report of a GEOAccess Map showing participating mental health Providers by zip code of office locations and shall highlight all Providers with less than eighty percent (80%) panel availability.

C.9.2.12.12 Failure to maintain an adequate and sufficient network that ensures Enrollees have access to covered Mental Health services without unreasonable delays, and as described in Section C.9, can result in corrective action, fines, penalties and/or sanctions imposed by the District, including, but not limited to the amount listed in C.9.2.2.

C.9.2.13 Laboratory Providers

Contractor shall demonstrate that it has sufficient laboratory Providers within thirty (30) minutes Travel Time from Enrollees' residence. Laboratory Providers must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of registration or a CLIA certificate of waiver.

C.9.2.14 FQHCs and Safety Net Providers

C.9.2.14.1 If DHCF notifies Contractor that an FQHC or FQHC Look-Alike was not selected to be a Contractor, the Contractor shall contract for the provision of primary care services, preventive care services and/or specialty/referral services with Federally Qualified Health Centers (FQHCs) or FQHC Look-Alike. Contractor shall ensure Enrollees currently using FQHC services shall be offered the opportunity to continue receiving services from the FQHC. Additionally, if an FQHC or FQHC Look-Alike is not selected to be a Contractor, then all selected Contractors shall negotiate a formal agreement that specifies the services and value of the contract with the FQHC.

C.9.2.14.2 Contractor may make a written request for an exemption from this requirement if Contractor can demonstrate, with supporting documentation, that it has adequate capacity to and shall provide a comparable level of clinical and enabling services (e.g., outreach, referral, social support services, culturally sensitive services, and Case Management services) within the geographic area served by the FQHC and/or FQHC look-alike.

C.9.2.14.3 Contractor shall be aware of and consider the unique status of FQHCs when developing Provider networks. Contractor shall contract with FQHCs located in the District of Columbia. In accordance with 42 U.S.C. §1396b(m)((1)(A)(ix), Contractors shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center.

C.9.2.14.4 DHCF estimates that nearly one hundred (100%) of the Alliance enrollees currently use the safety-net clinics identified below. Contractor's Alliance Network shall include the safety net clinics located in the District. Contractor shall have the option of paying the safety net clinics on a Fee-for-Service basis or capitated basis. The Contractor shall pay the safety net clinics no less than ninety-five dollars (\$95.00) per visit if the Contractor elects to pay on a Fee-for-Service basis. Contractor shall pay the safety net clinics on the same terms and conditions as other clinics if the Contractor elects to pay the safety net clinics on a capitated basis. If Contractor is unable to execute a satisfactory subcontract with any of the safety net clinics listed below it shall notify DHCF by November 1, 2012. DHCF reserves the right to require Contractor to enter into binding arbitration to resolve any outstanding issues with the safety net clinic. At a minimum, Contractor's Alliance Network shall include the following safety net clinics:

C.9.2.14.4.1 Bread for the City, Inc.;

C.9.2.14.4.3 Community of Hope and Family Health and Birth Center

C.9.2.14.4.4 Family Medical Counseling Service, Inc.;

C.9.2.14.4.5 La Clinica del Pueblo, Inc.;

C.9.2.14.4.6 Mary's Center for Maternal and Child Care, Inc.;

C.9.2.14.4.7 Perry Family Health Center;

C.9.2.14.4.8 Planned Parenthood of Metropolitan Washington D.C.;

C.9.2.14.4.9 So Others Might Eat;

- C.9.2.14.4.10 Spanish Catholic Center;
- C.9.2.14.4.11 Unity Health Care, Inc.;
- C.9.2.14.4.12 Carl Vogel Center
- C.9.2.14.4.13 Whitman Walker Clinic: and
- C.9.2.14.4.14 Women’s Health Specialists

In addition to a PCP (or, at the Enrollee’s option, in lieu of a PCP) a female Enrollee may have a women’s health specialist. Contractor shall provide female Enrollees with direct access to a women’s health specialist within the network for Covered women’s routine and preventive health care services.

C.9.2.15 Pharmacies

C.9.2.15.1 Contractor shall demonstrate that it has an adequate and appropriate number of pharmacies participating in its network to provide sufficient pharmacy services to Medicaid Enrollees. Contractor shall ensure that at least two (2) pharmacies are located within two (2) miles of Enrollee’s residence.

Contractor’s pharmacy network must include at least one (1) twenty-four (24) hour seven (7) day a week pharmacy and at least one (1) pharmacy that provides home delivery service within four (4) hours. Contractor shall also include at least one (1) mail-order service.

C.9.2.15.2 Contractor shall participate in the pharmacy benefit program for Alliance Enrollees utilizing the pharmacies operated by the District’s contracted provider. Alliance pharmacy disbursement information is provided in Attachment J.21.

C.9.2.16 Integrated Care Centers

Contractor shall demonstrate that its network includes facilities providing integrated care for Enrollees with complex conditions that require multi-disciplinary assessment, diagnosis, and/or treatment. Such facilities may include multi-disciplinary teams practicing at a common location such as specialty outpatient departments, specialty clinics, and developmental centers.

C.9.2.17 IDEA Service Providers

Contractor’s network shall include certified early intervention Providers for health related IDEA services to children under age three (3). Additionally, Contractor’s network shall include Providers qualified to perform evaluations for IDEA eligibility and provide health related IDEA services for children three (3) years of age and older unless and until these services are provided by DCPS. Such Providers shall include those who provide rehabilitation services for improvement, maintenance, or restoration of functioning, including respiratory (including home-based), occupational, speech, and physical therapies.

C.9.2.18 Allied Health Professionals

Contractor's network shall include sufficient numbers of the following classes of allied health professionals. The sufficiency of the numbers of the professionals shall be determined in accordance with the standards described for PCPs in Section C.9.3.4.1.

C.9.2.18.1 Social workers;

C.9.2.18.2 Personal care aides/assistants;

C.9.2.18.3 Home health Providers;

C.9.2.18.4 Registered dietitians;

C.9.2.18.5 Speech, physical, occupational, and respiratory therapists;

C.9.2.18.6 Audiologists; and

C.9.2.18.7 Providers of genetic screening and counseling.