District Dual Choice: Network Adequacy Requirements and Standards

What is network adequacy?

Network adequacy refers to a health plan's ability to provide access to a sufficient number of in-network providers and deliver all services included under the terms of the health plan's contract.

What are the network adequacy requirements under District Dual Choice?

- The health plan shall ensure that its Provider Network is sufficient in number, geographic distribution, and type of Providers to ensure that all Covered Services, including an appropriate range of acute and primary care, long-term services and supports, and other specialty services are accessible to meet the needs of the anticipated number of Enrollees within 90 days of the Start Date.
- The health plan shall meet relevant District network adequacy standards, in accordance with 42 C.F.R. § 438.68, in all geographic areas in which the health plan operates, as well as, adhere to the time and distance standards developed by the District for the following Provider types:
    - PCPs, as applicable;
    - OB/GYN Providers;
    - Behavioral Health (mental and substance use disorder) providers, as applicable;
    - Specialist Providers, as applicable;
    - Hospitals;
    - Pharmacies;
    - LTSS providers delivering care outside the home, including nursing facilities, adult day health programs, and assisted living facilities; and
    - Any additional Provider types when it promotes the objectives of the Medicaid program as determined by CMS and adopted by DHCF.

- The health plan is not required to contract with more providers than necessary to meet the needs of its Enrollees or use different reimbursement amounts for different specialties or for different practitioners in the same specialty.

- The health plan shall establish measures that are designed to maintain quality of services and control costs that are consistent with its responsibilities to Enrollees in accordance with 42 C.F.R. § 438.12(b).

- Providers that have not been enrolled or reenrolled with DHCF shall be excluded in the health plan's network adequacy assessment or accessibility requirements.

Primary Care

- For all Enrollees, the health plan shall have at least two (2) PCPs who are both geographically available and contractually required to meet Mileage and Travel Time Standards and other requirements of this Contract. The health plan shall continuously monitor and manage its PCP network composition.

Obstetric-Gynecological Care

- The health plan shall develop and maintain a Provider network that ensures that female Enrollees have access to care from Obstetric-Gynecological Providers in accordance with the Mileage and Travel Time Standards.
- The health plan shall demonstrate that its Provider Network includes family planning providers to deliver timely access to Covered Services by enrollees seeking the respective services.
- The health plan shall ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for all Dual Eligible Special Needs Plan (D-SNP) Enrollees, no matter their physical or behavioral health needs.

Behavioral Health and Hospital Care

- The health plan shall ensure that the Travel Time to general acute care hospitals or behavioral health Providers shall not exceed thirty (30) minutes Travel Time by public transportation.

Long-term Services and Supports

- The health plan shall ensure that the Travel Time to nursing facilities and assisted living facilities shall not exceed sixty (60) minutes Travel Time by public transportation.
- The health plan shall ensure that the Travel Time to adult day health programs shall not exceed thirty (30) minutes Travel Time by public transportation.

  For all LTSS Providers, the contractor shall:
  - Extend an offer to contract with all Medicaid-enrolled adult day health programs and home health agencies delivering in-home services and supports to FBDE Enrollees as of December 31, 2021, with documentation of attempts to execute an agreement negotiated in good faith by both parties;
  - Throughout the base and option years, ensure network coverage of at least:
    - One (1) Medicaid-enrolled Home Health Agency (HHA) contracted per 150 Enrollees authorized to receive personal care services or in-home skilled nursing or therapy, and no fewer than three such Providers in total;
    - One (1) Medicaid-enrolled chore/homemaker agency contracted per 150 Enrollees authorized to receive chore or homemaker services, and no fewer than three such Providers in total;
    - One (1) Medicaid-enrolled Adult Day Health Program (ADHP) Provider contracted per 150 Enrollees authorized to receive adult day health services, and no fewer than three such Providers in total;
    - One (1) Medicaid-enrolled medical alert devices and services (MADS) Provider contracted per 500 Enrollees authorized to receive MADS, and no fewer than two such Providers in total;
    - One (1) Medicaid-enrolled nursing facility contracted per 100 Enrollees authorized to receive nursing facility services, and no fewer than three such Providers in total; and

- One (1) Medicaid-enrolled assisted living facility contracted per 50 Enrollees authorized to receive assisted living services, and no fewer than three such Providers in total.

Pharmacies

- The health plan shall ensure that at least two (2) pharmacies are located within two (2) miles of each Enrollee's residence. The health plan'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. The health plan shall also include at least one (1) mail-order service.

Laboratory Providers

- The health plan shall demonstrate that it has Laboratory Providers in accordance with Mileage and Travel Time Standards. Providers must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of registration or a CLIA certificate of waiver.

How are network adequacy standards analyzed under District Dual Choice?

- In accordance with 42 C.F.R. § 438.68 the health plan shall demonstrate its ability to meet DHCF's network adequacy standards which includes analysis of:
  - The anticipated D-SNP enrollment;
  - The expected utilization of services, considering Enrollee characteristics and the health care needs of specific Medicaid populations covered by this Contract;
  - The number and types of Providers (in terms of training, experience, capacity, and specialization) required to furnish contracted Covered Services;
  - The number of Network Providers not accepting new patients;
  - 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;
  - The routine appointment waiting times (i.e., time routinely spent waiting to see the Provider once the Enrollee has arrived) at Network Providers and the time it takes for an Enrollee to schedule an initial and follow-up appointment;
  - The ability of Network Providers to communicate with Enrollees who have limited English proficiency in their preferred language;
  - The ability of Network Providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Enrollees with special health care needs; and
  - The availability of triage lines or screening systems, as well as the use of Telemedicine in accordance with 29 DCMR § 910, e-visits, and/or other evolving and innovative technological solutions.

- At a minimum, the health plan must have full-time equivalent (FTE) PCPs, regardless of specialty type, sufficient to serve the total enrollment in the D-SNP.

- The health plan shall report to DHCF quarterly, all PCPs, including groups, health centers, and individual physician practices and sites, which are not accepting new patients and have been granted the ability to do so by the health plan. The health plan shall not allow any individual PCP to have a panel that includes more than five hundred (500) Enrollees at any point in time unless the health plan requests and receives prior written approval from DHCF to temporarily waive the five (500) Enrollee restriction. Such approval shall be granted at the sole discretion of DHCF.

- The health plan shall use the minimum requirements established in this Contract to determine network adequacy.

- Whenever the health plan has an insufficient number or type of Network Providers to provide a covered service, the health plan shall develop and implement a CAP to address network adequacy and ensure that the Enrollees obtain the covered service at no cost; as if the covered service was obtained from the health plan's network.

- The health plan shall provide an access plan to DHCF quarterly and upon request. The access plan must be consistent with the GeoAccess or comparable software reporting requirements and maps, and describe or contain at least the following:
    - A list of the names and specialties of the health plan's participating Providers;
    - The health plan's procedures for making referrals within and outside of its network;
    - The health plan's process for monitoring and ensuring on an ongoing basis, the sufficiency of the health plan's network to meet the special health care needs of D-SNP Enrollees; and
    - The health plan's methods for assessing the health care needs of Enrollees.
    - A log of provider complaints and appeals.

- The health plan shall recruit licensed, Board-certified, or Board-eligible Providers needed to provide comprehensive, accessible, and Culturally Competent care on an ongoing basis.

- The health plan shall demonstrate that there are sufficient I/T/UI Health Providers in the network to ensure timely access to services available under the Contract for Enrollees who are eligible to receive services from such Providers.

Primary Care Providers

- The health plan shall align its Primary Care network under the coverage requirements of 42 CFR 422, Subpart C with any provisions of this section.
- For the purposes of the contract, a PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN, 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.

- Enrollees may designate a clinic as a PCP. In addition, each Full-time Equivalent PCP in the clinic may have no more than a total patient load of 2,000 Medicaid and Alliance Enrollees, which includes individuals enrolled in D-SNP. The Appointment Standards in the Appointment Time Standards section below shall apply to clinics.
- The health plan shall ensure that PCPs have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards, including any CMS or DHCF guidance on this issue. In evaluating the capacity of PCPs, the health plan shall take into consideration both a PCP's existing health plan 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. The health plan shall also consider whether the Provider is in compliance with the Appointment Time Standards in the Appointment Time Standards section below. In no event shall the health plan assign additional Enrollees to a single PCP if the health plan believes that the PCP has reached his/her capacity to provide high quality services to Enrollees. The health plan shall provide evidence of adequate capacity to DHCF, upon request.

Specialty Care Providers

- In alignment with the coverage requirements of 42 CFR 422, Subpart C, the health plan shall have a network that includes sufficient numbers and classes of specialty Providers to furnish covered specialty services to meet the appointment access and availability standards. The health plan's network shall include medical sub-specialists.
- The health plan's network shall, at a minimum, include:
    - Dermatologists,
    - Orthopedic surgeons,
    - Neurologists,
    - Neurosurgeons,
    - Oncologists/Hematologists,
    - Allergists and Immunologists,
    - Cardiologists,
    - Endocrinologists,
    - Gastroenterologists,
    - Geneticists,
    - Nephrologists,
    - Obstetricians/Gynecologists,
    - Ophthalmologists,
    - Otolaryngologists
    - Podiatrists,
    - Pulmonary Specialists,
    - Rheumatologists,
    - Surgeons,
    - Urologists,
    - Inpatient specialty facilities, and
    - Rehabilitation Providers.

- In the event the health plan's network is insufficient to furnish a specialty service, the health plan shall pay for the cost of out of network services, including transportation, for as long as the health plan is unable to provide the services through a Network Provider.

Dental Providers

- The health plan shall maintain a sufficient network of Dental Providers, including Dentists, Orthodontists, and Oral Surgeons, to meet the needs of Enrollees.
- The health plan shall submit a monthly report on the number and distribution of participating Dental Providers categorized as Dentists, Orthodontists, or Oral Surgeons and identify whether the Dental Providers have fully open patient panels and identify those known to the health plan to be closed to accepting new patients.
- The health plan shall ensure there is at least one (1) dentist that has a fully open patient panel for every 750 Enrollees.

Hospitals

- The health plan must demonstrate that all hospitals are accredited by The Joint Commission and verifies to the District that the hospital has met all state licensing and certification requirements. Moreover, the health plan must comply with the requirements of § 1867 of the Act, 42 U.S.C. § 1395dd.
- For Enrollees who receive Emergency Services at an out-of-network hospital, the health plan shall pay the out-of-network hospital the District's FFS rates. If the health plan has a contract with the out-of-network hospital, the health plan shall pay the out-of-network hospital those contracted rates.

Behavioral Health Providers

- The health plan shall have a sufficient number of appropriately skilled Providers to provide Covered Mental Health Services to Enrollees. health plan's mental health services network shall include the Department of Behavioral Health's Core Service Agencies (CSA) as this term is defined by DBH (unless this requirement is waived, in writing, by DHCF), as well as a sufficient number of the following to meet the needs of the health plan's enrolled beneficiaries:
    - Psychiatrists;
    - Specialists in developmental delays and disorders;
    - Behavioral Health medicine;
    - Psychologists;
    - Social Workers, including those specializing in treatment of mental health and substance abuse;
    - Inpatient psychiatric units for Enrollees;
    - Residential treatment facilities;
    - Partial Hospitalization and Intensive Outpatient Programs; and
    - Coordination and Case Management service Providers.

- The health plan shall have the capacity necessary to effectively manage individuals dually diagnosed with both mental health and substance abuse disorders.
- The health plan shall submit a quarterly report of a GeoAccess or comparable software showing participating mental health Providers by zip code of office locations and shall highlight all Providers with less than eighty percent (80%) panel availability.

- Failure to maintain an adequate and sufficient network that ensures Enrollees have access to covered Mental Health services without unreasonable delays, and as described under the Covered Services section of the Contract, , can result in corrective action, fines, penalties and/or sanctions imposed by the District.
- The health plan shall ensure that services for the assessment and stabilization of psychiatric crises are available on a twenty-four (24) hour basis, seven (7) days a week, including weekends and holidays. Phone based assessment and/or screening must be provided within fifteen (15) minutes of request and, when Medically Necessary, intervention or face-to-face assessment shall be provided within ninety (90) minutes of completion of the phone assessment. These services shall be provided by practitioners with appropriate expertise in mental health with on-call access to a psychiatrist.
- The health plan shall report to DBH any changes in a mental health Provider's credentialing information, including health plan's refusal to credential or re-credential a mental health Provider.

FQHC Providers

- The health plan shall contract for the provision of primary care services, dental services, preventive care services and/or specialty/referral services with FQHCs or FQHC look-alikes. The health plan shall ensure Enrollees currently using FQHC services are offered the opportunity to continue receiving services from the FQHC.
- If the health plan is unable to execute a provider agreement with any of the FQHCs in the District, the health plan shall notify DHCF in writing.
- In the event an FQHC renders a service not covered under 42 CFR 422 Subpart C, the health plan shall reimburse FQHCs and FQHC look-alikes at the established DHCF Prospective Payment System (PPS) rate or the Alternative Payment Methodology (APM) rate, in accordance with DCMR Chapter 45, Title 29.

Women's Health

- In addition to a PCP (or, at the Enrollee's option, in lieu of a PCP) a female Enrollee may have a provider who specializes in Women's Health. The health plan shall provide female Enrollees with direct access to a provider that specializes in Women's Health within the network for Covered women's routine and preventive health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a provider who specializes in Women's Health.
- In accordance with 42 C.F.R.§ 431.51, all Enrollees have the right to receive family planning services from a provider of their choice, whether the provider is in or out of the health plan's network. In addition, Enrollees do not need a referral to access family planning services. Out-of-network family planning providers should be paid directly by the health plan for services provided to Enrollees and such payments should be at a rate no less than the Medicaid fee-for-service rate or in-network rates, whichever is greater.

Long-term Services and Supports

- Health plan shall have a sufficient number of appropriately skilled and licensed Providers to provide Covered Long-term Services and Supports to Enrollees. Health plan's long-term care services network shall include a sufficient number of the following to meet the needs of the health plan's enrolled beneficiaries:
    - Home health agencies licensed to provide in-home skilled care, including nursing care, physical therapy, occupational therapy, speech therapy, or other therapies, and personal care

services, to include respite care;
    - Assisted living facilities;
    - Skilled nursing facilities with capacity to provide both short-term and/or post-acute skilled nursing care and long-term custodial care;
    - Medical alert devices and services providers capable of installation, monitoring and maintenance of devices capable of preserving Enrollee health and safety in the home or community, such as Personal Emergency Response Services (PERS) or remotely monitored Medication Management Devices (MMDs);
    - Adult Day Health Program (ADHP) providers certified and enrolled by DHCF to provide community-based services to eligible Enrollees according to standards described in either the District's 1915(i) State Plan Amendment or the 1915(c) Medicaid Waiver for the Elderly or Persons with Physical Disabilities;
    - Any other provider types licensed, certified, or enrolled by DHCF to deliver services covered under the District's 1915(i) State Plan Amendment or the 1915(c) Medicaid Waiver for the Elderly or Persons with Physical Disabilities.

Allied Health Professionals

- The health plan's network shall include the following classes of Allied Health professionals:
    - Registered Dieticians;
    - Speech, Physical, Occupational, and Respiratory Therapists;
    - Audiologists; and
    - Providers of genetic screening and counseling.

Health Plan Referrals to Out-of-Network Providers for Services

- If the health plan's network is unable to provide Medically Necessary Services required under the Contract, the health plan must cover these services through an Out-of-Network Provider until the health plan establishes a provider agreement. The health plan shall coordinate with Out-of-Network Providers for authorization and payment in these instances and ensure that cost of the services and transportation to the Enrollee is no greater than it would be if the services were furnished within the health plan's network. The health plan's accessibility standards are applicable to services provided to Enrollees by Out-of-Network Providers.
- The health plan shall pay I/T/U Providers, whether participating in the provider network or not, for covered managed care services provided to Indian Enrollees who are eligible to receive services from the I/T/U either at a negotiated rate between the health plan and the I/T/U Provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the Provider were not an I/T/U Provider, in accordance with. 42 CFR 438.14 (b)(2).

Capacity to Serve Enrollees with Diverse Cultures and Languages

- The health plan shall include Providers in its network that understand and are respectful of health-related beliefs, cultural values, communication styles, attitudes, intersectionality, and behaviors of the cultures represented in the D-SNP Enrollee population and provide translation services to those that request instructions in their native language, in accordance with the District's language access and cultural competence requirements
- In accordance with section C.5.9, the health plan shall ensure that its non-English speaking Enrollees have access to free interpreters, if needed, in the following situations:

- During emergencies, twenty-four (24) hours a day, seven (7) days a week;
- During appointments with their Providers and when talking to the health plan; and
- When technical, medical, or treatment information is to be discussed.
- A family member or friend may be used as an interpreter only if that individual can be relied upon to provide a complete and accurate interpretation of information between Provider and the Enrollee, provided that the Enrollee is advised that there is a free interpreter available, and the Enrollee expresses a preference to rely on the family member or friend. If a family member or friend is used as an interpreter, the health plan shall document the reason for doing so. Family members or friends that are selected for use as interpreters by the Enrollee must be at least twenty-one (21) years of age.

What are the provider directory requirements under District Dual Choice?

- The health plan shall publish a Provider Directory that complies with the District's language access and cultural competence requirements and written materials and translation services requirements. The Provider Directory shall be made available to Enrollees in paper form upon request and on the health plan's public website in a machine-readable file.
- The health plan shall publish a Provider Directory that is made available in prevalent languages and alternative formats in accordance with DC Language Access Act of 2004, upon request.
- In accordance with 42 C.F.R. § 438.10 (h)(1), the Provider Directory shall, at a minimum, include:
    - A list of health plan's current Provider Network, including home health agencies, nursing and assisted living facilities, specialists, hospitals and other Providers listed above;
    - Alphabetical and geographical Provider list by type of Provider (e.g. physician, Behavioral Health, LTSS, Hospital);
    - Whether or not the office is accessible for people with disabilities, including offices, exam room(s) and equipment;
    - Instructions for the Enrollee to contact the health plan's toll-free Enrollee Services telephone line for assistance in finding a convenient Provider;
    - Providers' Addresses and telephone numbers;
    - The availability of evening and weekend hours for Providers;
    - Identification of Providers that are not accepting new patients, which health plan shall review and/or revise quarterly to ensure that the information is accurate;
    - Information regarding Board certification, hospital admitting privileges, and languages spoken by the Provider;
    - The Network Providers' web site URLs, as appropriate;
    - Information regarding specialty care, as appropriate; and
    - The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
- The health plan shall update the paper format Provider Directory monthly and update the electronic format no later than 30 calendar days after the health plan receives updated Provider information. Provider Directories shall be made available to Enrollees and DHCF upon request.
- The health plan shall submit a complete database of all Network PCPs, including unique National Provider Identifiers (NPIs) to DHCF. Such PCP database shall be submitted electronically in a format and timeframe established by DHCF.
- The health plan shall submit a complete database of all Network Long-Term Services and Supports Providers, including NPIs, to DHCF. Such database shall be submitted electronically in a format and timeframe established by DHCF.

- The health plan shall provide DHCF with additional updates and materials that DHCF may request for purposes of providing information to assist Enrollees in selecting a health plan, or to assist DHCF in assigning an Enrollees who do not make a selection.
- The health plan's Provider directory must include the above information for each of the following provider types covered under this Contract:
    - Physicians, including specialists;
    - Hospitals;
    - Pharmacies;
    - Behavioral health providers; and
    - Long Term Support Services providers.

Hours of Operation

- The health plan's Network Providers shall offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or hours that are comparable to Medicaid FFS, if the Provider serves no commercial Enrollees.
- Routine Care shall be available from Providers during their regular and scheduled office hours. The health plan shall ensure that a sufficient number of its Providers offer evening and weekend hours of operation, in addition to scheduled daytime hours. This information shall be included in the Enrollee Handbook and Provider Directory.
- Providers may maintain more than one practice location. DHCF may require that the health plan delete a location from its network if it, in its sole discretion, believes that the location's hours of operation or staffing levels are inadequate. Providers must provide clear information to Enrollees about the hours of operation at each location and the information regarding each location's hours of operation and staffing must:
    - Be reported to DHCF once each year, when the hours of operation or staffing levels change, and at DHCF's request; and
    - Be clearly printed in the health plan's D-SNP Enrollee Handbook.

What are the appointment time standards for services under District Dual Choice?

- The health plan shall meet and require its Network Providers to meet all DHCF standards for timely access to care and services, taking into account the urgency of the need for services. The health plan shall make services included in the Contract available 24 hours a day, 7 days a week, when Medically Necessary. The health plan shall establish mechanisms to ensure compliance with accessibility standards by Network Providers. The health plan shall monitor Network Providers regularly to determine compliance with accessibility standards and take corrective action if there is a failure to comply by a Network Provider.
- The health plan shall have established criteria for monitoring appointment scheduling for Routine and Urgent Care and for monitoring wait times in Provider offices. The health plan's established criteria and data regarding appointment wait times and the monitoring criteria must be submitted quarterly and upon DHCF's request.
- The health plan shall ensure that its PCPs offer new D-SNP Enrollees, as applicable, an initial appointment within forty-five (45) days of their date of enrollment with the PCP or within thirty (30) days of request, whichever is sooner.
- The following routine appointments shall take place within thirty (30) days of the Enrollee's request:
    - Diagnosis and treatment of health conditions and problems that are not urgent;
    - Routine and well-health assessments; and
    - Non-urgent referral appointments with specialists.

- The health plan shall ensure that there is a reliable system for providing twenty-four (24) hour access to Urgent Care and Emergency Care seven (7) days a week, including weekends and holidays. Urgent Care may be provided directly by the PCP or directed by health plan through other arrangements.
- The health plan shall ensure that direct contact with a qualified clinical staff person is available through a toll-free telephone number at all times.
- The health plan shall ensure that services for the assessment and stabilization of psychiatric crises are available on a twenty-four (24) hour basis, seven (7) days a week, including weekends and holidays. Phone based assessment must be provided within fifteen (15) minutes of request and, when Medically Necessary, intervention or face- to-face assessment shall be provided within ninety (90) minutes of completion of the phone assessment. These services shall be provided by practitioners with appropriate expertise in mental health with on-call access to a psychiatrist.
- The health plan shall ensure that Covered Services provided by a home health agency are initiated within 72 hours of acceptance of a referral, consistent with 29 DCMR Chapter 50.

What are the requirements regarding second medical opinions under District Dual Choice?

- The health plan shall, upon Enrollee request, provide Enrollees the opportunity to have a second opinion from a qualified Network Provider, subject to referral procedures. If an appropriately qualified Provider is not available within the network, the health plan shall arrange for a second opinion outside the network at no charge to the Enrollee.

What are the choice of health care professional requirements under District Dual Choice?

- The health plan shall offer each Enrollee the opportunity to choose Providers, including PCPs and LTSS providers, affiliated with the health plan, to the extent possible and appropriate. If the health plan assigns Enrollees to PCPs, then the health plan must notify beneficiaries of the assignment. The health plan must permit Enrollees to change PCPs upon the Enrollee’s request.