Policy:	GA.7111
Title:	**Health Network Certification Process**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/ Michael Hunn 07/25/2024*
Effective Date:	11/02/2023
Revised Date:	07/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines requirements for delegation and monitoring of Health Networks and details the Subcontractor Network Certification (SNC) process, including the SNC document submission, to provide assurances that CalOptima Health's Health Networks and delegates meet state and federal network adequacy and access requirements.

II. POLICY

A. Health Network Monitoring

1. Delegation Accountability

a. If CalOptima Health delegates any activity or obligation to a Health Network, whether directly or indirectly, CalOptima Health must ensure communication of its policies and procedures to the Health Network. Additionally, the Health Network Delegation Agreement must:

i. Specify any and all delegated activities, obligations, and related reporting responsibilities;

ii. Include the Health Network's agreement to perform the delegated activities, obligations, and reporting responsibilities;

iii. Provide for the revocation of the delegation of activities or obligations, or specify other remedies where the Department of Health Care Services (DHCS) or CalOptima Health determines the Health Network is not performing satisfactorily; and

iv. State that the Health Network agrees to comply with all applicable Medicaid laws and regulations, including all sub regulatory guidance and contract provisions, as well as the applicable state and federal laws.

2. Ownership and Control Disclosures

a. CalOptima Health shall collect and review their Health Network's ownership and control disclosures as set forth in Title 42, Code of Federal Regulations (CFR), Section 455.104.

    i. Review of ownership and control disclosures applies to all Health Networks that contract with CalOptima Health, include disclosing entities, fiscal agents, and managed care entities.

b. Health Networks shall accurately provide all required information in their disclosures.

    i. Information shall include the date of birth and social security number for each person with an ownership or control interest and for each managing employee.

    ii. An officer or director of a disclosing entity that is organized as a corporation should be considered a person with control interest.

    iii. A board member of a disclosing entity shall be listed as a "managing employee" and/or "person with an ownership or control interest" to the extent that they meet that definition in Title 42, Code of Federal Regulations (CFR), Section 455.101.

c. CalOptima Health shall review ownership controls and disclosures to identify potential conflicts of interest and make Health Networks' ownership and control disclosures available upon request, as the information is subject to audit by DHCS.

    i. CalOptima Health shall alert their Managed Care Operations Division (MCOD) Contract Manager within ten (10) working days upon discovery that a Health Network is noncompliant with these requirements, and/or if a disclosure reveals any potential violations of the ownership and control requirements.

3. Data Reporting

    a. CalOptima Health shall monitor the quality and compliance of Health Network data that is submitted to DHCS or other entities, pursuant to reporting responsibilities under state and federal laws.

        i. Data reported by Health Networks shall be complete, accurate, reasonable, and timely.

        ii. This includes, but is not limited to, encounter data, monthly 274 Provider Network data files, data reported through quarterly templates, electronic visit verification reporting, and any other ad hoc data requests required by DHCS.

            a) Encounter data shall include all items and services furnished to Members either directly or through Health Network or other arrangements with Providers.

    b. CalOptima Health shall have in place mechanisms, including data validation and reporting systems, sufficient to ensure a Health Network's Network Provider encounter data is complete, accurate, reasonable, and timely prior to submission to DHCS.

4. Monitoring, Corrective Action, and Sanctions

    a. CalOptima Health shall regularly monitor all functional areas delegated to Health Networks.

b. CalOptima Health shall impose corrective action and/or financial sanctions on Health Networks upon discovery of noncompliance with the terms of their Health Network Delegation Agreement or any Medi-Cal requirements.

c. CalOptima Health shall report any significant instances (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their MCOD Contract Managers within three (3) working days of the discovery or imposition.

B. Subcontractor Network Certification

1. Circumstances for Submission

a. CalOptima Health shall undergo a SNC annually that is separate and distinct from the submission process for the Annual Network Certification (ANC).

b. SNC is also required when:

i. CalOptima Health enters into a new risk-based Health Network Delegation Agreement with a Health Network that expands CalOptima Health's existing Provider Network; and

ii. A Health Network's Provider Network experiences a significant change.

a) A significant change is an event that impacts the provision of health care services for 2,000 or more Members or when a Health Network's Provider Network change causes CalOptima Health to become noncompliant with any of the Network adequacy and access standards outlined in the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements or any superseding APL.

b) For significant change, CalOptima Health shall submit the applicable SNC documentation for only the Network adequacy and access standards impacted by the significant change or noncompliance.

c) If a significant change occurs within the ninety (90) calendar days prior to the SNC annual submission date, CalOptima Health can document the change as part of that Reporting Year (RY) SNC filing.

d) For any significant changes that occur after the SNC annual submission date, CalOptima Health should submit the applicable SNC documentation for only the Network adequacy and access standards impacted by the significant change and report the change in the SNC for that RY.

2. Subcontractor Network Criteria

a. Health Networks are only required to meet the Network adequacy and access standards for the Members assigned to the Health Network's Provider Network, and for Covered Services the Health Network is contracted to arrange for Members on behalf of CalOptima Health.

b. For the annual SNC, CalOptima Health shall include all Health Networks Provider Network reported via the 274 Provider Network data file, unless the Health Networks Provider Network reported is exempt per the criteria listed in Section II.B.2.c. of this Policy and the required documentation provided substantiates the exemption.

c. Health Networks may be exempt from SNC if:

i. CalOptima Health only contracts directly with individual Providers where no Health Network Provider Network exists;

ii. CalOptima Health only contracts with one Health Network in the service area, and no Providers directly contract with CalOptima Health;

iii. The Health Network only provides specialty or ancillary services; or

iv. The Health Network only provides care through single case agreements and is not available to all CalOptima Health Members upon enrollment.

III. PROCEDURE

A. SNC Submission

1. CalOptima Health shall submit the required SNC documentation to DHCS that accurately reflects the monitoring of Health Networks, no later than forty-five (45) calendar days following the RY or, if the date falls on a weekend, the next working day, as outlined in DHCS APL 23-006: Delegation and Subcontractor Network Certification or any superseding APL.

2. CalOptima Health shall submit all required SNC documentation as described in the Subcontractor Network Certification Instruction Manual with the correct file naming conventions through the DHCS Secure File Transfer Protocol site.

3. Failure to submit complete and accurate SNC documentation by the SNC annual submission date are subject to the imposition of an Annual Network Certification Corrective Action Plan (ANC-CAP) and/or other enforcement actions pursuant to the contract with DHCS, Welfare and Institutions Code (WIC) section 14197.7(e), and DHCS APL 23-012: Enforcement Actions: Administrative and Monetary Sanctions or any superseding APL.

4. CalOptima Health shall submit the following as part of the SNC submission:

a. The Subcontractor Network Exemptions Request template

b. The Network Adequacy and Access Assurances Report (NAAAR)

i. Section A of the template is prepopulated with the state's Network adequacy and access standards for which Health Networks are held accountable as applicable.

ii. Section B to be completed by CalOptima Health delineates the types of analyses used to monitor and determine the Network adequacy and access compliance of Health Networks.

iii. Section C to be completed by CalOptima Health details the compliance results and findings of all the Subcontractor Network monitoring analyses conducted within the RY.

c. Verification documents for DHCS' to review and verify the compliance results and findings reported on the NAAAR.

i. DHCS will verify documents for a subset (one-third) of Health Networks and will provide a list of Health Networks to be sampled, at a minimum, at least thirty (30) days in advance of the annual SNC submission date of forty-five (45) days after the end of the RY, or the next Working Day if the date falls on a weekend.

ii. Verification documents for Health Networks are only required if DHCS provides a list of Health Networks to be sampled per Services Area for the specified RY.

iii. DHCS may request additional verification documentation at any time in order to confirm that the information provided on the NAAAR is accurate.

iv. Failure to provide DHCS with the requested documentation or a determination by DHCS that the information in the SNC submission is invalid or inaccurate may lead to implementation of an ANC-CAP and/or other enforcement actions.

B. Noncompliance

1. Health Network deficiencies impacting Member access to care, identified by CalOptima Health monitoring, must result in CalOptima Health, or the Health Network:

   a. Authorizing Covered Services from an Out-of-Health Network Provider for impacted Members, which may include Providers from the direct network or those Out-of-Network, regardless of association, transportation or Provider costs until the deficiency is addressed.

   b. Informing Members that Out-of-Network access to services is available.

   c. Training Member services staff on the Members' right to request out-of-network access for Covered Services and transportation to Providers where the Health Network is unable to comply with network adequacy or access standards.

C. Deficiencies and Corrective Action

1. If an ANC-CAP notification letter is received from DHCS, CalOptima Health shall provide an initial ANC-CAP response, no later than thirty (30) calendar days after the issuance of the ANC-CAP notification letter, that details a plan of action and sets forth steps to correct the deficiencies identified.

2. CalOptima Health shall correct all deficiencies within six (6) months and during which time must provide DHCS with monthly status updates that demonstrate action steps to address the ANC-CAP.

   a. DHCS may impose sanctions, or other appropriate enforcement actions, for failure to comply with network adequacy and access standards at the end of the six (6) month ANC-CAP period.

3. If a Health Network fails to meet Subcontracted Network Certification components, a Subcontracted Network Certification Corrective Action Plan (SNC-CAP)may be issued and the Health Network shall:

   a. Provide an initial SNC-CAP response no later than thirty (30) calendar days after the issuance of the SNC-CAP notification letter.

b. Authorize out-of-network access to Medically Necessary providers within timely access standards and applicable time or distance standards, regardless of associated transportation or provider costs until the SNC-CAP is completed and closed by CalOptima Health.

4. If a Health Network is unable to meet time or distance standards and has made good faith efforts to exhaust all reasonable contracting options with additional providers within the time or distance standards, an Alternate Access Standard (AAS) request shall be submitted to CalOptima Health.

   a. Health Networks shall document all efforts to contract with additional out-of-network providers identified in their AAS requests that are in their county and bordering counties where they have network deficiencies and shall provide all documentation of failed contracting efforts to CalOptima Health.

   b. Upon receipt of AAS approvals from CalOptima Health, Health Networks shall:

      i. Inform affected Members who reside in the zip code where AAS requests were approved by posting all approved AAS on the Health Networks website within thirty (30) calendar days after the AAS approval.

      ii. Assist any requesting Member in obtaining an appointment with an appropriate out-of-network Core Specialist, in-person or via Telehealth, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services and Welfare and Institutions Code, Section 14197.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
C. CalOptima Health Policy HH.2002: Sanctions
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements (Supersedes APL 21-006)
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes 17-004)
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-012: Enforcement Actions: Administrative and Monetary Sanctions
G. Title 42, Code of Federal Regulations (C.F.R.), §§ 455.101, 455.104
H. Welfare and Institutions Code (WIC), §§ 14197, 14197.7(e)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/31/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/23/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
11/02/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/02/2023	GA.7111	Health Network Certification Process	Medi-Cal
Revised	07/01/2024	GA.7111	Health Network Certification Process	Medi-Cal

IX. GLOSSARY

Term	Definition
Annual Network Certification Corrective Action Plan (ANC-CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified during the Annual Network Certification (ANC) processes by CalOptima Health, Department of Health Care Services (DHCS), or designated representatives.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Certification	This indicates the subcontracted network has undergone a formal evaluation or assessment to meet certain standards or requirements.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services;

Term	Definition
	2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;

Term	Definition
	16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Service Area	The county or counties that CalOptima Health is approved to operate in under the terms of their DHCS Contract.
Subcontracted Network Certification (SNC)	A process that entails CalOptima Health's reporting on their monitoring of Subcontractors' and Downstream Subcontractors' Provider Networks and submitting documentation to DHCS verifying the compliance and/or noncompliance reported.
Subcontracted Network Certification Corrective Action Plan (SNC-CAP)	A plan delineating specific identifiable activities or undertakings to address any shortcomings or deficiencies identified during the Subcontracted Network Certification processes by CalOptima Health.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.