California Department of Insurance
Network Adequacy Filing Instructions
v.1, May 18, 2016

General Filing Instructions:

Permanent changes to the Department's provider network adequacy regulations, 10 CCR §§ 2240-2240.7, were adopted on March 8, 2016. The Permanent Regulations can be found here: https://www.insurance.ca.gov/0400-news/0100-press-releases/2016/upload/NetworkAdequacyRegulation3-8-16.pdf .

Disclaimer: These filing instructions are for informational purposes only. Descriptions of legal requirements in these instructions may be paraphrased for brevity; therefore, please review the applicable statute and regulations to ensure compliance with state law. Filing in reliance upon these filings instructions does not mean that the filing will be approved as filed.

Scope: These instructions relate to the submission of network filings pursuant to 10 CCR §2240.5(a). These filing instructions apply to health insurance network filings, including specialized health insurance policies that cover mental health benefits (behavioral health-only policies).

Note: Specialized health insurance policies (other than specialized mental health insurance policies) must comply only with the requirements specified in 10 CCR § 2240(a), as specified therein. Dental-only policies must comply with the requirements in 10 CCR § 2240.1(a)(1) and (a)(3). Dental-only policies that cover the pediatric oral essential health benefit must comply with the requirements specified in 10 § CCR 2240.1(a)(1), (a)(2), and (a)(3). All other specialized health insurance policies (other than specialized mental health insurance policies) must comply with 10 CCR § 2240.1(a)(3). Currently, student blanket policies are not subject to the requirements of 10 CCR § 2240, *et seq*.

Required Filings

A) Annual Filings:

Insurers are required to submit an annual network filing, on or before June 1st of each year, for networks providing current coverage. (10 CCR § 2240.5(a).)

B) Filings related to new health policy forms, or upon Commissioner Request:

A network filing must be submitted when approval is sought for any new health insurance policy or at the request of the Commissioner. (10 CCR § 2240.5(a).)

C) Other filings required by the network adequacy regulations:

- 6-month Interim Attestation: An insurer must measure network adequacy every six months. An attestation that the network remains adequate, or is adequate considering previously filed waivers, must be filed with the Department through SERFF no later than December 31 of each year. If the network adequacy standards are not met at the time of the measurement, a corrective action plan must be submitted to the commissioner along with the attestation. (10 CCR § 2240.1(l).)

- Notification of Contract Termination: – An insurer must notify the Department at least 10 days prior to contract termination with a provider, provider group or facility, demonstrating that an insurer's network remains in compliance with network adequacy requirements. Include an updated network adequacy report for the terminated provider or facility type in the affected geographic area and, for facility terminations, specific identification of alternate facilities. Please see 10 CCR § 2240.4(d) for further detail.
- Notification of Material Change/Non-Compliance –An insurer must immediately notify the Department at any time a material change to any of its networks results in the insurer being out of compliance with the network adequacy regulations. The insurer must submit a corrective action plan specifying all action the insurer is taking or will take to come into compliance with the network adequacy regulations. The insurer must include an estimate of the time it expects to take to come into compliance. (10 CCR § 2240.5(f).)

How to File: A separate network adequacy filing is required for each network. Please file using the new "Network" filing type in SERFF. Do not include information for more than one (1) network in a filing. If a network is used with multiple products only one filing is required. Note that adequacy for tiered networks must be demonstrated at the lowest cost tier. (10 CCR §§ 2240.15(b)(1) & 2240.1(k).) Once submitted, do not file any new/revised documents except as a part of a response to an objection letter, or with approval from the primary reviewer.

SERFF Binders: Please submit the CMS Network ID Template, Essential Community Providers/Network Adequacy Template, and Service Area Template. These templates are available through SERFF. These templates are also available, with instructions, at the CMS website, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Step-3-Complete-Application-.html#Application Areas and Templates, under "Essential Community Providers/Network Adequacy."

Supplemental Provider Data Template for CDI: Please complete the Supplemental Provider Data Template for CDI for the provider types listed in the second tab of the template. Attach this Supplemental template under the "supplemental documents" tab of your network filing. The Supplemental Template is available in SERFF in the General Instructions for the California Life & Health instance, and also on the Department's website at https://www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/hpab/index.cfm.

File in SERFF: Network adequacy reports and accompanying documents must be electronically filed on the System for Electronic Rate and Form Filing (SERFF) of the National Association of Insurance Commissioners (NAIC). (10 CCR § 2240.5(b).) Please file using the new "Network" filing type in SERFF. Please attach each accompanying document in the appropriate field under the Supporting Documentation tab on SERFF. Please identify under the General Information tab the **state tracking numbers** of all form

filings associated with the network. **Do not use SERFF or company tracking numbers**. Do not cross-reference form filings for products that will not be used with the network.

Documentation and reports that must be submitted as a part of a network filing pursuant to 10 CCR § 2240.5(a).
A complete network filing must include the following documents. A network filing lacking any of the documents listed in these instructions is not in compliance with state law and will be rejected.

1. **Network Report:**
    - **a.** Compliance with ratio and time-and-distance standards
    - **b.** Narrative description of
        - **i.** Implementation of triage, telemedicine, health information technology
        - **ii.** The service area covered by the network
        - **iii.** Cross-reference to annual complaint report
        - **iv.** Identify prior 6-month interim attestation
        - **v.** Identify prior waivers
2. **Attestation**
3. **Policies/Procedures for monitoring/evaluating accessibility of care**
4. **Policies/Procedures for recruiting, selecting, credentialing, accrediting, tiering network providers**
5. **Policies/Procedures for transition from hospital to community settings**
6. **Policies/Procedures for timely access**
7. **Policies/Procedures for quality assurance processes**
8. **Mental Health/Substance Use Disorder Narrative Report**
9. **Timely Access Compliance Report**
10. **Noncompliance report**
11. **Hospital Physician Network Report**
12. **Enrollment Report**
13. **Transplant Center Report**
14. **Provider Contracts**
15. **Survey results:**
    a. Covered Person
    b. Provider
16. **Out-of-Network Coverage Utilization Data**

17. Emergency Room Data
18. Provider/Facility Data: Binder templates and Supplemental Provider Template
Detailed requirements for each of these documents are provided below

1) Network Report: A network adequacy filing shall include a network report as required by 10 CCR § 2240.5(c). 10 CCR § 2240.5(c) specifies that the network report shall include the following:

10 CCR § 2240.5(c)(1) The network filing shall include a report (network report) describing the number and location, by county and zip code, of all network providers and facilities, by categories as described below, utilized by the insurer to provide services to covered persons. The report must demonstrate access for the insurer's actual enrollment, as well as anticipated enrollment for the next plan year (including geographic areas in the service area in which there are no covered persons currently enrolled), under the quantitative access (time and distance) standards included in 10 CCR § 2240.1(c). The report should identify those zip codes for which the network is not in compliance with the time and distance standard in any category of network provider, as well as the average distance to a network provider.

10 CCR § 2240.5(c)(1) The network report shall identify the location and extent of areas of non-compliance.

10 CCR § 2240.5(c)(1) The network report shall demonstrate that the insurer is in compliance with all the accessibility and availability requirements of the network adequacy regulations.

A. Demonstrate Time and Distance Compliance for the Following Provider and Facility Report Categories

	Full-Time Equivalent Physicians and Primary Care Physicians	The equivalent of at least one full-time physician per 1,200 covered persons and at least the equivalent of one full-time primary care physician per 2,000 covered persons. (10 CCR § 2240.1(c)(1).)
	Primary Care Providers	There are primary care network providers with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance 15 miles of each covered person's residence or workplace. (10 CCR § 2240.1(c)(2).)
	Specialists	There are medically required network specialists who are certified or eligible for certification by the appropriate specialty board with sufficient capacity to accept covered persons within a maximum travel time of 60 minutes or a maximum travel distance of 30 miles of each covered person's residence or workplace. (10 CCR § 2240.1(c)(4).)

	Mental Health/Substance Use Disorder/Behavioral Health	There are mental health, substance use disorder, and behavioral health providers with skills appropriate to care for the mental health needs of covered persons and with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of a covered person's residence or workplace. The Network Report must include (1) a demonstration that the network meets this time and distance standard for mental health and substance use disorder providers, and (2) a separate demonstration that the network meets this time and distance standards for providers of behavioral health treatment qualified to provide that treatment as specified in Insurance Code § 10144.51(c). (10 CCR § 2240.1(c)(6).)
	Network Hospitals	There is a network hospital with sufficient capacity to accept covered persons for covered services within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace. (10 CCR § 2240.1(c)(7).)
	General Dentists	There are general dentists with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace. (10 CCR § 2240.1(c)(2) & (a)(2)(A).)
	Specialist Dentists	There are specialist dentists with sufficient capacity to accept covered persons within a maximum travel time of 60 minutes or a maximum travel distance of 30 miles of each covered person's residence or workplace. The network must include orthodontists. (California Insurance Code (CIC) § 10112.27(a)(5).) (This standard applies to Exchange dental plans as well.)(10 CCR § 2240.1(c)(4) & (a)(2)(A).)
	Optometrists	There are optometrists with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace (10 CCR § 2240.1(c)(2).)
	Ophthalmologists	There are ophthalmologists with sufficient capacity to accept covered persons within a maximum travel time of 60 minutes or a maximum travel distance of 30 miles of each covered person's residence or workplace. (CIC § 10112.27(a)(4) & 10 CCR § 2240.1(c)(4).)
B. Narrative Descriptions: Include descriptions responsive to the following requirements in the narrative portion of your Network Report		
	i. Triage, Telemedicine, Health Information Technology	Describe the implementation and use by the insurer and its contracting providers of triage, telemedicine, and health information technology to provide timely access to care. (10 CCR § 2240.5(d)(9).)

	ii. Service Area	Describe the service area covered by the network, by county, or by zip code for a partial county, and describing any change to the service area since the filing of the most recently filed network adequacy report. (10 CCR § 2240.5(c)(2).)
	iii. Annual complaint report cross-reference	Include a cross-reference to the state tracking number for this report. (10 CCR § 2240.5(g).)
	iv. Identify prior 6-Month Interim Attestation	Include state tracking numbers and submission date and state tracking number of the most recent 6-Month Interim Attestation. (10 CCR § 2240.1(l).)
	v. Identify Prior Waivers	Include a reference to any waivers approved for the network involved in the submission by the Department pursuant to 10 CCR § 2240.7. Include the date in which the waiver was approved as well as a reference to the state tracking number for the waiver. (10 CCR § 2240.7.)
2) Attestation: The network filing shall include an attestation that the network satisfies all requirements of 10 CCR §§ 2240 through 2240.7 (10 CCR §2240.5(d)(1)), **including specific reference to the following:**		
	Sufficient licensed/accredited providers	There are a sufficient number, capacity, and specialties of licensed/accredited providers to provide for the medical needs and characteristics of the covered population. If network providers do not provide a service within scope of practice, there are sufficient other providers within the network to provide that service. (10 CCR § 2240.1(b).)
	Full-Time Equivalent Primary Care Physicians	There are adequate full-time equivalents of primary care physicians in the network accepting new patients covered by the policy to accommodate anticipated enrollment growth. (10 CCR § 2240.1(c)(3.))
	Mental Health/Substance Use Disorder/Behavioral Health	The mental health, substance use disorder, and behavioral health network complies with the following: (10 CCR § 2240.1(c)(6).)
		• The network must take into account the pattern and frequency with which different therapies, particularly behavioral health therapy, are provided for different patient populations at different ages, such that if it is clinically necessary for a network to have services available in closer proximity to affected covered persons than required by the minimum time and proximity standards stated above then the insurer shall make the services available in such closer proximity. (10 CCR § 2240.1(c)(6).)

		• An insurer must include a sufficient number of the appropriate types of mental health and substance use disorder treatment providers and facilities based on normal utilization patterns. (10 CCR § 2240.1(c)(6)(D).)
	Admitting Privileges	There are adequate numbers of available primary care providers and specialists with admitting and practice privileges at network hospitals. (10 CCR § 2240.1(c)(8).)
	Post-Acute Care Services	There are facilities to provide post-acute care services with sufficient capacity to serve the entire population of covered persons based on normal utilization patterns. (10 CCR § 2240.1(c)(9))
	Outpatient Retail Pharmacies	There are an adequate number of network outpatient retail pharmacies located in sufficient proximity to covered persons to permit adequate routine and emergency access. (10 CCR § 2240.1(c)(10).)
	Ancillary Laboratory and Other Services	Ancillary laboratory and other services dispensed by order or prescription of the prescribing provider are available from contracting providers at locations (where covered persons are personally served) within a reasonable distance from the prescribing provider. (10 CCR § 2240.1(c)(10).)
	Preventive Services	There are a sufficient number of providers to assure access to preventive services required by Insurance Code § 10112.2, including women's preventive care, which includes access to services and contraceptive methods as required by Insurance Code § 10123.196. (10 CCR § 2240.1(g).)
The following additional documents must be submitted along with the network report under the "supporting documentation" tab.		
<u>Provide Policies and Procedures Regarding the Following:</u>		
3)	**Monitoring and evaluating accessibility of care:** A copy of the written procedures for rendering network provider services, which includes a documented system for monitoring and evaluating accessibility of such care. The monitoring of waiting time for appointments, as described in 10 CCR §§ 2240.15 and 2240.16, shall be a part of such a system. (10 CCR §§ 2240.5(d)(2) & 2240.1(b)(7).)	
4)	**Recruiting, selecting, credentialing, accrediting and tiering network providers**: Copies of all written policies and procedures for recruiting network providers, credentialing or accrediting network providers, contracting with network providers, and managing the insurer's network, as required by 10 CCR § 2240.4(a), including the selection and tiering standards (if the network is a tiered network) required by 10 CCR § 2240.1(i). (10 CCR §§ 2240.5(d)(4), 2240.1(i), & 2240.4(a))	

5)	**Transition from hospital to community settings:** Written policies and procedures for the coordination of the transition of an insured person from an inpatient hospital to an appropriate community setting consistent with the insured person's post-discharge care needs. (10 CCR §§ 2240.5(d)(4).)
6)	**Timely Access Policies and Procedures:** The timely access standards set forth in the insurer's policies and procedures. (10 CCR § 2240.5(d)(6).)
7)	**Quality Assurance Processes Policies and Procedures:** Compliance monitoring policies and procedures, filed for the Commissioner's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include: (A) Tracking and documenting network capacity and availability with respect to the standards set forth in 10 CCR §§ and 2240.16; and … (D) Reviewing and evaluating, no less frequently than quarterly, the information available to the insurer regarding accessibility, availability and continuity of care, including but not limited to information obtained through covered person and provider surveys, covered person grievances and appeals, and triage or screening services.
	<u>Provide the Following Reports</u>
8)	**Mental Health/Substance Use Disorder Narrative Report**: A narrative report describing the adequacy of the insured's mental health and substance use disorder network as required by 10 CCR § 2240.1(c)(6)(C). This report should also provide, for approval by the Department, the insurer's standard for the number and geographic distribution of mental health providers who treat severe mental illnesses of persons of any age, and severe emotional disturbances of a child, including all mental and behavioral health practitioners. (10 CCR §§ 2240.5(d)(5), 2240.1(c)(6)(C), & 2240.1(c)(6)(B).)
9)	**Timely Access Compliance Report:** A report describing the rate of compliance, during the reporting period, with the time elapsed standards set forth in 10 CCR §§ 2240.15 and 2240.16. (10 CCR § 2240.5(d)(7).)
10)	**Noncompliance Report:** A report regarding any noncompliance by the insurer with the provisions of this article. The report shall state whether or not an incident or pattern described in 10 CCR §§ 2240.5(d)(8)(A) or (d)(8)(B) occurred during the reporting period and, if so, shall include a description of the identified non-compliance and the insurer's responsive investigation, determination and corrective action. (10 CCR § 2240.5(d)(8).)
11)	**Hospital Physician Network Report:** A report describing, for each network hospital, the percentage of physicians in each of the specialties of (A) emergency medicine, (B) anesthesiology, (C) radiology, (D) pathology, and (E) neonatology practicing in the hospital who are in the insurer's network(s). (10 CCR § 2240.5(d)(14).)

12)	**Enrollment Report:** Information confirming the status of the insurer's provider network and enrollment at the time of the report, which shall include, on a county-by-county basis: (A) The insurer's enrollment in each product which uses the network, on a county by county basis. (10 CCR § 2240.5(d)(15).)
13)	**Transplant Center Report:** Identify and locate each transplant center in its network by name and address, and type of transplant provided in the facility. (10 CCR §§ 2240.1(f) & 2240.5(d)(13).)
Contracts	
14)	**Provider Contracts:** Provide complete copies, including all appendices, attachments and exhibits, of the most commonly utilized network provider contracts for each type of provider the insurer (or its agent if using a leased network) includes in the provider network, including but not limited to hospital, individual physician, group physician, laboratory, mental health and substance use disorder, rehabilitation and ancillary service contracts. (10 CCR § 2240.5(d)(3).)
Survey Results	
15)	**Covered person and provider surveys:** The results of the most recent annual covered person and provider surveys required by 10 CCR § 2240.15(c)(2)(B) and (c)(2)(C) and a comparison with the results of the prior year's surveys, if any such surveys were conducted, including a discussion of the relative change in survey results.
Data/Information	
16)	**Out-of-network coverage utilization**: Provide data regarding the extent to which members used out-of-network services during the reporting period, including the number of out-of-network claims by type of provider, dollar value of total claims, average value per claim, total amount paid by the health plan, average amount paid per claim, total unpaid claim balances and average unpaid claim balance per claim. (10 CCR § 2240.5(d)(11).)
17)	**Emergency room data:** Provide data regarding the extent to which members used emergency room services during the reporting period. (10 CCR § 2240.5(d)(12).)
18)	**Provider and facility data: Binder templates and Supplemental Provider Template** Enrollment in each product line and a complete list of the insurer's contracted physicians, hospitals, and other contracted providers, including name, location, specialty and subspecialty qualifications, California license number and National Provider Identification Number, as applicable. Physician specialty designation shall specify board certification or eligibility consistent with the specialty designations recognized by the American Board of Medical Specialties.

<table>
<tr><td></td><td>This requirement is satisfied by submission of

(1) The CMS Network ID Template, Essential Community Providers/Network Adequacy Template, and Service Area Template) through a SERFF binder. These templates are available through SERFF. These templates are also available, with instructions, at the CMS website, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Step-3-Complete-Application-.html#Application Areas and Templates, under “Essential Community Providers/Network Adequacy,” and,

(2) The Supplemental Provider Data Template for CDI for the provider types listed in the second tab of the template. Attach this Supplemental template under the “supplemental documents” tab of your network filing. The Supplemental Template is available in SERFF in the General Instructions for the California Life & Health instance, and also on the Department’s website at https://www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/hpab/index.cfm. The provider types for the Supplemental Template are

a) Optometrist
b) Substance Use Disorder (not otherwise listed under other provider categories)
c) Qualified Autism Service Provider (CIC § 10144.51(c)(3))
d) Qualified Autism Service Professional (CIC § 10144.51(c)(4))
e) Qualified Autism Service Paraprofessional (CIC § 10144.51(c)(5))
• For the Qualified Autism Service categories, provide the practitioner’s National Provider Number (NPI), if available. Otherwise, leave the NPI field blank.</td></tr>
<tr><td colspan="2">Waivers</td></tr>
<tr><td></td><td>Discretionary Waivers/Alternate Access Delivery System Requests: Include state tracking numbers for all waivers previously approved for this network. Please see separate Filing Instructions for Alternate Access Delivery System (Waiver) Requests. Waivers must be resubmitted annually. (10 CCR § 2240.7.)</td></tr>
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