# Specialist Physician Ratio Standards and Methodology

## I. Standards and Methodology

The Department of Managed Health Care (DMHC) will evaluate the ability of health care service plan (plan) networks to demonstrate sufficient capacity of specified specialist physician types to ensure compliance with network adequacy standards referenced in Health & Safety Code Sections 1367, 1367.03, 1367.035, and 1374.72, and 28 CCR §§ 1300.67.2, 1300.74.72, and 1300.67.2.2.[[1]](#footnote-2) As part of this review, for reporting year (RY) 2025, the DMHC will evaluate reported annual network data against a minimum capacity requirement, through a ratio standard for specialist physicians.[[2]](#footnote-3) The ratio standard takes into consideration the full-time equivalent (FTE) ratio of specialist physician types to enrollees within a network, and within counties in the network service area. Additionally, the ratio standard considers a plan’s reported network providers that offer specialist physician services exclusively via telehealth modalities.[[3]](#footnote-4)

In some cases, a plan’s network may not meet the established ratio standard but, due to specific circumstances, may still provide reasonable access to care. To address these circumstances, the standard includes alternative methodologies and ratio modifiers that the DMHC will implement when applicable to the network, county, and provider type.

If a plan’s network does not meet the standard in one or more counties within the network service area, the plan will be informed of the findings and may be required to submit a corrective action plan or otherwise demonstrate that its network includes the identified specialist physician type with sufficient capacity to ensure accessibility of services as required under the Knox-Keene Act and implementing regulations.[[4]](#footnote-5) Where the network does not offer sufficient capacity, the Plan must address the requirements set forth in Rule 1300.67.2(i) in its corrective action plan. In subsequent reporting years, the DMHC may also rely upon the standards as a basis for taking enforcement action pursuant to the Administrative Procedures Act exemptions established in Section 1367.03(f).

### Defined Terms

Plans will be assessed for compliance with this standard using the defined terms below:[[5]](#footnote-6)

1. “Applicable county” means the county or partial county within the plan’s network service area.
2. “County Types” means the combination of counties that are similarly situated with regard to population size and density, as defined by the Centers for Medicare and Medicaid Services (CMS) in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). County types are set forth according to the county designations released by CMS, available at [www.cms.gov](http://www.cms.gov).
3. “Large Metro Counties” means counties designated as “large metro” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated Large Metro Counties for the RY 2025 standards: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Francisco, San Mateo, and Santa Clara.
4. “Metro Counties” means counties designated as “metro” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated Metro Counties for the RY 2025 standards: Butte, El Dorado, Fresno, Kern, Kings, Marin, Merced, Monterey, Napa, Nevada, Placer, Riverside, San Bernardino, San Diego, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo, and Yuba.
5. “Rural Counties” means counties designated as “rural” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated Rural Counties for the RY 2025 standards: Calaveras, Colusa, Del Norte, Glenn and Mariposa.
6. “Micro Counties” means counties designated as “micro” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated Micro Counties for the RY 2025 standards: Amador, Humboldt, Imperial, Lake, Madera, Mendocino, San Benito, Shasta, Tehama and Tuolumne.
7. “Counties with Extreme Access Consideration (CEAC)” means counties designated as “Counties with Extreme Access Considerations (CEAC)” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated CEAC Counties for the RY 2025 standards: Alpine, Inyo, Lassen, Modoc, Mono, Plumas, Sierra, Siskiyou, and Trinity.
8. “Exclusive provider” means a provider that is a network provider for only one reporting plan for the reporting year.
9. “Full-time” shall have the definition set forth in Rule 1300.67.2.2(b).
10. “Full-Time-Equivalent” or “FTE” means a comparable approximation of the amount of time a provider is available to provide covered services to enrollees in a network service area and county.
11. “FTE value” means a numerical value assigned to approximate the percentage of a provider’s time allocated to enrollees within the network, derived through a repeatable methodology.
12. “Full-value count” or “full-value provider count” means a count of each individual provider, where each individual counts as one complete provider, without regard to full-time equivalent value.
13. “In-person appointments on an outpatient basis” shall have the meaning set forth in Rule 1300.67.2.2(b).
14. References to “in-person” network providers shall mean network providers who take in-person appointments on an outpatient basis.
15. “Network” shall have the definition set forth in Rule 1300.67.2.2(b)(5).
16. “Network adequacy” shall have the definition set forth in Rule 1300.67.2.2(b)(6).
17. “Network provider” shall have the definition set forth in Rule 1300.67.2.2(b)(10).
18. “Network service area” shall have the definition set forth in Rule 1300.67.2.2(b)(11).
19. “Part-time” shall have the definition set forth in Rule 1300.67.2.2.
20. “Practice address” or “practice location” shall have the definition set forth in Rule 1300.67.2.2.
21. “Reporting plan” shall have the definition set forth in Rule 1300.67.2.2.
22. “Specialist Physician Type” means the type of physician or physicians with the specialty identified in the plan’s data reported to the DMHC. For purposes of application of this standard, the provider must meet the definition of network provider and be appropriately reported consistent with health plan credentialing and physician specialty and subspecialty designations recognized by the American Board of Medical Specialties (ABMS) and the Knox-Keene Act. For those specialty types for which the ABMS is not applicable, the specialty designation shall be based on areas of specialization available through the appropriate licensing board, as applicable.[[6]](#footnote-7) Specialist physician types measured for this standard include the following:
    1. Allergy/Immunology means a physician reported as the following specialist physician type: allergy/immunology.
    2. Cardiovascular Disease means a physician reported as one of the following specialist physician types: cardiovascular disease or pediatric cardiology.
    3. Dermatology means a physician reported as one of the following specialist physician types: dermatology or pediatric dermatology.
    4. Endocrinology means a physician reported as one of the following specialist physician types: endocrinology or pediatric endocrinology.
    5. Gastroenterology means a physician reported as one of the following specialist physician types: gastroenterology or pediatric gastroenterology.
    6. Hematology means a physician reported as one of the following specialist physician types: hematology or pediatric hematology/oncology.
    7. Nephrology means a physician reported as one of the following specialist physician types: nephrology or pediatric nephrology.
    8. Neurology means a physician reported as one of the following specialist physician types: neurology, epilepsy, or pediatric neurology.
    9. Obstetrics/Gynecology means a physician reported as the following specialist physician type: obstetrics/gynecology.
    10. Oncology means a physician reported as one of the following specialist physician types: oncology or pediatric hematology/oncology.
    11. Ophthalmology means a physician reported as the following specialist physician type: ophthalmology.
    12. Otolaryngology means a physician reported as one of the following specialist physician types: otolaryngology or pediatric otolaryngology.
    13. Pain Medicine means a physician reported as the following specialist physician type: pain medicine.
    14. Physical Medicine and Rehabilitation means a physician reported as one of the following specialist physician types: physical medicine and rehabilitation or pediatric rehabilitation medicine.
    15. Podiatry means a podiatrist reported as the following specialist physician type pursuant to the California Board of Podiatric Medicine: podiatry.
    16. Psychiatry means a physician reported as one of the following specialist physician types: psychiatry, child and adolescent psychiatry, consultation-liaison psychiatry, geriatric psychiatry or addiction psychiatry.
    17. Pulmonology means a physician reported as one of the following specialist physician types: pulmonology or pediatric pulmonology.
    18. Radiation Oncology means a physician reported as the following specialist physician type: radiation oncology.
    19. Rheumatology means a physician reported as one of the following specialist physician types: rheumatology or pediatric rheumatology.
    20. Surgery-General means a physician reported as one of following specialist physician types: surgery - general or pediatric surgery.
    21. Surgery-Orthopedic means a physician reported as one of the following specialist physician types: surgery - orthopaedic or orthopaedic sports medicine.
    22. Urology means a physician reported as one of the following specialist physician types: urology or pediatric urology.
23. “Specialty” or “subspecialty” shall have the definition set forth in Rule 1300.67.2.2(b).
24. “Telehealth” shall have the definition set forth in Business and Professions Code section 2290.5(a)(6).
25. “Telehealth modality” shall have the definition set forth in the Definitions section of the Annual Network Submission Instruction Manual, as incorporated in 28 CCR § 1300.67.2.2.
26. “Telehealth-only network provider” means a network provider that delivers services to enrollees only via telehealth modalities in the reported network. A “telehealth-only network provider” does not include a Third-Party Corporate Telehealth Provider, as defined in Health and Safety Code section 1374.141(b)(4).

### Ratio Standard for Specialist Physicians

1. The network, and each applicable county within the network service area, shall include network providers that meet the listed ratio standard for the following specialist physician types, measured by the full-time equivalent (FTE) value of each specialist physician:
2. The following specialty types shall each meet a one FTE per 5,500 enrollees ratio:
3. Psychiatry
4. Obstetrics/gynecology
5. Surgery - general
6. The following specialty types shall each meet a one FTE per 8,000 enrollees ratio:
7. Cardiovascular disease
8. Surgery - orthopaedic
9. Neurology
10. The following specialty types shall each meet a one FTE per 15,000 enrollees ratio:
11. Oncology
12. Ophthalmology
13. Pulmonology,
14. Gastroenterology
15. Dermatology
16. Podiatry
17. The following specialty types shall each meet a one FTE per 22,000 enrollees ratio:
18. Hematology
19. Nephrology
20. Pain medicine
21. Otolaryngology
22. Endocrinology
23. Urology
24. Physical medicine and rehabilitation
25. The following specialty types shall each meet a one FTE per 32,000 enrollees ratio:
26. Rheumatology
27. Radiation oncology
28. Allergy/immunology
29. The following additional factors shall apply:
30. Each specialist physician type listed above shall include network providers that offer in-person appointments on an outpatient basis, as defined. The specialist physician type may also include telehealth-only network providers, as defined, subject to the limitations in section D. below.
31. Each county within a plan’s network service area must include a minimum enrollment count of 25 enrollees for CEAC counties, and 50 enrollees for Rural, Metro, Large Metro and Micro counties when calculating ratios. If the plan’s reported enrollment in a county for the network is less than the minimum enrollment count, the county shall be allocated the minimum enrollment count for the purposes of calculating the ratio.

### FTE Value for In-Person Network Providers

1. FTE Value: The FTE Value for an in-person specialist physician shall comprise the FTE Starting Value and FTE Starting Value Adjustments that are applicable to the specialist physician, as follows:
   1. FTE Starting Value– In-person specialist physicians shall receive an FTE starting value based on the reported county type in which the network provider delivers services. County types are set forth according to the county designations released by CMS, available at [www.cms.gov](http://www.cms.gov).
2. The FTE starting value is based on the typical number of plans and networks the specialist physician type contracts with, by county type, based on network data reported to the DMHC. This calculation takes into account the total number of networks across all of the different health plans with which a network provider is likely to be contracted in the county type.
3. A complete list of potential FTE Starting Values, based on county type, is available in the attached **Schedule D**.
   1. FTE Starting Value Adjustments – When evaluating whether each county within the network meets the established ratio standard for a particular specialty type, the FTE starting values for providers within the county being evaluated may be adjusted under certain circumstances. The FTE starting value for each reported specialist physician within each county shall be adjusted for the following factors, as applicable:
4. **Part-Time** **and Practice Location(s) in One County** – Part-time network providers reported as practicing in only one county have an adjusted starting value of 60% of the established FTE starting value for that specialty type and county type. The adjustment shall be calculated as a percentage of the starting value of a full-time network provider with a practice location or locations in the county being evaluated. The adjusted starting value does not vary if the network provider has more than one practice location within a county.
5. **Full-Time and Multiple County Practice Locations** – Full-time network providers reported at practice locations in two or more counties have an adjusted starting value of 50% of the established FTE starting value for that specialty type and the county type of the county being evaluated. The adjusted starting value does not vary if the network provider has more than one practice location within a county.
6. **Part-Time and Multiple County Practice Locations** – Part-time network providers reported as having practice locations in two or more counties have an adjusted starting value of 30% of the established FTE starting value for that specialty type and the county type being evaluated. The adjusted starting value does not vary if the network provider has more than one practice location within a county.
7. A complete list of a network provider’s potential Starting Value Adjustments as identified above, is available in the attached **Schedule D**.

### Ratio Modifier for Telehealth-Only Network Providers

1. Telehealth-only network providers may be applied to meet the Specialist Physicians Ratio Standard through a telehealth-only ratio modifier. The modifier shall be calculated based on the specific specialty type being evaluated, in accordance with the following conditions:
2. For each specialist physician type, the telehealth-only ratio modifier shall be applied to a county or network summed FTE in a manner proportional to the full-value count of telehealth-only network providers reported for the network (for the specialty type) divided by the full-value count of in-person providers reported for the network (for the specialty type); and
3. Notwithstanding subsection a., the telehealth-only ratio modifier shall not exceed 5% of the summed FTE value of each specialist physician network provider type used to meet a ratio standard within a county or network service area.
4. The ratio modifier for telehealth-only network providers is not subject to additional FTE adjustments or alternative ratio modifiers. The ratio modifier formula for telehealth-only network providers is set forth in the attached **Schedule D-1**.

### Alternative Methodology – Additional Ratio Modifiers

1. When a Plan is not able to meet the FTE ratio standard for an applicable county, the DMHC shall conduct a further review based on the presence of one or more of the following factors that may impact specialist physician capacity for the specialist physician type in the applicable county or network:
2. The network includes specialist physicians of the applicable specialty type that are exclusive providers (EP), as defined. Network providers that are EPs are expected to have higher FTE values for the reported network, as their time is not distributed across multiple reporting plans;
3. A plan network’s enrollment in the county represents a large percentage of total population in the county compared to other reported networks. Networks that enroll a substantial share of the county population are expected to account for a larger share of a provider FTE compared to networks with relatively low levels of enrollment;
4. The county is a Rural or CEAC county, and the network has sufficient capacity in an adjacent county or counties to service enrollees in the combined counties; [[7]](#footnote-8)
5. The county is a Large Metro, Metro, or Micro County in which the Plan’s specialist physician network providers comprise a large percentage of the licensed providers in the county for the specialist physician type, and the network has sufficient capacity in an adjacent county or counties to service enrollees in the combined counties.[[8]](#footnote-9)
6. Each ratio modifier set forth below is an alternative review methodology for the DMHC to measure the capacity ratio for the listed specialist physician types, based on the factors above.
7. FTE Modifier for exclusive providers (EP) – This FTE modifier is applicable to specialist physicians that are EPs, as defined. The starting value FTE is replaced by a modified FTE value for EPs that is equal to one divided by the number of the plan’s networks in the county. After the modified EP FTE value is calculated for each EP, any applicable FTE starting value adjustments set forth in section I.C. will be applied to the modified EP FTE value.
   * + 1. The FTE modifier for EPs is set forth in **Schedule D-2.**
8. Provider FTE Modifier for High Enrollment Counties – A provider FTE modifier for high enrollment counties shall apply to counties in which enrollment for the network is reported above a threshold percentage of population value for the county, based on the county population counts reported in the DMHC’s *California ZIP Code and County Combinations and Population Points* document issued annually in the DMHC’s web portal, pursuant to Rule 1300.67.2.2(b)(11). The threshold percentage for eligibility is set forth in **Schedule D-3.** The following requirements apply to this review:
9. For county networks that are eligible, the DMHC shall multiply the network’s total FTE value for the county by a multiplier based on the percentage of county population enrolled in the network. The total FTE value includes the FTE starting values (or the alternative EP FTE value if applicable) and FTE starting value adjustments. It does not include the telehealth ratio modifier, which is applied after the FTE alternative review methodologies are considered.
10. The DMHC shall use a pre-determined multiplier based on the percentage of county population enrolled in a network, according to enrollment levels. Enrollment levels are set forth in **Schedule D-3.**
11. The adjusted total FTE value for the county network shall not exceed 80% of the full-value count of Counseling MHPs the network reported for the county.
12. Provider FTE modifiers and threshold values for high enrollment network counties are set forth in **Schedule D-3**.
13. Combined County Ratio Modifier for CEAC and Rural counties – The ratio modifier for CEAC and rural counties allows certain adjacent counties to be combined for the purposes of calculating a single specialist physician ratio for the specialty type, applied to each of the combined counties. The Combined County Ratio Modifier for CEAC and Rural counties is subject to the following requirements:
14. A combined pair or grouping of counties shall consist of one of the following:
15. Deficient County Anchor - Grouping: A single Rural or CEAC county that fails to meet the FTE ratio standard, combined with one or more adjacent counties which meet the ratio standard; or
16. Sufficient County Anchor - Grouping: A single county that meets the ratio standard, combined with one or more adjacent Rural or CEAC counties which do not meet the ratio standard.
17. No county shall be included in more than one county grouping for the specialist physician type within the same network for the purposes of meeting the ratio standard for the specialty type.
18. In order to be combined in a grouping, each Rural or CEAC county in the grouping that fails to meet the ratio standard (deficient county) must be geographically adjacent to each county in the grouping that meets the ratio standard (sufficient county). Certain exceptions apply, as set forth in **Schedule D-4.** For adjacent counties and adjacent county exceptions, please refer to **Schedule D-4** and the attached document entitled **“Adjacent Counties and Exceptions for RY 2025 Standards and Methodology.”**
19. A sufficient county may be a county outside of the network service area.
20. The methodology for the Combined County Ratio Modifier is set forth in **Schedule D-4.**
21. Combined County Ratio Modifier for Large Metro, Metro, and Micro counties – The ratio modifier for Large Metro, Metro, and Micro counties allows certain adjacent counties to be combined for the purposes of calculating a single ratio for the specialist physician type, applied to each of the combined counties. This modifier is only available if reported data demonstrates the plan network meets or exceeds a threshold number of licensed providers practicing in the county. The Ratio Modifier for Large Metro, Metro, and Micro counties is subject to the following requirements:
22. Large Metro, Metro, and Micro counties are only eligible to be combined when the plan has reported a minimum number of network providers of the specialist physician provider type, within the county. The threshold requirements for eligibility for each county and specialist physician type are set forth in the attached **Schedules D-4 and D-5,** and the attached document entitled **“RY 2025 Combined County Modifier – Thresholds for Eligibility.**”
23. A combined pair or grouping of counties shall consist of one of the following:
    * 1. Deficient County Anchor - Grouping: A single Large Metro, Metro, or Micro county that fails to meet the FTE ratio standard, combined with one or more adjacent counties which meet the ratio standard; or
      2. Sufficient County Anchor - Grouping: A single county that meets the ratio standard, combined with one or more adjacent Large Metro, Metro, or Micro counties which do not meet the ratio standard.
24. The grouping of counties to meet the FTE ratio standard shall be subject to the following rules:
25. No county shall be included in more than one county grouping the specialist physician type within the same network for the purposes of meeting the ratio standard for the specialty type.
26. In order to be combined in a grouping, each county in the grouping that fails to meet the ratio standard (deficient county) must be geographically adjacent to each county in the grouping that meets the ratio standard (sufficient county). Certain exceptions apply, as set forth in **Schedule A-4**. For adjacent counties and adjacent county exceptions, please refer to **Schedule D-4** and the attached document entitled “**Adjacent Counties and Exceptions for RY 2025 Standards and Methodology**.”
27. A sufficient county may be a county outside of the network service area.
28. Large Metro, Metro, or Micro counties that meet the threshold requirement for a combined county grouping, shall be combined according to the formulas for the Combined County Ratio Modifier set forth in **Schedules D-4 and D-5.**
29. Ratio Modifier for Partial Counties – Where the Plan’s network service area includes a partial county and the network is unable to meet the ratio standard for the partial county, the DMHC will treat the county like a CEAC or Rural county for the purposes of applying the Combined County Ratio Modifier for CEAC and Rural Counties to the partial county, if the following conditions are met: 1) The ZIP Codes within the network service area cover less than 20% of the county population, and 2) The population within these ZIP Codes is below 20,000, as measured by population points.

### The Network Ratio Standard and Alternative Methodologies

1. Reported networks shall meet the FTE ratio standard for each specialist physician type, for the entire network. The network ratio is calculated by dividing the total enrollment reported for the network by the combined FTE values of all network providers reported for the network for the specialist physician specialty type, subject to the following rules:
2. The combined FTE value for all network providers of the specialty type is the summation of the following two network provider FTE values:
   * 1. The total FTE values from each network service area county, including the telehealth-only modifier and applicable alternative methodologies that impact the FTE values; and
     2. If applicable, the FTE values for in-person network providers who have practice locations in counties outside of the network service area. The telehealth-only modifier and alternative methodologies are not applied to network providers in counties outside of the network service area.
3. When an alternative methodology is applied to a network provider that modifies the provider’s original FTE value, the application of the alternative methodology shall not generate an FTE value for the provider that exceeds 0.8.
4. **Schedule D-6** sets forth the calculations for a network ratio, including any applicable alternative methodologies.

## II. Attachments

1. Schedules D through D-6
2. Reporting Year 2025 Combined County Modifier – Thresholds for Eligibility
3. Adjacent Counties and Exceptions for RY 2025 Standards and Methodology

1. The Knox-Keene Act is set forth in California Health & Safety Code sections 1340 et seq. References to “Section” are to sections of the Act. References to “Rule” refer to the California Code of Regulations, title 28. [↑](#footnote-ref-2)
2. The standards and methodology in this document apply to all reporting plan networks, including Medi-Cal networks. [↑](#footnote-ref-3)
3. Compliance with these standards does not alone constitute compliance with federal and state laws regarding mental health and substance use disorder coverage and parity, including 42 U.S.C. § 300gg-26, [29 CFR § 2590.712](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000547&cite=29CFRS2590.712&originatingDoc=I6C886820B56411EEB590FF4B157C4E61&refType=LQ&originationContext=document&transitionType=DocumentItem&ppcid=cd618f34ed0548d3b8713facaa616aa7&contextData=(sc.Search)), 45 CFR § 146.136, Sections 1374.72 and 1374.76 of the Health and Safety Code, and Rules 1300.74.72, 1300.74.72.01, and 1300.74.721 of this title. [↑](#footnote-ref-4)
4. *See* Rule 1300.67.2.2(i)(5). [↑](#footnote-ref-5)
5. Defined terms pertain to the DMHC’s review under the identified standard, and do not abrogate a Plan’s requirements for maintaining a provider directory, or other reporting requirements under the law. [↑](#footnote-ref-6)
6. For example, the California Board of Podiatric Medicine. See Rule 1300.67.2.2(h)(8)(D)(iii) and The Annual Network Submission Instruction Manual, Appendix B. [↑](#footnote-ref-7)
7. For the purposes of the Specialist Physician Ratio Standards and Methodology, adjacent out-of-state border counties may be eligible to be combined. Certain non-adjacent counties are treated as an adjacent county to a deficient county, as described in **Schedule D-4** and the document entitled “**Adjacent Counties and Exceptions for RY 2025 Standards and Methodology”** attached to this document. [↑](#footnote-ref-8)
8. See footnote 9 above. [↑](#footnote-ref-9)