TECHNICAL ASSISTANCE GUIDE FOR MEDICAL AUDITS

Category 3: Network and Access to Care

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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INTRODUCTION

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal Managed Care Plans (MCPs) on an annual basis. Medical audits evaluate MCPs' compliance with the DHCS contractual requirements and applicable laws and regulations. The Contract and Enrollment Review Division (CERD) of DHCS' Audits and Investigations (A&I) is responsible for performing the mandated audits. The audit scope encompasses the following six categories of review:

- Category 1 – Utilization Management
- Category 2 – Population Health Management and Coordination of Care
- Category 3 – Network and Access to Care
- Category 4 – Grievances, Appeals, and Member's Rights
- Category 5 – Quality Improvement and Health Equity Transformation Program
- Category 6 – Plan Organization and Administration

USING THE TECHNICAL ASSISTANCE GUIDE (TAG)

The TAGs are designed to identify key elements commonly evaluated by A&I's audit process to promote transparency. The TAG is grouped by subcategories and includes the following components, as applicable:

Requirement: This column identifies "key" statutory, regulatory, and contractual requirements related to core managed care organization systems and processes that may be included in scope and additional areas identified based on risk. While this narrows the audit scope, the audit team may investigate the MCP's compliance with other requirements.

- MCPs are ultimately responsible for ensuring compliance with all provisions of the DHCS contract as well as any applicable All Plan Letters (APLs), Plan Letters (PLs) and Dual Policy Letters.
- The contract requirements can be supplemented with applicable laws, regulations, APLs, etc.
- This TAG cites language from the DHCS Boilerplate Contract and related Federal and State laws and regulations.
- "Contractor" means "MCP" or "Plan" in this document.

Documentation Reviewed: The items in this column reflect a hierarchy of documents.

- Initially listed items (√) indicated will most likely confirm contractual compliance or not.
- Lower listed alternate/optional documents (△) may contain information that will help determine the status of the MCP's compliance with a particular requirement.
- Documents are not only reviewed for individual compliance, but as reference in the review of all other evidence and interviews to determine actual implementation in practice, effectiveness and MCP actions taken.
- The Documents include, but are not limited to:
    - Policies and Procedures
    - Organizational Charts
    - Committee Meeting Minutes
    - Monitoring Reports
    - Data Logs
- Verification Studies (▲) are listed in this section where applicable.

Examples of Best Practices: This column details strategies implemented by some MCPs to either demonstrate compliance with a contract requirement or correct an identified deficiency. MCPs and individual audits can present distinct characteristics, and best practices may not transfer seamlessly. The audit team does not audit to best practices but may use them to evaluate compliance. It remains the responsibility of the MCP to demonstrate that it is meeting its contractual obligations.

CATEGORY 3: NETWORK AND ACCESS TO CARE OVERVIEW

Introduction/Overview

Network and Access to Care refers to a Managed Care Plan's (MCP) responsibility to maintain a provider network that provides timely, geographically accessible, and culturally and linguistically appropriate care for all members. Category 3 of the audit program assesses compliance with Contract Section 5.2, including network adequacy, composition, provider ratios, emergency access, continuity of care, cultural and linguistic services, and access for seniors and persons with disabilities. The category also covers requirements related to transportation services, prompt and accurate provider payments, and provider dispute resolution. The aim is to ensure that all members can receive medically necessary services without delay, financial hardship, or discrimination, and that providers are supported in delivering care through efficient administrative processes.

The Category 3 Audit Program includes the following subcategories from Section 5.2 of the 2024 Contract:

- 3.1: Access to Network Providers and Covered Services
- 3.2: Network Capacity
- 3.3: Network Composition
- 3.4: Network Ratios
- 3.5: Network Adequacy Standards
- 3.6: Access to Emergency Service Providers and Emergency Services
- 3.7: Out-of-Network Access
- 3.8: Specific Requirements for Access to Programs and Covered Services
- 3.9: Network and Access Changes to Covered Services
- 3.10: Access Rights
- 3.11: Cultural and Linguistic Programs and Committees
- 3.12: Continuity of Care for Seniors and Persons with Disabilities
- 3.13: Network Reports
- 3.14: Site Review
- 3.15: Street Medicine

The Category 3 Audit Program also includes additional subcategories from other Contract sections:

- 3.16: Transportation (Section 5.3.7 of the 2024 Contract: *Services for All Members*)
- 3.17: Timely Payments (Section 3.3.5 of the 2024 Contract: *Claims Processing*)
- 3.18: Provider Disputes (Section 3.2.2 of the 2024 Contract: *Provider Dispute Resolution Mechanism*)

CATEGORY 3.1: ACCESS TO NETWORK PROVIDERS AND COVERED SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.1 **A. Primary Care** 1. Contractor must ensure that each Member has an assigned Primary Care Provider (PCP) who is available and physically present at the Service Location for sufficient time to ensure access and appointments for the assigned Member when medically required. This requirement does not preclude an appropriately licensed Provider from being a substitute for the Member's assigned PCP in the event of vacation, illness, or other unforeseen circumstances. 2. Contractor must have processes in place to assist Members in selecting PCPs who are accepting new patients. 3. Contractor must consider the requirements in Welfare and Institutions Code (W&I) section 14182(b)(11) when assigning Members who are Seniors and Persons with Disabilities (SPD) to a PCP. Additionally, Contractor must ensure that Members have the option of selecting an Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), as their PCP, where available.	✓ Policies and Procedures ✓ Member Handbooks ✓ Member assignment logs ✓ PCP Availability-related Grievance Files ✓ Provider Directory ✓ Plan Website	Each Member is assigned to a PCP with physical availability at the service location. Licensed substitute providers are available when the PCP is unavailable. Members receive assistance selecting PCPs who are accepting new patients. Assignment processes account for SPD Members' needs and IHCP/FQHC/RHC options.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.1 **B. Specialists** **A.** Contractor must ensure that Members have access to Specialists for Medically Necessary Covered Services in accordance with W&I section 14197, 22 CCR section 53853, and 28 CCR section 1300.67.2.2. **B.** Contractor must maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I section 14197(h)(2), within its Network to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I sections 14182(c)(2) and 14197.	✓ Policies and Procedures ✓ Member Handbooks ✓ Network Adequacy Report ✓ Adequacy Monitoring Tool and Reports ✓ Provider Directory	The network includes core adult and pediatric specialists as required. Members receive timely referrals to medically necessary specialty care. Network adequacy is regularly assessed for both access and provider mix.
Contract Exhibit A, Attachment III, Section 5.2.1 **C. Adequate Networks and Staff Within Plan's Service Area** Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors have adequate Networks and staff within its Service Area, including Physicians, nurses, and administrative and other support staff to ensure that they have sufficient capacity to provide and coordinate care for Covered Services are provided in accordance with W&I section 14197, 22 CCR section 53853, 28 CCR section 1300.67.2.2, and all requirements in this contract.	✓ Policies and Procedures ✓ Network Staffing Rosters – by provider type and location	The network includes adequate providers and staff to meet Member needs. Service sites are geographically accessible. Staffing and site capacity are reviewed as enrollment changes. In-area contracting is prioritized before seeking out-of-area providers.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.1 **D. Monitoring Subcontractors for C&L Services** Contractor must monitor Subcontractors and Downstream Subcontractors to ensure they can adequately deliver culturally and linguistically competent care including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language. *Note: The above section is covered more extensively in the Category 4 Audit Program: Grievances, Appeals and Member's Rights.*	✓ Policies and Procedures ✓ Subcontractor Oversight and Monitoring Reports ✓ Interpreter Services Logs and Tracking Tools ✓ C&L-related Grievances	Interpreter services are available when Members need them. Members are informed of their right to free language assistance. Providers and staff are trained in culturally and linguistically appropriate care. The Plan monitors subcontractors' compliance with language access standards.
Contract Exhibit A, Attachment III, Section 5.2.1 **E. Access, Referrals and Tracking NSMHS** Contractor must ensure that Members have access to all Non-specialty Mental Health and Substance Use Disorder (SUD) Covered Services in accordance with 42 Code of Federal Regulations (CFR) section 438.900 et seq. Contractor must coordinate care for all Specialty Mental Health Services (SMHS) and SUD services and provide referrals including mechanisms to track completion of follow up visits, to the county mental health plan (MHP) and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services as outlined in Exhibit A, Attachment III, Section 5.5 (Mental Health and Substance Use Disorder Benefits).	✓ Policies and Procedures ✓ Tracking and Monitoring records ✓ Provider Directories ✓ SMHS, SUD, and DMC Grievances	Members are promptly referred to appropriate SMHS and SUD services. Referral systems track follow-up appointment completion. Coordination protocols exist with county MHPs and DMC/DMC-ODS. Staff are trained on referral and follow-up processes.

Requirement	Documentation to Review	Examples of Best Practices
Note: NSMHS more extensively in the Category 2 Audit Program: Population Health Management and Coordination of Care.		

CATEGORY 3.2: NETWORK CAPACITY

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.2 **Network Capacity** A. Contractor must maintain a Network adequate to provide the full scope of benefits to 60 percent of all Potential Members or current Member Enrollment, whichever is higher, within its Service Area. Contractor must increase the capacity of the Network as necessary to accommodate all Enrollment growth beyond 60 percent. B. Contractor may request to renegotiate its Network capacity requirement with DHCS if utilization by Contractor's Members does not exceed 75 percent of the required Network capacity, after the first 12 months of operation. Any such change is subject to DHCS review and approval.	✓ Policies and Procedures ✓ Reports demonstrating capacity to serve 60 percent of potential Members or current enrollment ✓ Tracking and Monitoring Records ✓ DHCS Correspondence	Network capacity is actively tracked against enrollment levels. The Plan expands the network promptly as enrollment grows beyond 60 percent. Utilization data is reviewed to assess whether renegotiation is appropriate. Requests for capacity adjustments are documented and submitted per DHCS guidance.

CATEGORY 3.3: NETWORK COMPOSITION

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.3 **PCPs, OB/GYN, BH, NSMHS, Specialists, Hospitals, and LTC** A. Contractor must maintain an adequate Network within its Service Area, in compliance with W&I section 14197, and if necessary to ensure contract compliance with Network adequacy. Contractor may offer to contract with Providers in adjoining Service Areas but must make good faith efforts to contract with Providers within Contractor's Service Area. Contractor's Network must include at a minimum adult and pediatric PCPs, obstetrics, and gynecology (OB/GYNs), adult and pediatric Behavioral Health Providers, adult and pediatric Non-specialty outpatient Mental Health Service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and Long-Term Care (LTC) Providers to ensure adequate access to all Medically Necessary Covered Services for all Members and to meet all Network adequacy requirements.	✓ Policies and Procedures ✓ Provider Directories ✓ Sample Provider Contracts ✓ Network Adequacy Reports ✓ External Quality Review Organization (EQRO): Annual External Quality Review (EQR) Technical Reports	The network includes all required provider types across age groups and service types. Good faith efforts are documented for contracting with in-area providers first. Out-of-area providers are used only when local access is not available. Network adequacy is routinely evaluated for both geographic and service-type coverage.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.3 **Allied Health, Paramedical, Public Hospitals, Care Navigators, Caseworkers** B. Contractor must maintain an adequate Network of Allied Health Personnel, supportive paramedical personnel, public hospitals and health care systems, care navigators, caseworkers, and public health nurses, and an adequate number of accessible service sites to ensure adequate access to all Medically Necessary Covered Services for all Members.	✓ Policies and Procedures ✓ Provider Directories ✓ Sample Provider Contracts ✓ Network Adequacy Reports	The network includes adequate allied health, paramedical, and public health providers. Service sites and staffing levels are sufficient to meet Member needs across the Service Area. Network adequacy reviews include care navigators, caseworkers, and public hospital systems.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.3 **Indian Health Care Providers, FQHCs, RHCs, Freestanding Birthing Centers, Certified and Licensed Midwives** C. Contractor must include in its Network, where available, IHCP, FQHC, RHCs, Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNMs), and Licensed Midwives (LM) in accordance with W&I section 14087.325, Medicaid State Health Official Letter #16-006, All Plan Letter (APL) 18-022, and APL 23-001. 1. If Contractor is a local initiative health plan model, it must offer to contract with all FQHCs and RHCs in its county(ies), in accordance with W&I section 14087.325. Local initiative health plans must maintain and provide supporting documentation of all contracting efforts with each FQHC and RHC in its county(ies) to DHCS upon request, even if Contractor has a minimum of one active contract with an FQHC and RHC in their county(ies). 2. If Contractor is not a local initiative health plan model, it must contract with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the Network, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law. D. Contractor must offer to contract with all IHCP available in each county(ies) in which Contractor operates in accordance with 22 CCR section 55120. If	✓ Policies and Procedures ✓ Network Rosters, Contracts, Provider Directory ✓ Records of outreach or contracting efforts	The Plan includes IHCPs, FQHCs, RHCs, and FBCs in the network where available. Local initiative plans document offers made to all FQHCs and RHCs in the county. Non-local initiative plans include at least one FQHC, one RHC, and one FBC per Service Area. Contracting efforts with IHCPs are ongoing and documented. Members are allowed to access out-of-network IHCPs when contracting is not possible.

Requirement	Documentation to Review	Examples of Best Practices
Contractor is unable to contract with an IHCP, Contractor must allow eligible Members to obtain services from out-of-Network IHCP in accordance with 42 CFR section 438.14.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.3 **Cancer Centers** E. Contractor must make good faith efforts to contract with at least one cancer center within their Networks and subcontracted Networks, if applicable, within each county in which Contractor operates for the provision of Covered Services to any eligible Member diagnosed with complex cancer diagnosis in accordance with W&I section 14197.45.	✓ Policies and Procedures ✓ Network Rosters, Contracts, Provider Directory ✓ Records of outreach or contracting efforts	The Plan makes and documents good faith efforts to contract with at least one cancer center per county. Members with complex cancer diagnoses are referred promptly.
Contract Exhibit A, Attachment III, Section 5.2.3 **Composition and Ethnic, Cultural and Linguistic Needs** F. Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.	✓ Policies and Procedures ✓ Evidence of periodic assessments and adjustments	The network reflects Members' cultural and linguistic needs.
Contract Exhibit A, Attachment III, Section 5.2.3 **Network Adequacy for NSMHS Providers** G. Contractor must have an adequate number of NSMHS Providers to provide Medically Necessary, NSMHS based on current and anticipated utilization trends for its Members.	✓ Policies and Procedures ✓ Network Rosters, Contracts, Provider Directory ✓ Utilization Data or Analysis	The Plan maintains an adequate number of NSMHS providers based on Member needs and utilization trends. Network adequacy for NSMHS is reviewed and adjusted regularly.
Contract Exhibit A, Attachment III, Section 5.2.3 **Traditional and Safety Net Providers** H. Contractor must include in its Network any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that	✓ Policies and Procedures ✓ Network Data ✓ Records of contract offers	The Plan includes any willing traditional or safety-net provider under the same terms as other similar providers.

Requirement	Documentation to Review	Examples of Best Practices
Contractor offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).		
Contract Exhibit A, Attachment III, Section 5.2.3 **Inclusion of LTC Providers in Contractor's Network** I. Contractor must ensure that every LTC Provider in its Service Area that is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in Contractor's Network, to the extent that the LTC Provider remains licensed, certified, operating, and is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms and meets Contractor's Credentialing and quality standards. If Contractor determines that additional LTC Providers are necessary to meet the needs of its Members, Contractor must offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas. J. Contractor must receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for LTC Providers undergoing a change of ownership. Network Provider Agreements must have a clause that LTC Providers must notify Contractor if it is undergoing a change of ownership so Contractor can obtain preapproval or assessment of suitability from CDPH.	✓ Policies and Procedures ✓ Network Rosters, Contracts, Provider Directory ✓ Documentation of outreach efforts and executed contracts ✓ Documentation used to assess the network	The Plan includes all qualified, licensed LTC providers willing to contract. Additional LTC providers are contracted as needed to meet Member demand. Change of ownership processes include timely CDPH preapproval and notifications.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.3 **CBAS Providers** K. Contractor must ensure that every CBAS Provider within Contractor's Service Area, that has been approved by the California Department of Aging (CDA) as a CBAS Provider, is included in Contractor's Network to the extent that the CBAS Provider remains licensed as an Adult Day Health Care (ADHC) Center, is certified and enrolled as a Medi-Cal Provider, is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms, and meets Contractor's credentialing and quality standards. Contractor must contract with a sufficient number of Community-Based Adult Service (CBAS) Providers to timely meet the needs of Members who are CBAS-eligible. Contractor must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time of its CBAS-eligible Members and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. Contractor must also meet expected CBAS-utilization without a waitlist.	✓ Policies and Procedures ✓ List of contracted and geographically located Providers ✓ Network Adequacy Analysis	The Plan includes licensed and certified CBAS providers willing to contract. CBAS sites are located within one hour's travel time for eligible Members. Network capacity supports timely access without a waitlist.

CATEGORY 3.4: NETWORK RATIOS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.4 **Network Ratios** A. Contractor must continually comply with 22 CCR sections 53853(a)(1) - (2)) and ensure that its Network meets the following full-time equivalent (FTE) Physician to Member ratios: 1. FTE Primary Care Providers that are Physicians: Member: 1:2,000 2. FTE Total Physicians: Member 1:1,200 B. Contractor must ensure that FTE non-physician medical practitioner's Member caseload does not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3). C. Contractor must ensure compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1. Contractor must ensure full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following: 1. Physician Supervisor: Nurse Practitioners 1:4 2. Physician Supervisor: Physician Assistants 1:4 3. A Physician supervisor may not supervise more than four non-physician medical practitioners in any combination.	✓ Policies and Procedures ✓ Reports showing Member-to-Provider Ratios ✓ Credentialing or HR Records ✓ Oversight Documentation	The Plan monitors FTE physician and non-physician ratios to ensure compliance. Supervision ratios for nurse practitioners and physician assistants are tracked and enforced. Caseload limits are maintained to ensure safe and timely care.

CATEGORY 3.5: NETWORK ADEQUACY STANDARDS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.5 **A. Timely Access** 1. Contractor must continuously monitor and enforce Network Providers', Subcontractors', and Downstream Subcontractors' compliance with the requirements in W&I section 14197 (d)(1)(A), 28 CCR section 1300.67.2.2, and the requirements in this Contract. 2. Contractor must develop, implement, and maintain procedures to monitor and ensure that Contractor, Network Providers, Subcontractors, and Downstream Subcontractors: a. Comply with requirements for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, Children's preventive periodic health assessments, and adult Initial Health Appointments (IHAs) in accordance with W&I section 14197, and 28 CCR section 1300.67.2.2: i. Urgent Care appointment for services that do not require Prior Authorization within 48 hours of a request; ii. Urgent Care appointment for services that do require Prior Authorization within 96 hours of a request; iii. Non-urgent appointments for Primary Care within ten (10) business days of request; iv. Non-urgent appointments with Specialists within 15 business days of request;	✓ Policies and Procedures ✓ Appointment Availability Reports ✓ Provider and call center training materials ✓ Monitoring Logs or Audit Reports ✓ Medical Records with justification for delayed appointments	The Plan actively monitors provider compliance with timely access standards using real-time appointment data and audits. Providers inform Members of expected wait times and document justifications for any delays directly in the Member's Medical Record. The Plan ensures appointment standards and triage protocols are shared with all Network Providers and enforced across the Network. Telephone customer service is promptly accessible within ten minutes and supported by trained staff 24/7. A medical director or designee is always available to address urgent access issues. Authorization requests for SNFs and ICFs are approved within required timeframes.

Requirement	Documentation to Review	Examples of Best Practices
v. Non-urgent appointment with a non-physician mental health Provider with ten (10) business days of request; vi. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, or illness within fifteen (15) business days of request; vii. Availability of LTC Providers for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara within five (5) business days of request; viii. Availability of LTC Providers for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura within seven (7) business days of request; and ix. Availability of LTC Providers for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba within 14 business days of request. b. Offer Members appointments for Covered Services within a time frame appropriate for their health condition but no longer than the appointment timeframes set forth in 28 CCR section 1300.67.2.2, unless the Member's preference is to wait for a later		

Requirement	Documentation to Review	Examples of Best Practices
appointment from a specific Network Provider. The applicable waiting time for a particular appointment may be extended if the following conditions are met: i. The Member's Medical Record notes that waiting will not have a detrimental impact on the Member's health, as determined by the referring or treating licensed health care Provider, or by the health professional providing triage or screening services, who is acting within the scope of their practice consistent with professionally recognized standards of practice; ii. The Provider's decision to extend the applicable waiting time is noted in the Member's Medical Record and made available to DHCS upon request; and iii. Contractor ensures that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a Grievance disputing the extension. c. Contractor must provide the appointment time standards to Network Providers, Subcontractors, and Downstream Subcontractors, and monitor appointment waiting times in Network Providers' offices pursuant to 42 CFR section 438.206, W&I section 14197, and 28 CCR section 1300.67.2.2. Contractor must also ensure that Network Providers comply with requirements for follow up on missed appointments; d. Offer hours of operation to Members that are no less than the hours of operation offered to non-Medi Cal		

Requirement	Documentation to Review	Examples of Best Practices
patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries if the Network Provider serves only Medi-Cal beneficiaries; and e. Maintain procedures for triaging Members' telephone calls, providing telephone medical advice, and accessing telephone interpreters 24 hours a day, seven days a week. 3. During normal business hours, the waiting time for a Member to speak by telephone with Contractor's customer service representative must not exceed ten minutes. 4. Contractor must ensure its customer service representatives have knowledge and competency to assist in resolving Members' questions and concerns. 5. Contractor must have a medical director or licensed Physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to assist with access issues.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.5 **B. Time or Distance** 1. Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors meet the time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric mental outpatient health Providers, and hospitals, as required by W&I section 14197(b) and (c). 2. Contractor must either exhaust all other reasonable options for contracting with Providers, including offering to contract with Providers in adjoining Service Areas, or provide evidence to DHCS demonstrating that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I section 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS. 3. If Contractor is unable to comply with the time or distance standards set forth in W&I section 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL 23-001 detailing how it intends to arrange for Covered Services in accordance with W&I section 14197(e)(3). 4. Contractor must publish on its website its approved AAS requests in accordance with W&I section 14197.04. 5. If Contractor has received an AAS approval from DHCS for a core Specialist, upon a Member's request, Contractor must assist the Member in	✓ Policies and Procedures ✓ Member Handbooks ✓ Geographic Accessibility Reports ✓ Records of local contracting efforts ✓ DHCS-approved AAS Requests ✓ Tracking and Monitoring Records	Geo-access reports confirming time or distance standards for required provider types AAS requests submitted with documentation after local contracting efforts Approved AAS posted online; staff assist with referrals, case agreements, and transportation Member-specific support for core Specialist access, including cross-county arrangements

Requirement	Documentation to Review	Examples of Best Practices
obtaining an appointment with the appropriate core Specialist in accordance with W&I section 14197.04. Contractor must either make its best effort to establish a Member-specific case agreement with an out-of-Network Provider or arrange for an appointment with a Network Provider in an adjoining Service Area within the time or distance standards in accordance with W&I section 14197.04. If needed, Contractor must assist in arranging transportation for the Member. Contractor must not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused to contract in the previous 12 months.		

CATEGORY 3.6: ACCESS TO EMERGENCY SERVICE PROVIDERS AND EMERGENCY SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.6 **Access to Emergency Service Providers and Services** **A.** Contractor must have within its Network, at a minimum, a designated Emergency Services facility, providing care 24 hours a day, seven days a week. This designated Emergency Services facility must have one or more Physicians and one nurse on duty in the facility at all times. **B.** Contractor must ensure that Members with Emergency Medical Conditions are seen on an emergency basis and that Emergency Services are available and accessible within Contractor's Service Area seven days a week, 24 hours a day, in accordance with 42 USC sections 1395dd and 1396u-2(b)(2), 42 CFR sections 438.114 and 438.206(c)(1)(iii), and 28 CCR 1300.67(g)(1). **C.** Contractor must reimburse the costs of Emergency Services without Prior Authorization pursuant to 42 USC section 1395dd, 42 CFR section 438.114, 28 CCR section 1300.67(g), and 22 CCR section 53216 and 53855. **D.** Contractor must have a medical director or licensed physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital	✓ Policies and Procedures ✓ Member Handbooks ✓ Geographic accessibility reports ✓ Records of local contracting efforts ✓ DHCS-approved AAS Requests ✓ Tracking and Monitoring Reports	The Plan maintains an up-to-date network of emergency departments, hospitals. Policies and Member materials clearly instruct that prior authorization is never required for emergency services. 24/7 access to triage and emergency medical consultation is available via phone. Staff are trained to guide Members on urgent care versus emergency care and support out-of-area emergency access. Emergency claims and encounters are reviewed to identify barriers and improve coordination. Communication protocols are in place to follow up after emergency visits and ensure continuity of care.

Requirement	Documentation to Review	Examples of Best Practices
inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized. **E.** Contractor must ensure that Members have timely access to Medically Necessary follow-up care including but not limited to appropriate referrals to Primary Care, Behavioral Health Services, and social services for Members who have been screened in the emergency room and do not require Emergency Services. **F.** Contractor must coordinate access to Emergency Services in accordance with Contractor's DHCS-approved emergency department protocol, as required in Exhibit A, Attachment III, Section 3.2 (Provider Relations). **G.** If Contractor delegates its Emergency Services and Post-Stabilization Care Services oversight obligations to Network Providers, Subcontractors, or Downstream Subcontractors, it must ensure a licensed physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate Network Provider, if necessary, as required under Health & Safety Code (H&S) section 1371.4.		

CATEGORY 3.7: OUT-OF-NETWORK ACCESS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.7 **Out-of-Network Access** **A.** Contractor must authorize and arrange for out-of-Network access in the following circumstances: 1. Contractor does not meet Network adequacy requirements set forth in W&I section 14197; 2. Contractor does not have an AAS approved by DHCS and fails to meet the Network adequacy standards set forth in W&I section 14197; 3. Contractor fails to comply with the requirements for timely access to appointments; or 4. Contractor must arrange for access to out-of-Network LTC when Medically Necessary for a Member in cases where Contractor does not have in-Network LTC capacity. **B.** Contractor must authorize and arrange for services from out-of-Network Providers when the Provider type is unavailable within the Network but available in an adjoining county(ies). If there is no Network Provider in the adjoining county(ies), Contractor must authorize out-of-Network services to the most appropriate Provider as close to time or distance requirements as possible. **C.** Contractor must provide Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-Network Provider, at no cost to the Member. Contractor must inform Members of their right to obtain NEMT or	✓ Policies and Procedures ✓ Logs or tracking reports ✓ Member Handbooks	The Plan maintains protocols to promptly authorize out-of-network services when in-network care is unavailable or inadequate. The Plan tracks and reports out-of-network referrals to identify network gaps and improve access planning. The Plan educates Members on their rights to out-of-network care in specific situations, including continuity of care needs.

Requirement	Documentation to Review	Examples of Best Practices
NMT services to access out-of-Network services in accordance with W&I section 14197.04. **D.** Contractor must adequately and timely cover and reimburse Providers for out-of-Network services rendered to its Members for as long as Contractor is unable to provide these services in its Network. Contractor must ensure that the Member is not charged for services furnished out-of-Network. Contractor must also ensure that Members are not balance-billed for any service provided out-of-Network.		

CATEGORY 3.8: SPECIFIC REQUIREMENTS FOR ACCESS TO PROGRAMS AND COVERED SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.8 **A. Family Planning Services** 1. Contractor must ensure Members have access to family planning services through any available family planning Provider regardless of whether they are in or out of the Network, without requiring Prior Authorization. Contractor must provide family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning consistent with 42 CFR section 441.20. 2. Contractor must not restrict a Member's Provider choice for family planning services covered pursuant to 42 CFR section 431.51(a)(3) and W&I section 14132.07. 3. Contractor's Member Handbook must inform Members of their right to access any qualified family planning Provider regardless of whether the Provider is in the Network and without Prior Authorization, in addition to requirements included in Exhibit A, Attachment III, Section 5.1 (Member Services). 4. Contractor must ensure that Members are advised of their options for all contraceptive methods to allow them to provide informed consent for their choice of contraceptive method, including sterilization, as required by 22 CCR sections 51305.1 and 51305.3. Members of childbearing age may access the	✓ Policies and Procedures ✓ Member Handbooks ✓ Evidence of Access to Covered Services ✓ Provider Directories ✓ Provider Manual ✓ Grievances related to Family Planning ✓ Prior Authorization Logs ✓ Non-contracting Family Planning Claim Reports/Logs for the Plan and selected delegates ✓ Non-contracting Family Planning Claims (Adjudicated) for the Plan and selected delegates ✓ Verification Study ▲	The Plan's policies and procedures ensure Members have access to family planning services through any available family planning provider without requiring Prior Authorization. The Plan provides family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning. Member Handbook clearly states Members' rights to access services out-of-Network, through LHD clinics, family planning clinics, or through other community STD service Providers without Prior Authorization.

Requirement	Documentation to Review	Examples of Best Practices
following services from an out-of-Network family planning Provider to temporarily or permanently prevent or delay pregnancy: a. Health education and counseling necessary to make informed choices and understand contraceptive methods; b. Limited history and physical examination; c. Laboratory tests if medically indicated as part of the decision-making process in choice of contraceptive methods, except pap smears if Contractor provides pap smears to meet the United States Preventive Services Taskforce (USPSTF) guidelines, http://www.uspreventiveservicestaskforce.org; d. Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider; e. Provision of contraceptive pills, devices, and supplies; f. Tubal ligation; g. Vasectomies; and h. Pregnancy testing and counseling.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 3.3.9 **Non-Contracting Family Planning Providers** Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS Rate, for services listed in Exhibit A, Attachment III, Subsection 5.2.8 (*Specific Requirements for Access to Programs and Covered Services*), provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.	See Above	The Plan offers Member education and outreach to ensure awareness of free access to family planning, STD, and HIV services from both in-network and out-of-network providers. The Plan ensures Members are advised of their options for all contraceptive methods delivering confidential services, including informed consent for contraceptive methods and HIV counseling/testing. The Plan monitors service utilization data to identify access gaps and implements outreach strategies to underserved populations. Family Planning claims and encounters are reviewed to identify barriers and improve coordination. The Plan's reimbursement for non-contracting family planning Providers is at no less than the appropriate Medi-Cal FFS Rate.

Requirement	Documentation to Review	Examples of Best Practices
APL 23-008 **A. Prop. 56 Directed Payments for Family Planning Services** This directed payment program is intended to enhance the quality of patient care by ensuring that Providers in California who offer family planning services receive enhanced payment for their delivery of family planning services. Timely access to vital family planning services is a critical component of Member and population health. In particular, this program is focused on the following categories of family planning services: » Long-acting contraceptives » Other contraceptives (other than oral contraceptives) when provided as a medical benefit » Emergency contraceptives when provided as a medical benefit » Pregnancy testing » Sterilization procedures (for females and males)	✓ Oversight Documents: - Oversight Monitoring Reports ✓ Claims Reports: - Family Planning Claim Reports / Logs with Proposition 56 supplemental payments ✓ Medical Records ▲ Verification Study ✓ Determine compliance with APL 23-008; Proposition 56 Directed Payments for Family Planning Services.	Verification Study results show compliance with the APL requirements, including evidence in the medical records demonstrating the Family Planning Services were rendered and paid appropriately.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.8 **B. Sexually Transmitted Diseases** Contractor must ensure Members have access to Sexually Transmitted Disease (STD) services from any Network Provider or out-of-Network Provider without requiring Prior Authorization or referral. Contractor must allow Members to access out-of-Network STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service Providers. **C. HIV Testing and Counseling** Contractor must ensure that Members have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any Network Provider or out-of-Network Provider without requiring Prior Authorization. **D. Minor Consent Services** Contractor must ensure access to Minor Consent Services for Members less than 18 years of age from any Network Provider or out-of-Network Provider without requiring Prior Authorization. Contractor must ensure Members are informed of the availability of these services without Prior Authorization. Minors less than 18 years of age do not need parent, legal guardian, or Authorized Representative (AR) consent to access these services, and Contractor, Network Providers, Subcontractors, or Downstream Subcontractors are prohibited from disclosing any information relating to Minor Consent Services without the express consent of	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
the minor Member. Minor Consent Services include treatment for the following: 1. Sexual assault, including rape; 2. Drug or alcohol abuse for Children ages 12 and over; 3. Pregnancy; 4. Family planning; 5. STDs in Children ages 12 and over; 6. Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and 7. NSMHS for Children ages 12 and over who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.8 **E. Immunizations** Members may access LHD clinics for immunizations regardless of whether the LHD is in the Network or out-of-Network, without Prior Authorization. Upon request, Contractor must provide updated information on the status of the Member's immunizations to the LHD clinic. Contractor must reimburse LHD clinics that provide immunizations to its Members after receipt of claims and supporting immunization records. **F. Indian Health Care Providers** Contractor must ensure qualified Members have timely access to IHCPs within its Network, where available, as required by 42 USC section 1396j. IHCPs, whether in the Network or out-of-Network, can provide referrals directly to Network Providers without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). Contractor must also allow for access to an out-of-Network IHCPs without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). **G. Certified Nurse Midwife and Nurse Practitioner Services** 1. Contractor must ensure that its Members have access to CNM services as required by 42 United States Code (USC) section 1396d(a)(17) and 22 CCR section 51345.	✓ Policies and Procedures ✓ Member Handbook ✓ Plan Website ✓ Member Newsletters ✓ Contracts, Claims, or Payment Documentation ✓ Training Materials	The Plan's policies and procedures ensure Members may access LHD clinics for immunizations without Prior Authorization. The Plan updates LHD on the status of Member's immunizations, upon request. The Plan reimburses LHD clinics, after receipt of claims and supporting immunization records. Member materials clearly state that these services are available confidentially, without prior authorization, and may be accessed out-of-Network. The Plan ensures adequate network capacity or referral mechanisms for these services.

Requirement	Documentation to Review	Examples of Best Practices
2. Contractor must ensure its Members have access to Nurse Practitioner (NP) services as required in 22 CCR section 51345.1. 3. Contractor must inform its Members that they have a right to obtain out-of-Network CNM services if CNM services are not available in- Network.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.8 **H. Services to Which Network Provider, Subcontractor, or Downstream Subcontractor Has a Moral Objection** 1. If a Network Provider, Subcontractor, or Downstream Subcontractor has religious or ethical objections to perform or otherwise support the provision of Covered Services, Contractor must timely arrange for, coordinate, and ensure the Member receives the Covered Services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure, at no additional expense to DHCS or the Member. 2. Contractor's Member Handbook must identify services to which a Network Provider, Subcontractor, or Downstream Subcontractor may have a moral objection and explain that the Member has a right to obtain such services from another Provider. Contractor must also inform the Member that it will assist the Member in locating a Network Provider who will perform the service or procedure. **I. Federally Qualified Health Center, Rural Health Clinic, and Freestanding Birthing Center Services** Contractor must meet federal requirements for access to a FQHC, RHC, and FBC services consistent with 42 USC section 1396b(m) and Medicaid State Health Official Letter #16-006.	✓ Policies and Procedures ✓ Member Handbooks ✓ Plan Website ✓ Member Newsletters ✓ Documentation of Contact Efforts ✓ Provider Directories or Network Roster	The Plan's policies and procedures describe the coordination to arrange for the provision of Covered Services. Members are informed of their right to access services when a Provider has a moral objection, and staff assist with timely referrals to alternative Providers without delay or extra cost. The Plan ensures network access to FQHCs, RHCs, and FBCs in compliance with federal access requirements and monitors utilization of those services.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.8 **J. Community-Based Adult Services** Contractor must provide Members with access to CBAS as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Special Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successor demonstration, waiver, or other Medicaid authority. Without limitation, Contractor must do the following: 1. Provide and coordinate the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS Provider capacity in a county within the Service Area relative to the capacity that existed on April 1, 2012; and 2. Arrange Medically Necessary Covered Services for Members with similar clinical conditions as CBAS recipients if there is insufficient CBAS Provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.	✓ Policies and Procedures ✓ Provider Directories ✓ Records or Logs demonstrating coordination of unbundled CBAS services or referrals to community resources ✓ Tracking and Monitoring Records	The Plan's policies and procedure ensure Members' rights to access CBAS. The Plan monitors CBAS network capacity and coordinates unbundled services or alternative care when capacity is reduced. Members with similar clinical needs are supported through referrals and access to community resources, consistent with CalAIM requirements.

CATEGORY 3.9: NETWORK AND ACCESS CHANGES TO COVERED SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.9 **A. DHCS Notification Requirements** 1. Contractor must provide notification to DHCS immediately upon discovery of a Network Provider initiated termination or at least 60 calendar days before any change occurs in the availability or location of services Contractor's Covered Services. Contractor must provide this notice if the change impacts more than 2,000 Members or impacts Contractor's ability to meet Network adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstance, Contractor must notify DHCS of the change in the availability or location of services as expeditiously as possible. 2. Contractor must provide notification to DHCS immediately, or within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003. 3. Contractor must notify DHCS when it is unable to contract with a certified CBAS Provider or upon termination of a CBAS Network Provider Agreement. If Contractor and the CBAS Provider cannot come to an agreement on terms, Contractor must notify DHCS within five Working Days of Contractor's decision to exclude the CBAS Provider from its	✓ Policies and Procedures ✓ Copies of Notices sent to DHCS ✓ Records of DHCS approvals or correspondence regarding proposed changes ✓ Tracking and Monitoring Records	The Plan's policies and procedures contain a provision to notify DHCS upon discovery of a Network Provider initiated termination. The Plan notifies DHCS in accordance with timeframes outlined in APL 21-003. The Plan reviews exclusionary databases on a regular basis, at least monthly, and takes appropriate action in connection with the exclusion as set forth in APL 21-003.

Requirement	Documentation to Review	Examples of Best Practices
Network. DHCS may attempt to resolve the contracting issue when appropriate. 4. In accordance with APL 21-003, Contractor must notify DHCS within 60 calendar days of termination of a LTC Network Provider or immediately if the termination is a result of the LTC Network Provider having been decertified by the California Department of Public Health (CDPH). DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC Network Provider Agreement is for a cause related to Quality of Care or patient safety concerns, Contactor may expedite termination of the LTC Network Provider Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. Contractor must not continue to assign or refer Members to a LTC Network Provider during the 60 calendar days between notifying DHCS and the termination effective date.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.9 **B. Member Notification Requirements** 1. Contractor must ensure Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a Network Provider, Subcontractor, or Downstream Subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release. 2. Contractor must obtain DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. Contractor may use a member notice template previously approved by DHCS. Any changes from the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.	✓ Policies and Procedures ✓ Sample Member Notices ✓ Evidence of the distribution method ✓ Logs or Reporting Records	The Plan identifies all Members affected by Provider terminations and generates targeted, written notifications. Notices clearly state the Provider's termination date, any replacement options, and instructions for continuing care. Members are notified at least 30 days in advance, or within 15 calendar days after receipt of the 60 days in the case of hospital or multiple PCP terminations. The Plan obtains DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination.

CATEGORY 3.10: ACCESS RIGHTS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.10 **A. Equal Access for Linguistic Services** Contractor must ensure equal access to the provision of high quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 21-004. **B. Linguistic Services** 1. Contractor must comply with W&I section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this provision, either through interpreters, telephone language services, or other legally compliant electronic options. 2. Contractor must ensure that any lack of interpreter services does not impede or delay a Member's timely access to care. 3. Contractor must comply with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members: a. Oral interpreters, sign language Providers, or bilingual Network Providers, Network Provider staff, Subcontractors, and Downstream Subcontractors at all key points of contact. These	✓ Policies and Procedures ✓ Tracking logs of Language Access Services ✓ Provider Training Materials and Attestations ✓ Member Handbooks ✓ Internal Audits or Monitoring Reports ✓ Grievances	The Plans policies and procedures describes the provision for linguistic services to ensure high quality interpreter and linguistic services. The Plan ensures timely access to interpreters and auxiliary aids for LEP Members and Members with disabilities. 24/7 telephonic interpretation is available in all required languages. Member materials are translated and offered in alternative formats as needed. Staff are trained in cultural, linguistic, and disability access requirements. Referrals to culturally and linguistically appropriate community services are available.

Requirement	Documentation to Review	Examples of Best Practices
services must be provided in all languages spoken by Medi-Cal Members and Potential Members and not limited to those that speak the threshold or concentration standards languages. b. Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404(a), and 438.408(d); W&I section 14029.91; and 22 CCR section 53876 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, Marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004; c. Referrals to culturally and linguistically appropriate community service programs; and d. Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats, in accordance with written informing materials in alternative formats,		

Requirement	Documentation to Review	Examples of Best Practices
selected by the Member, as specified in APL 21-004 and APL 22-002. 4. Key points of contact include: a. Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and b. Non-medical care settings, such as Member services, orientations, and appointment scheduling.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.10 **C. Access for Persons with Disabilities** Contractor must comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990 (42 USC sections 12131 et seq. and 12181 et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), Government Code (GC) sections 7405 and 11135, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water. *Note: The above sections are covered more extensively in the Category 4 Audit Program: Grievances, Appeals and Member's Rights.*	See Above	See Above

CATEGORY 3.11: CULTURAL AND LINGUISTIC PROGRAMS AND COMMITTEES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.11 A. Cultural and Linguistics Program B. Linguistic Capability of Employees and Contracted Staff C. Diversity, Equity, and Inclusion Training D. Community Engagement E. Community Advisory Committee *Note: The above sections are covered more extensively in the Category 4 Audit Program: Grievances, Appeals and Member's Rights.*	See Category 4 Audit Program	See Category 4 Audit Program

CATEGORY 3.12: CONTINUITY OF CARE FOR SENIORS AND PERSONS WITH DISABILITIES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.12 A. Continued Access to Out-of-Network Provider B. Member Rights to Request Continuity of Care C. Completion of Covered Services D. Person-Centered Planning E. Provision of Discharge Planning *Note: The above sections are covered more extensively in the Category 2 Audit Program: Population Health Management and Coordination of Care.*	See Category 2 Audit Program	See Category 2 Audit Program

CATEGORY 3.13: NETWORK REPORTS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.13 **A. Network Certification Report** 1. Contractor must submit its Network certification report to DHCS. The report must demonstrate Contractor's capacity to serve the current and expected membership for its Service Area in accordance with 42 CFR section 438.207(b), W&I section 14197(f)(1), and APL 23-001. 2. Contractor must demonstrate good faith compliance with contracting and referral requirements with certain cancer centers in accordance with W&I section 14197.45. 3. Contractor must demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time or distance standards for adult and pediatric PCPs, core Specialist and outpatient mental health Providers in accordance with W&I section 14197(f)(2). 4. Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e) Contractor must submit its Network certification report as outlined in APL 23-001.	✓ Policies and Procedures for Network Certification and Change Reporting ✓ Submitted Network Certification and Change Reports to DHCS ✓ Records of Significant Network Changes ✓ Subcontractor Network Certification Reports and related data ✓ Documentation of Corrective Actions	The Plan submits timely, complete Network Certification and Change Reports in the DHCS-required format. Tracks and reports Significant Network Changes promptly with required documentation. Conducts annual Subcontractor Network certification to ensure compliance with adequacy standards. Supplements Subcontractor Networks under corrective action to maintain Member access. Posts Network Certification reports publicly to promote transparency.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.13 **B. Periodic Reporting Requirements** 1. Contractor must report to DHCS any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services, such as the following: a. Change in Covered Services or benefits; b. Change in geographic Service Area; c. Change in the composition of, or the payments to, its Network Providers, Subcontractors, or Downstream Subcontractors; or d. Enrollment of a new population. 2. Contractor must provide supporting documentation detailing any Significant Change to DHCS. DHCS will determine what information Contractor must provide after Contractor reports a Significant Change to its Network pursuant to 42 CFR section 438.207. **C. Network Change Report** 1. Contractor must submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Network. 2. Contractor must submit the report 30 calendar days following the end of the reporting quarter.	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.13 **D. Subcontractor Network Certification Report** 1. Contractor must develop, implement, and maintain a process to annually certify the Network(s) of its Subcontractor(s) and Downstream Subcontractor(s) that provide Medi-Cal Covered Services for compliance with Network Ratios set forth in Exhibit A, Attachment III, Subsection 5.2.4 (Network Ratios), Network Adequacy Standards set forth in Subsection 5.2.5 (Network Adequacy Standards), and Network Composition requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3 (Network Composition) of this Contract in accordance with APL 23-006. 2. Contractor must submit complete and accurate Network Provider Subcontractor and Downstream Subcontractor Network Provider Data to confirm its Subcontractor Network(s) is compliant with all applicable network adequacy requirements, as set forth in Exhibit A, Attachment III, Subsection 2.1.4 (Network Provider Data Reporting). 3. Contactor must have a process in place to impose Corrective Action and sanctions and report to DHCS when Subcontractor and Downstream Subcontractors that provide Covered Services fail to meet Network adequacy standards as set forth in APL 23-006. Contractor must ensure all Members assigned to a Subcontractor or Downstream Subcontractor Network that is under a Corrective Action continue access to Medically Necessary Covered Services within timely access standards and	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
applicable time or distance standards as set forth in Exhibit A, Attachment III, Subsection 5.2.5 (Network Adequacy Standards) by supplementing the Subcontractor or Downstream Subcontractor Network until the Corrective Action is resolved. 4. Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit the results of its Subcontractor and Downstream Subcontractor Network Certification to DHCS in a format specified by DHCS and post its submitted certification on its website.		

CATEGORY 3.14: SITE REVIEW

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.14 **A. General Requirement** 1. Contractor must conduct Facility Site Reviews (FSR) and Medical Record reviews, initially and every three years, on all PCP sites in accordance with APL 22-017. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors have the capacity to provide Primary Care services, appropriate Preventive Care services, coordination and continuity of care in accordance with 42 CFR section 438.207. 2. Contractor must ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. Contractor must also conduct facility site physical accessibility reviews on PCP sites, Provider sites which serve a high volume of SPD Members, and all Provider sites including CBAS and ancillary service Providers, in accordance with Policy Letter (PL) 12-006 and W&I section 14182(b)(9). **B. Pre-Operational Site Reviews** The number of Site Reviews to be completed prior to initiating Contractor operation in a Service Area must be based upon the total number of new Primary Care sites in the Network. For more than 30 sites in the Network, a five (5) percent sample size or a minimum of 30 sites, whichever is greater in number, must be reviewed six (6)	✓ Policies and Procedures ✓ Completed Site Review Checklists and Reports ✓ Corrective Action Plans ✓ Credentialing Files ✓ Site Review Data Submissions to DHCS	The Plan conducts timely Facility Site and Medical Record Reviews every three years for all PCP sites, ensuring compliance with 42 CFR 438.207. FSRs include assessments of accessibility and accommodation for Members with disabilities, per PL 12-006. Pre-operational reviews are completed six weeks before service launch, with all remaining reviews done within six months. Credentialing processes recognize valid existing site surveys to avoid duplication and maintain efficiency.

Requirement	Documentation to Review	Examples of Best Practices
weeks prior to Contractor operation. Site Reviews must be completed on all remaining sites within six (6) months of Contractor operation. For 30 or fewer sites, reviews must be completed on all sites six (6) weeks prior to Contractor operation.		
Contract Exhibit A, Attachment III, Section 5.2.14 **C. Credentialing Site Review** Site Review is required as part of the Credentialing process when both the facility and the Provider are added to Contractor's Network. If a Provider is added to Contractor's Network, and the Provider site has a current passing Site Review survey score, a site survey need not be repeated for Provider Credentialing or recredentialing purposes. **D. Corrective Action** Contractor must ensure that a Corrective Action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in APL 22-017. PCP sites that do not correct cited deficiencies must be terminated from Contractor's Network; Contractor must assign Members to other Network Providers in accordance with APL 21-003. **E. Data Submission** Contractor must submit the Site Review data to DHCS up to quarterly, or in a manner or timeframe specified	See Above	In addition to above: Corrective Action Plans (CAPs) are enforced for deficiencies; uncorrected sites are removed, and Members reassigned accordingly. The Plans submits the Site Review data to DHCS. All data elements are included in the data submission report. The Plan ensures accountability for all Site Review activities even if this function is delegated.

Requirement	Documentation to Review	Examples of Best Practices
by DHCS. All data elements defined by DHCS must be included in the data submission report. **F. Continuing Oversight** Contractor must retain accountability for all Site Review activities even if this function is delegated.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.14 **G. Medical Record Documentation** 1. General Requirement: Contractor must ensure the documentation of appropriate Medical Records for Members and that Medical Records are available to Providers at each Encounter in accordance with 42 USC section 1396a(w), 28 CCR section 1300.67.1(c), and APL 20-006. 2. **Medical Records:** Contractor must have policies and procedures for developing, implementing and maintaining written procedures for all forms of Medical Record retention including but not limited to: a. For storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval, identification, and distribution; b. To ensure that Medical Records are protected and confidential in accordance with all federal and State law; c. For the release of information and obtaining consent for treatment; and d. To ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy). 3. **On-Site Medical Records:** Contractor must have policies and procedures to ensure that an individual is delegated the responsibility for securing and maintaining the security of Medical Records at each site.	✓ Policies and Procedures, including Network certification and change reporting, securing, storing, and releasing Medical Records ✓ Sample Medical Records ✓ Documentation of Interpreter Services and Advance Directives ✓ Logs or summaries of outreach and follow-up	As part of the Site Review, the Plan ensures medical records are legible, complete, and updated in real time at each Member encounter. Records include documentation of: Language needs and informed consent, including for interpreter services and sterilization procedures when applicable. Problem lists, immunization histories, allergies, and Advance Directives are clearly documented and reviewed periodically. Abnormal results from labs or specialty referrals are clearly noted, with evidence of follow-up. Secure medical record storage policies are implemented and regularly monitored at all Provider sites.

Requirement	Documentation to Review	Examples of Best Practices
4. **Member Medical Record:** Contractor must ensure that a complete, legible Medical Record is maintained for each Member in accordance with 22 CCR section 53861, which reflects all aspects of patient care, including, but not limited to, ancillary services, and at a minimum includes: a. Member identification on each page; personal/biographical data in the record; b. Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964; c. All entries dated with the author identified. For Member visits, all entries must include at a minimum, the documentation of subjective complaints, the objective findings, the plan for diagnosis and treatment, and follow-up care; d. A problem list, a complete record of immunizations and health maintenance or preventive services rendered, and documentation of any outreach efforts surrounding any missed appointments; e. Allergies and adverse reactions prominently noted; f. All appropriate informed consent documentation, including the human sterilization consent procedures required by 22 CCR sections 51305.1 - 51305.6, if applicable; g. Reports of Emergency Services provided (directly by the Network Provider or through an		

Requirement	Documentation to Review	Examples of Best Practices
emergency room) and the hospital discharge summaries for all hospital admissions, including any follow-up after the provision of Emergency Services or hospitalizations; h. Consultations and referrals, including for Complex Care Management (CCM), Enhanced Care Management, and Specialists, as well as evidence of review of specialty referrals, pathology, and laboratory reports. Any abnormal results must have an explicit notation in the Medical Record, including follow-up or outreach; i. For Medical Records of adults, documentation of whether the individual has been informed and has executed an Advance Directive, such as a durable power of attorney, for health care for Members ages 18 and over; j. Health education behavioral assessment and referrals to health education services where appropriate; and k. Documentation of blood lead screening, immunizations, and other preventive services provided in accordance with the American Academy of Pediatrics Bright Futures Periodicity Schedule, the United States Preventive Services Task Force Grade A and B recommendations, the American College of Obstetrics and Gynecologists, and the Advisory Committee on Immunization Practice recommendations. Member refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the Member's Medical		

Requirement	Documentation to Review	Examples of Best Practices
Record as described in Exhibit A, Attachment III, Section 5.3 (Scope of Services).		

CATEGORY 3.15: STREET MEDICINE

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.15 **Overview** Contractor may provide medical and other Covered Services as described in APL 24-001 via a Street Medicine program for Members experiencing unsheltered homelessness through contracted Street Medicine Providers. Street Medicine Providers are Providers or entities that Contractor has determined can provide Street Medicine services to eligible Members in an effective manner consistent with Street Medicine industry protocols and practices. Street Medicine Providers may act in the role of the Member's assigned PCP, through a direct contract with Contractor, as an Enhanced Care Management (ECM) Provider, a Community Supports Provider, a referring or treating contracted Provider, or Community Health Worker as set forth in APL 24-001. This subsection refers only to Street Medicine programs and Street Medicine Providers that Contractor may choose to offer.	See next page for more detailed information	See next page for more detailed information

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.15 A. **Street Medicine Providers Acting in Role of the PCP** Contracted Street Medicine Providers acting in the role of a Member's assigned PCP are licensed physician and non-physician medical practitioners (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), NP, and CNM. For a non-physician medical practitioner (PA, NP, and CNM), Contractors must ensure compliance with State law and Contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of Street Medicine, a supervising Physician must be a practicing Street Medicine provider, with knowledge of, and experience in, Street Medicine clinical guidelines and protocols. Street Medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, such as Basic Population Health Management; Care Coordination and health promotion; support for Members, their families, and their ARs; referrals to Specialists, including Behavioral Health, community, and social support services, when needed; use of Health Information Technology to link services, as feasible and appropriate; and provision of primary and preventative services to assigned Members. If the Street Medicine Provider does not have the capability to provide Primary Care services on the street, the Street Medicine Provider	✓ Policies and Procedures ✓ Provider Agreements ✓ Referral Tracking Reports, Billing System Documentation, and Data Sharing Submission Logs ✓ ECM/Community Supports Provider Training Materials and Attendance Logs ✓ DHCS approval letters	The Plan ensures that only appropriately licensed and supervised Street Medicine Providers are assigned as PCPs and are trained in the unique aspects of Street Medicine. Street Medicine Providers commit to delivering all essential components of the Medical Home, including care coordination, referrals, and preventive services. The Plan verifies that Street Medicine Providers have referral, billing, and data reporting capabilities equivalent to brick-and-mortar providers. ECM and Community Supports training and systems are in place for Street Medicine Providers to comply with relevant APLs. The Plan secures DHCS approval before program implementation, based on complete policy and procedure submissions.

Requirement	Documentation to Review	Examples of Best Practices
must be affiliated with a facility that has a physical location.		
Contract Exhibit A, Attachment III, Section 5.2.15 B. **Referrals, Care Coordination, Billing, Dat Sharing, and Reporting Capability** Contractor must ensure Street Medicine Providers have the capability to, and comply with, referral and Care	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
Coordination, administrative, billing and claim, data sharing, and reporting requirements.		
Contract Exhibit A, Attachment III, Section 5.2.15 C. **Street Medicine Providers Acting as ECM and Community Support Providers** Contractor must ensure Street Medicine Providers acting in the capacity of an ECM and/or Community Supports Providers comply with requirements as set forth in APL 21-012 and/or APL 21-017. Contractor is to ensure Street Medicine Providers receive appropriate Provider training and manuals and have adequate systems in place to adhere to such requirements.	See Above	See Above
Contract Exhibit A, Attachment III, Section 5.2.15 D. **Policies and Procedures / Approval from DHCS** Contractor must submit contractually required policies and procedures exhibiting compliance with program policy and requirements, and receive approval from DHCS, before operating a Street Medicine program.	See Above	See Above

CATEGORY 3.16: TRANSPORTATION

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.3.7 (I) **Emergency Medical Transportation (EMT)** I. Contractor must cover transportation services as required in this Contract and directed in APL 22-008 to ensure Members have access to all Medically Necessary services. 1. Contractor must cover Emergency Medical Transportation (EMT) services necessary to provide access to all emergency Covered Services.	✓ Policies and Procedures ✓ Member Handbooks ✓ Plan Website ✓ Member Newsletters ✓ EMT Claims and Encounter Data	The Plan ensures Emergency Medical Transportation (EMT) is available and covers all emergency Medically Necessary services.
Contract Exhibit A, Attachment III, Section 5.3.7 **Non-Emergency Transportation (NEMT)** 2. Contractor must cover NEMT services necessary for Members to access Covered Services, subject to a prescription and Prior Authorization when required, in accordance with 22 CCR section 51323. a. Contractor must require Members to have an approved Physician Certification Statement (PCS) form prescribing NEMT by their provider before Prior Authorization can be granted for NEMT services. For Covered Services requiring recurring appointments, Contractor must provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months, and ensure the Member has a standing order guaranteeing assigned rides for the duration of the recurring appointments.	✓ Policies and Procedures ✓ Documentation showing coordination of NEMT for Medi-Cal services not covered under the Contract ✓ System Records or Internal Logs ✓ Inquiry Logs, Grievances ✓ Verification Study ▲ - To document approved PCS Form and Prior Authorization when required	The Plan approves NEMT upon receipt of a valid PCS form and honors the provider's prescribed mode without changes. Recurring rides are authorized for up to 12 months with standing orders in place. NEMT is coordinated for pharmacy trips and non-contracted Medi-Cal services. PCS forms are verified for completeness, and ride schedules are monitored regularly.

Requirement	Documentation to Review	Examples of Best Practices
Contractor cannot modify the form once the provider prescribes the mode of NEMT.		
Contract Exhibit A, Attachment III, Section 5.3.7 **NEMT: Referrals and Coordination of Services** 2. Contractor must cover NEMT services necessary for Members to access Covered Services, subject to a prescription and Prior Authorization when required, in accordance with 22 CCR section 51323. b. Contractor must refer and coordinate NEMT services for Medi-Cal services that are not covered under the Contract. However, Contractor must provide NEMT services for their Members for all pharmacy prescriptions prescribed by the Member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.	See Above	See Above
Contract Exhibit A, Attachment III, Section 5.3.7 **NEMT: Brokers and Providers Oversight** 2. Contractor must cover NEMT services necessary for Members to access Covered Services, subject to a prescription and Prior Authorization when required, in accordance with 22 CCR section 51323. c. Contractor must have a process in place to ensure transportation brokers and providers are meeting these requirements and to impose corrective action if non-compliance is identified through oversight and monitoring activities.	✓ Policies and Procedures ✓ Broker Contracts and Service Agreements ✓ Oversight and Monitoring Activities, including but not limited to logs, internal audit reports, or evaluations ✓ Records of Corrective Actions	The Plan monitors transportation brokers and providers for compliance with NEMT requirements and enforces corrective action when deficiencies are identified through oversight activities.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.3.7 **Non-Medical Transportation (NMT)** 3. As provided for in W&I section 14132(ad), Contractor must authorize all NMT for Members to obtain Covered Services in accordance with the requirements and guidelines set forth in APL 22-008. Nothing in this provision will be construed to prohibit Contractor from developing policies and procedures that may include reasonable Prior Authorization requirements for NMT. Contractor must also provide NMT for all Medi-Cal services not covered under this Contract. These services include, but are not limited to, Specialty Mental Health Service (SMHS), SUD services, dental, pharmacy, pharmaceutical services, and any other benefits delivered through Medi-Cal FFS.	✓ Policies and Procedures ✓ Documentation showing coverage of all required NMT services ✓ Verification Study ▲ - To document approved PCS form and Prior Authorization when required	The Plan authorizes and provides NMT for all Covered Services and Medi-Cal FFS services, including SMHS, SUD, dental, pharmacy, and other benefits delivered through Medi-Cal FFS, in compliance with APL 22-008.
Contract Exhibit A, Attachment III, Section 5.3.7 **Transportation for Parent, Legal Guardian or AR** 4. Contractor must provide NEMT or NMT for a parent, legal guardian, or AR when the Member is a minor. With the written consent of a parent, legal guardian, or AR, Contractor may arrange NEMT or NMT services for a minor who is unaccompanied by a parent, legal guardian, or AR. Contractor must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. Contractor must ensure all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor and cannot arrange	✓ Policies and Procedures ✓ Consent Form Templates and internal protocols for collecting and verifying written consent ✓ Sample Trip Logs or Transportation Requests	The Contractor provides NEMT or NMT for a parent, legal guardian, or AR when the Member is a minor and ensures appropriate consent is obtained before arranging transportation for unaccompanied minors, unless not required by law.

Requirement	Documentation to Review	Examples of Best Practices
NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless State or federal law does not require parental consent for minor's service.		
Contract Exhibit A, Attachment III, Section 5.3.7 **Transportation-Related Travel Expenses** 5. Consistent with 42 CFR sections 440.170(a) and 431.53, W&I section 14132(ad), and APL 22-008, Contractor must also cover transportation-related travel expenses for Members obtaining Medically Necessary services. Transportation-related travel expenses are subject to retroactive reimbursement.	✓ Policies and Procedures	The Plan reimburses Members for eligible transportation-related travel expenses incurred while accessing Medically Necessary services, in alignment with federal and state requirements.
ALL PLAN LETTER 22-008 **Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses** Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. MCP responsibilities regarding the coverage of transportation for pharmacy services with the implementation of Medi-Cal Rx, Medi-Cal enrollment requirements for	✓ Policies and Procedures ✓ Documentation showing coverage of all required NEMT and NMT services ✓ Grievances ✓ CalHHS Dataset	The Plan keeps Members informed about scheduling and timely access to ensure the Member does not miss their appointment. The Plan approves the PCS form and does not delegate the review and approval of the PCS form to its transportation brokers. The Plan ensures Members can identify specific drivers in a grievance.

Requirement	Documentation to Review	Examples of Best Practices
transportation providers, as well as MCP coverage of transportation related travel expenses.	✓ Broker Contracts and Service Agreements ✓ Oversight and Monitoring Activities, including but not limited to logs, internal audit reports, or evaluations ✓ Records of Corrective Actions ✓ Verification Study ▲ - To document approved PCS form and Prior Authorization when required	The Plan ensures all NEMT and NMT providers comply with enrollment requirements set forth in APL 19-004 or superseding APL.

CATEGORY 3.17: TIMELY PAYMENTS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 3.3.5 **Claims Processing: Clean Claims, Penalties and Timelines** Contractor must pay all Clean Claims submitted by Providers in accordance with this section, unless the Provider and Contractor have agreed in writing to an alternate payment schedule, subject to the following: A. Contractor must comply with 42 United States Code (USC) section 1396u-2(f) and Health and Safety Code (H&S) sections 1371 - 1371.36 and their implementing regulations. Contractor must be subject to any penalties and sanctions, including interest at the rate of 15 percent per annum, provided by law if Contractor fails to meet the standards specified in this section. B. Contractor is expected to pay Clean Claims within 30 calendar days of receipt. For the purpose of establishing compliance thresholds, Contractor must pay at least 90 percent of all Clean Claims from Providers within 30 calendar days of the date of receipt and 99 percent of all Clean Claims within 90 calendar days. For purposes of calculation, the date of receipt is considered the date Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is considered be the date of the check or other form of payment. Pursuant to H&S section 1371(a), if Contractor does not pay a Clean Claim within 45 Working Days of	✓ Policies and Procedures ✓ Written criteria for guidelines for claims payments review and monitoring ✓ Desktop Guides ✓ Claims Processing Logs or System-generated Reports ✓ Documentation of late payment interest calculations and payments made ✓ Internal Audit Reports or Monitoring Tools ✓ Provider Grievances related claim payments ✓ Verification Study ▲ - May include but is not limited to claim details, explanation of code (EOC), remittance advice details, and supporting documentation submitted with the claim	Effective January 1, 2026, H&S section 1371(a) requires the Plan pay 100% of Clean Claims within 30 calendar days. Interest at 15 percent per annum is automatically included in claims paid after 30 calendar days. Receipt and payment dates are clearly documented and used consistently for compliance tracking. Written agreements are in place for any alternative payment schedules with Providers.

Requirement	Documentation to Review	Examples of Best Practices
receipt, it will owe the Provider interest at the rate of 15 percent per annum beginning on the first day after a 45 Working Day period. For the purposes of calculating interest, the first day is considered to be the first calendar day after 45 Working Days following the receipt of the claim. Contractor must automatically include all accrued interest in any late payment.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 3.3.16 **Emergency Services** 1. Subject to 42 CFR section 422.113(b), Contractor is responsible for coverage and payment of Emergency Services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor. Contractor must not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR section 438.114(a)(i) – (iii). Further, Contractor must not deny payment for treatment obtained when a representative of Contractor instructs the Member to seek Emergency Services. Emergency Services must not be subject to Prior Authorization by Contractor. 2. Contractor must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to reimburse Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Providers, Contractor, or DHCS of the Member's screening and treatment for Emergency Services. A Member who has an Emergency Medical Condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.	✓ Claims Processing Policies and Procedures for Emergency Services ✓ Written Criteria or Guidelines for claims payments review and monitoring ✓ Emergency Claims Paid Data Universe ✓ Desktop Guides ✓ Claims Processing Logs or System-generated Reports ✓ Documentation of Late Payment Interest Calculations and Payments Made ✓ Internal Audit Reports or Monitoring Tools ✓ Provider Grievances related claim payments ✓ Verification Study ▲ - Includes, but is not limited to, claim details, explanation of code (EOC), remittance advice details, and supporting documentation	The plan's policies and procedures indicate that Plan has informing materials/written notification of denial, reduction, or delay in processing or payment of out-of-plan ER claims. The Plan's policies and procedures, provider manuals and member handbook indicates that member do not require prior authorization for emergency services. In determining appropriate and timely payments of claims, the Plan can demonstrate appropriate criteria selection and case adjudication. Members who have an Emergency Medical Condition are not held liable for payment of subsequent screening and treatment.

Requirement	Documentation to Review	Examples of Best Practices
	submitted with claim	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 3.3.16 **Emergency Services** 3. Contractor must reimburse Providers for Emergency Services received by a Member from out-of-Network Providers. Payments to non-contracting Providers must be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge. The treating Provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Contractor. Emergency Services must not be subject to Prior Authorization by Contractor. 4. At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated Providers for physician services at the lowest level of the emergency department evaluation and management physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology. 5. For all non-contracted Emergency Services Providers, reimbursement by Contractor or by a Subcontractor or Downstream Subcontractor who is at risk for out-of-Network Emergency Services for properly	See Above	In addition to above; ▲ Based on Verification Study, no claims for ER services were denied due to the rendering provider being an out-of-network provider.

Requirement	Documentation to Review	Examples of Best Practices
documented claims for services rendered by out-of-Network Provider pursuant to this provision must be made in accordance with Exhibit A, Attachment III, Subsection 3.3.5 (Claims Processing) above and 42 USC section 1396u-2(b)(2)(D).		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 3.3.5 **Clean Claims and Provider Training / Assistance** C. Contractor must provide direct instruction, training, and technical assistance to its providers to support information transmission and the submission of Clean Claims, including bills or invoices submitted by ECM providers; Community Support providers; Doulas, or other community-based providers that are unable to submit claims through an electronic file format. Contractor must make claiming, billing or invoicing guides and notices readily available to its Providers, including through Provider portals and/or Provider manuals. Contractor is required to train Network Providers to effectively use electronic systems to facilitate timely submission of Clean Claims, equivalent encounters, or bills or invoices.	✓ Policies and Procedures ✓ Provider Manual ✓ Provider Training Materials (includes slide decks, training schedules, and participant lists/attendance reports) ✓ Provider Newsletter ✓ Technical assistance Guides ✓ Billing Guides	Contractor provides direct instruction and training for network providers on how to use electronic systems and how to submit timely clean claims and invoices. Contractor's P&Ps outline clear instructions for providers that are unable to submit claims through an electronic file format.
Contract Exhibit A, Attachment III, Section 3.3.5 **Denied and Rejected Claims** D. If claims are denied, rejected, or contested in whole or in part, Contractor must specify the reason(s) for contesting or denying a claim and specify the additional information necessary to complete the claim as well as offering technical assistance to remediate deficiencies.	✓ Policies and Procedures ✓ Technical Assistance Guides ✓ Sample Denial Letters or System-generated Notifications ✓ Monitoring Reports (to show denial trends by provider or provider type to help identify technical assistance needs)	Contractor issues timely, clear denial notices with reasons and corrective steps, and offers support to help Providers resubmit clean claims.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 3.3.5 **Procedures for Pre-Payment/Post-Payment Claims Review** E. Contractor must maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and the Covered Services for which payment is claimed.	✓ Policies and Procedures ✓ Internal Review Tools or Audit Logs	Contractor applies consistent pre- and post-payment review protocols to detect errors or irregularities.
Contract Exhibit A, Attachment III, Section 3.3.5 **Sufficient Claims Processing and Tracking** F. Contractor must maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to provide an Incurred but Not Reported Claim Estimate as specified by 28 CCR sections 1300.77.1 and 1300.77.2.	✓ Policies and Procedures ✓ Incurred But Not Reported (IBNR) Claim Estimate Reports	The Plan maintains accurate and timely systems to track, process, and report claims, including generating required IBNR estimates.

CATEGORY 3.18: PROVIDER DISPUTES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 3.2.2 **Provider Dispute Resolution Mechanism** In accordance with Health and Safety Code (H&S) section 1367(h)(1), Contractor must have a fast, fair, and cost-effective Provider Dispute Resolution Mechanism in place for Network Providers and out-of-Network Providers to submit disputes. A. Contractor must have a formal procedure to accept, acknowledge, and resolve Network Provider and out-of-Network Provider disputes. The Provider Dispute Resolution Mechanism must occur in accordance with the timeframes set forth in H&S sections 1371 and 1371.35 for both Network Providers and out-of-Network Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding: 1. The authorization or denial of a service; 2. The processing of a payment or non-payment of a claim by Contractor; or 3. The timeliness of the reimbursement on an uncontested Clean Claim and any interest Contractor is required to pay on claims reimbursement per APL-23-020. B. Contractor's Provider Dispute Resolution Mechanism must be set forth in all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements. C. Contractor must inform all Network Providers, out-of-Network Providers, Subcontractors, and	✓ Policies and Procedures ✓ Sample Dispute Logs and Resolution Outcomes ✓ Quarterly and Annual Dispute Resolution Reports to DHCS ✓ Provider Training Materials ✓ Network/Subcontractor Agreements ✓ Monitoring Tools and/or Reports ✓ Verification Study ▲	The Plan maintains a clear, accessible dispute resolution process for both Network and out-of-Network Providers, with timely acknowledgments and documented outcomes. Resolution timeframes align with Health and Safety Code requirements, and Providers are informed of their rights and options to submit a dispute through multiple channels. Dispute mechanisms are formally integrated into all Provider, Subcontractor, and Downstream Subcontractor agreements. Annual analysis identifies trends and systemic issues, with action plans reported to DHCS. Results of dispute trends and outcomes are used to improve UM, claims processes and reduce recurring issues.

Requirement	Documentation to Review	Examples of Best Practices
Downstream Subcontractors that provide services to Contractor's Members of its Provider Dispute Resolution Mechanism, regardless of contracting status. D. Contractor must resolve Network Provider and out-of-Network Provider disputes within the timeframes set forth in H&S section 1371.35 of receipt of the dispute, including supporting documentation. E. Contractor must submit a Provider Dispute Resolution Mechanism report annually to DHCS which includes information on the number of Providers who utilized the Provider Dispute Resolution Mechanism and a summary of the disposition of those disputes, in accordance with H&S section 1367(h)(3). This report must be delineated by Network Providers and out-of-Network Providers, and by Contractor, Subcontractor, or Downstream Subcontractor. F. On an annual basis, Contractor must assess the Network Providers and out-of-Network Providers that utilize the Provider Dispute Resolution Mechanism to identify trends and systemic issues. Contractor must submit the results of its annual assessment to DHCS with discussion on how it is addressing trends and systemic issues identified based on the assessment.		