State of California—Health and Human Services Agency
Department of Health Care Services

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ALL PLAN LETTER 19-002
SUPERSEDES ALL PLAN LETTER 18-005

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NETWORK CERTIFICATION REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) on the reporting requirements for the Annual Network Certification process. This APL also outlines network adequacy standards pursuant to Title 42 of the Code of Federal Regulations (CFR), Sections 438.68, 438.206, and 438.207, and Welfare and Institutions Code (WIC), Section 14197.[2, 3] It also provides clarifying guidance regarding State and federal network requirements.

BACKGROUND:
The Annual Network Certification provides a prospective look at the MCP's network in the upcoming contract year (CY).[4] The Department of Health Care Services (DHCS) defines a "network" as Primary Care Physicians (PCPs), specialists, hospitals, pharmacies, ancillary providers, facilities, and any other providers that subcontract with an MCP for the delivery of Medi-Cal covered services. A Network Provider, as defined in APL 19-001, has the same definition for purposes of this APL.[5, 6]

MCPs are required to submit network certification documentation to DHCS annually.[7] Each MCP must also provide DHCS with supporting documentation that demonstrates the MCP's capacity to serve the anticipated membership in its service area in

[1] This APL applies to all MCPs and Senior Care Action Network (SCAN).
[2] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl.
[3] WIC, Section 14197 is available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=6.3.
[4] For purposes of this APL, the CY is the MCP's fiscal year except for the following MCPs: Family Mosaic, AIDS Healthcare Foundation and SCAN Health Plan. The CY for those MCPs is the calendar year.
[5] For more information on Network Providers, see APL 19-001, or any future iteration of this APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[6] 42 CFR, Section 438.2
[7] 42 CFR, Section 438.207(c)(2).

accordance with federal regulations.[8, 9] DHCS is required to review all MCP network submissions and provide evidence of compliance to the Centers for Medicare and Medicaid Services (CMS) before the CY begins.[10]

POLICY FOR NETWORK CERTIFICATION REQUIREMENTS:
DHCS is required to certify each MCP's network every year.[11] In addition to the Annual Network Certification, Title 42 of the CFR, Section 438.207 also requires MCPs to submit documentation to DHCS any time there is a network change, including:

- A new MCP enters into a contract with the State;
- A change in the composition of, or payments to, a Network Provider;
- A change in services or benefits;
- A change deemed by DHCS to be a significant change;
- A change in geographic service area; or
- Enrollment of a new member group.

DHCS has authority to determine if a network change is a significant change. A significant change may include, but is not limited to, a change in availability or location of covered services or a Network Provider and/or facility action. A Network Provider and/or facility action includes, but is not limited to, suspensions, terminations, or decertifications of an Independent Physician Association (IPA) or medical group, hospital, clinic, or PCP or Subcontractor that may impact the MCP's network adequacy or capacity to deliver services.[12] A Subcontractor is an individual or entity who has a subcontract with an MCP that relates directly or indirectly to the performance of the MCP's obligations under its contract with DHCS.[13] If DHCS determines there has been a significant change to the network, the MCP must follow all Annual Network Certification requirements described in this APL.

DHCS' Annual Network Certification process includes verification of the following:[14]

- The MCP network's ability to provide medically necessary services needed for its anticipated membership and utilization;

[8] For purposes of this APL, service area and reporting unit have the same meaning. Reporting units are outlined in Attachment B of this APL.
[9] 42 CFR, Sections 438.207, 438.68, and 438.206(c)(1).
[10] 42 CFR, Section 438.207(d).
[11] 42 CFR, Section 438.207(c)(2).
[12] For more information on suspension, termination, or decertification, see APL 16-001, or any future iteration of this APL.
[13] 42 CFR, Section 438.2
[14] 42 CFR, Section 438.68(c).

- The MCP network includes the required number and mix of primary and specialty care providers;
- The geographic location of Network Providers to ensure compliance with time and distance standards; and
- The MCP's compliance with service availability, physical accessibility, out-of-network access, timely access, continuity of care, and 24/7 language assistance.

ANNUAL NETWORK CERTIFICATION SUBMISSION:
MCPs must submit to DHCS a complete and accurate Annual Network Certification that reflects the MCP's entire network for each service area at the time of submission. MCPs must submit the Annual Network Certification and all supporting documentation to DHCS no later than 105 days before the CY begins (or the next business day if the due date occurs on a weekend or holiday). Each MCP must complete and submit to DHCS all required documentation outlined in this APL.

MCPs must submit all required Annual Network Certification documentation and ensure their network information is uploaded to DHCS in the MCP's 274 file submission.[15] The documentation must be submitted through the DHCS Secure File Transfer Protocol site and must be correctly labeled based on the instructions provided in Attachment B. The data in the 274 file submission must adhere to the instructions outlined in APL 16-019, or any future iteration of this APL. DHCS will periodically review and validate the 274 file submissions to ensure compliance with network adequacy standards and legal and contractual requirements.[16] MCPs are required to include all Network Providers in the 274 file submission regardless of whether the Network Provider is required to be certified in the Annual Network Certification.[17]

ANNUAL NETWORK CERTIFICATION COMPONENTS:

Network Providers
Each MCP must maintain and monitor an appropriate network that includes full-time equivalent (FTE) adult and pediatric PCPs, obstetrician-gynecologist (OB/GYN), primary,[18] and specialty care, adult and pediatric core specialists,[19] adult and pediatric mental health outpatient providers,[20] hospitals, pharmacies, and ancillary services.[21]

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[15] For more information on provider data reporting, see APL 16-019, or any future iterations of this APL.
[16] DHCS Boilerplate Managed Care Contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[17] For more information on Network Providers, see APL 19-001, or any future iteration of this APL.
[18] Only applicable if the MCP designates OB/GYN providers as PCPs.
[19] Core specialists are outlined in Attachment A of this APL.
[20] State Plan Amendment (SPA) 14-012. SPAs are available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/ApprovedSPA.aspx .
[21] MCP Contract, Exhibit A, Attachment 6, Network Composition.

MCP networks must also have the capacity to provide all medically necessary services. In addition, MCPs operating in County Organized Health Systems (COHS) or Cal MediConnect counties must include, where available, their Managed Long Term Services and Supports Network Providers in their 274 file submission.

Network Capacity and Ratios

MCPs must meet or exceed network capacity requirements, as defined in the MCP contract.[22] This may require MCPs to proportionately adjust the number of Network Providers to support any anticipated changes in enrollment. Each MCP must maintain network capacity to serve the following percentages of all eligible members, including seniors and persons with disabilities, within its service area:

- County/Regional/Two-Plan plan models – 60% or the current member enrollment in the MCP, whichever is higher;
- Geographic Managed Care plan model – 60% or the current member enrollment in the MCP, whichever is higher; and
- COHS plan model – 100%.

Additionally, MCPs must meet the FTE provider-to-member ratio for PCPs of one FTE PCP to every 2,000 members, and total network physician ratio of one FTE physician to every 1,200 members. MCPs are permitted to use non-physician medical practitioners, such as physician assistants, nurse practitioners, and certified nurse midwives, to meet required provider-to-member ratios.[23] DHCS calculates full-time equivalency based on the MCP's network capacity percentage by plan model, or their allotted member assignment, whichever is greater. In limited circumstances, DHCS may allow an MCP to renegotiate its network capacity requirements.[24]

MCPs may also utilize telehealth providers to meet physician and provider-to-member ratios. Current provider-to-member ratios for PCPs and total network physicians can be found in the MCP contracts. Network Providers who provide both in-person and telehealth services can only be counted once when calculating the MCP's available providers in any given specialty. Telehealth providers may be counted as an additional provider to meet provider-to-member ratio requirements if they do not provide in-person services.

[22] MCP Contract, Exhibit A, Attachment 6, Network Capacity.
[23] MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.
[24] MCP Contract, Exhibit A, Attachment 6, Network Capacity.

Mandatory Providers

MCPs must include at least one federally qualified health center (FQHC), one rural health clinic (RHC),[25] and one freestanding birth center (FBC),[26] where available in their contracted service area, per CMS State Health Official letter (SHO) #16-006.[27] In accordance with State and federal network adequacy requirements, each MCPs must include a minimum of one certified nurse midwife (CNM) and one licensed midwife (LM) in its network, to the extent that CNMs and LMs are available in the MCP's contracted service area.[28, 29, 30, 31] For more information on FBCs, CNMs, and LMs, see APL 18-022, or any future iteration of this APL.

State regulations in California provide protections for American Indians and American Indian Health Services. Indian Health Facilities (IHFs) are not required to contract with MCPs but can voluntarily enter into a contract with an MCP at any time. However, MCPs are required to offer to contract with each IHF in their service areas.[32, 33] MCPs must submit documentation to DHCS following the instructions in Attachment B, Exhibit A-2 documenting any and all efforts to contract with IHFs. This documentation must include information on why the MCP is unable to contract with each IHF in its service areas.

MCPs must include mandatory provider data in the MCP's 274 file submission to demonstrate compliance with network requirements for FQHCs, RHCs, FBCs, IHFs, CNMs, and LMs. If the MCP does not have a contract with at least one of these mandatory providers, the MCP must submit documentation to DHCS that shows why it was unable to contract with those mandatory providers (i.e., there are either no mandatory provider types in the service area, or no mandatory provider type was willing

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[25] A list of FQHCs and RHCs is available by selecting the "FQHC and RHC Current Rates" at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/default.aspx.

[26] The California Health and Human Services (CHHS) Agency maintains the Licensed and Certified Healthcare Facility Listing and is available at: https://data.chhs.ca.gov/dataset/healthcare-facility-locations.

[27] SHO #16-006 is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf.

[28] MCP Contract, Exhibit A, Attachment 9, Nurse Midwife and Nurse Practitioner Services.

[29] WIC, Sections 14132.39 and 14132.4.

[30] Title 42 of the United States Code (USC), Section 1396d(a)(17). The USC is available at: http://uscode.house.gov/

[31] A list of CNMs and LMs is provided and maintained by CHHS and is available at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017/resource/d7cd2c98-3454-46c5-810b-b5436b54de3a.

[32] Title 22 of the California Code of Regulations (CCR), Section 55120. 22 CCR, Section 55120 is available at: https://govt.westlaw.com/calregs/Document/I90DC11A05F7811DFBF84F211BF18441D?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default).

[33] A list of IHFs is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-020_Att1.pdf.

to contract with the MCP, or the provider/facility does not meet professional standards or has quality of care issues). These submissions must also follow the instructions in Attachment B, Exhibit A-2. DHCS will verify the MCP's 274 file submission and additional documentation to determine whether the MCP is in compliance with legal and contractual requirements for mandatory providers.

Time and Distance Standards

DHCS established network adequacy standards in accordance with State and federal regulations to ensure adequate availability and accessibility of services to members.[34] These standards include time and distance standards based on county population density.[35, 36] Time and distance standards are applicable to the following provider types: adult and pediatric PCPs, adult and pediatric core specialists, OB/GYN primary care and specialty care services, hospitals, adult and pediatric mental health providers, and pharmacies.[37] MCPs may use time or distance requirements to demonstrate compliance. Additionally, DHCS will allow MCPs to use telehealth, where necessary, for purposes of complying with time and distance standards.[38]

For each service area, MCPs must create and submit geographic access maps and accessibility analyses that demonstrate coverage of the MCP's entire service area, following the instructions provided in Attachment B, to confirm compliance with time or distance standards. MCPs may only include Network Providers included in the MCP's 274 file submission on their geographic access maps and accessibility analyses. The MCP's analysis must demonstrate its compliance with applicable time or distance standards.

Timely Access Standards

DHCS' External Quality Review Organization (EQRO) conducts a retrospective timely access survey of all MCPs to ensure compliance with provider availability and appointment time standards for urgent and non-urgent appointments among Network Providers.[39] The survey includes a statistically valid random sample of Network Providers to confirm the following information:

- The first three available times for urgent and non-urgent appointments;
- The differences in appointment times between pediatric and adult members;
- Whether the Network Provider is accepting new patients;

[34] 42 CFR, Section 438.207.
[35] WIC, Section 14197(b).
[36] For more information on county populations, see Attachment A of this APL.
[37] 42 CFR, Section 438.68(b)
[38] WIC, Section 14197(e)(4).
[39] For more information on Network Adequacy Standards, see Attachment A of this APL.

- Whether the Network Provider is contracted with other MCPs in the same service area; and
- The quality of the data that DHCS maintains for the Network Provider.

DHCS will provide the results of the timely access survey to MCPs on a quarterly basis and the final survey results on an annual basis. Survey results will identify any areas of non-compliance with appointment time standards, data quality issues, and any inconsistencies with MCP data submitted to DHCS through the 274 file submission. MCPs must submit a response to any timely access deficiencies found in the quarterly survey results and identify any changes or corrections necessary to achieve compliance with timely access requirements.

During the Annual Network Certification process, DHCS will analyze the final timely access survey results, compare the provider network data submitted by MCPs, and determine the rate of compliance by MCPs. The survey analysis allows DHCS to confirm that members have access to Network Providers consistent with timely access requirements regardless of geographic proximity.

ALTERNATIVE ACCESS STANDARDS:
If an MCP is unable to comply with the time or distance standards set forth in WIC, Section 14197, the MCP must submit an Alternative Access Standard (AAS) request to DHCS for review and approval.[40] DHCS will approve AAS requests only after the MCP has exhausted all other reasonable options for contracting with providers in order to meet network adequacy standards.[41] All new AAS requests must be received by DHCS no later than 105 days prior to the beginning of every CY (or the next business day if the due date occurs on a weekend or holiday) to be considered for the Annual Network Certification. DHCS will attempt to expedite any AAS requests received after the deadline but will not guarantee a decision prior to submission to CMS.

AAS requests will be approved or denied on a ZIP code and provider type basis. All new AAS requests must be submitted in Excel format, in accordance with Attachment C. Upon DHCS approval of an AAS request, the AAS approval is valid for one CY and must be approved every year thereafter if an AAS is still needed. MCPs that are Knox Keene licensed must include documentation of pending AAS requests and/or documentation of approved AAS requests by the Department of Managed Health Care (DMHC). Likewise, if an MCP requests approval of an AAS from DMHC, the MCP must include the DHCS approval and/or pending AAS request with its request to DMHC.

[40] AAS request template is Attachment C (formerly Attachment F).
[41] WIC, Section 14197(e)(1).

Having an approved AAS does not relieve an MCP of the ongoing requirement to notify DHCS when there is a change to its network that affects the MCP's ability to meet network adequacy standards, the Annual Network Certification components set forth in this APL, and State and federal requirements. DHCS will make the determination on whether the network change is deemed to be a significant change that warrants recertification of the MCP's network.

In cases where an MCP is unable to meet time or distance standards, DHCS is authorized to determine if that MCP is capable of delivering the appropriate level of care and access to members through an AAS.[42] In order to be considered for an AAS, the MCP must provide a written request to DHCS.[43]

DHCS will provide the requesting MCP a template on which to submit the formal AAS justification. DHCS will review the MCP's response and determine if the MCP's formal justification for AAS will meet the needs of its members and ensure appropriate and timely access to care.[44] If approved, the MCP is required to resubmit the formal AAS justification to DHCS annually to be reconsidered for approval.

Previously Approved Alternative Access Standard Requests

If an MCP has an approved AAS requests from the prior year's Annual Network Certification submission, then the MCP must complete Attachment D and include their previously approved AAS requests. MCPs are required to utilize external sources to identify new providers within a closer time or distance and justify the need for a new AAS request.[45] MCPs are required to follow template instructions and include the following information:

- Whether the AAS is still needed or is no longer needed (i.e. new Network Provider contract);
- Whether the provider information is still accurate;
- Changes to minutes and/or miles request; and
- Updates on contracting efforts.

MCPs are required to submit Attachment D no later than 105 days prior to the beginning of every CY (or the next business day if the due date occurs on a weekend or holiday). DHCS reserves the right to evaluate an approved AAS request to determine if the MCP

[42] WIC, Section 14197(e)(1)(B).
[43] WIC, Section 14197(e)(2).
[44] WIC, Section 14197(e)(3).
[45] External sources can include, but are not limited to: Fee for Service Open Data Portal, Health Care Options, or Office of Statewide Health Planning and Development.

will be required to take additional actions to achieve time and distance standards that comply more thoroughly with DHCS' requirements.

Telehealth and Mail-Order Pharmacy

MCPs may use telehealth as an alternative access to care to meet time and distance standards.[46] Services provided via telehealth must align with the telehealth policy in the Medi-Cal Provider Manual.[47] Telehealth providers must meet the following criteria:

- Licensed to practice medicine in the State of California;
- Certified and enrolled as providers in the Medi-Cal program, as applicable;[48] and
- Trained on contractual requirements of the Medi-Cal Managed Care program.[49]

Before using a telehealth provider to fulfill network adequacy requirements for time and distance standards in a defined service area, the MCP must make reasonable attempts to contract with an in-person provider.[50] The telehealth provider must be available to provide telehealth services to all members in the defined service area regardless of whether the member is assigned to an IPA or medical group or which IPA or medical group the member is assigned to. If the MCP intends to utilize telehealth providers to meet time and distance standards, the MCP must follow the instructions in Attachment B, Exhibit A-3 of this APL and submit documentation to DHCS for review and approval.

MCPs may also utilize mail-order pharmacies to fulfill network adequacy requirements for time and distance standards in a defined service area. If the MCP intends to utilize mail-order pharmacies to meet time and distance standards, the MCP must follow the instructions in Attachment B, Exhibit A-3 and submit documentation to DHCS for review and approval. When using mail-order pharmacies, MCPs must also have a mechanism in place to ensure that any medications that cannot be sent through the mail are delivered in a timely manner, consistent with the member's medical need.

Though MCPs may utilize telehealth or mail-order pharmacies to meet network adequacy standards, MCPs cannot require members to utilize telehealth or mail-order pharmacy services in place of in-person services.[51] Thus, if a member does not elect to

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[46] WIC, Section 14197(e)(4).
[47] The Medicine: Telehealth section of the Medi-Cal Provider Manual is available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc.
[48] For more information on provider certification and enrollment, see APL 17-019, or any future iteration of this APL.
[49] For more information, see the DHCS Boilerplate Managed Care Contracts.
[50] WIC, Section 14197(e)(1)(A).
[51] WIC, Section 14132.72(f). WIC, Section 14132.72 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14132.72.

use telehealth or a mail-order pharmacy, MCPs must provide transportation to an in-network or out-of-network pharmacy or provider with a physical location within timely access standards for medically necessary medications or services when requested by a member.[52, 53]

PROVIDER VALIDATION:
DHCS will validate a sample of each MCP's network of adult and pediatric PCPs, OB/GYNs primary and specialty care, adult and pediatric core specialists, adult and pediatric mental health outpatient providers, hospitals, and pharmacies to ensure Network Providers included in the MCP's 274 file submission are currently contracted with the MCP.

If DHCS is unable to validate that a provider is currently in the MCP's network, the MCP must provide to DHCS signed contract pages confirming there is a current executed contract with the provider, IPA, or medical group. MCPs are responsible for ensuring their 274 file submissions are accurate and complete. MCPs must also ensure that DHCS has all necessary provider contact information needed for the validation, including physical address, telephone number, and when possible, a current email address for all Network Providers included in the MCP's 274 file submission.

A&I TIMELY ACCESS MONITORING:
DHCS' Audits and Investigations Division (A&I) routinely performs full medical audits of each MCP. This includes a review of the MCP's infrastructure to assess MCP compliance with all access to care requirements, including but not limited to, service availability, physical accessibility, out-of-network access, timely access, continuity of care, and 24/7 language assistance. A&I will provide audit findings, including the timely access verification study, and coordinate with the Managed Care Quality and Monitoring Division (MCQMD) Network Certification team if the medical audit contains findings of non-compliance, including findings in Category 3 – Access and Availability.[54] Under these circumstances, MCQMD, as part of the Annual Network Certification process, will monitor the progress of any corrective action plan (CAP) that is imposed by A&I.

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[52] For more information on transportation service, see APL 17-010.
[53] WIC, Section 14185(a). WIC, Section 14185 is available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=5.6.
[54] For more information, Category 3 – Access and Availability is available at: http://www.dhcs.ca.gov/services/Documents/MMCD/AATAG10-05-17.pdf.

CONTRACTUAL RELATIONSHIPS AND DELEGATION:
MCPs are permitted to contract with Network Providers to fulfill their obligations to arrange for and deliver health care services under the MCP contracts. If an MCP delegates the responsibility to deliver Medi-Cal covered services from the MCP to a Network Provider, including but not limited to, a health plan partner, medical group, IPA, or clinic, whether under a capitated or fee-for-service payment arrangement, the Network Provider must have an adequate network that meets the requirements set forth in this APL. If the Network Provider does not have an adequate network, the MCP must allow assigned members to access services out-of-network for any deficient network component(s), as required by State and federal law, the MCP contract, and DHCS guidance, including any applicable APLs.[55, 56]

MCPs and their Network Providers must authorize services through out-of-network providers if the network of a delegated Network Provider fails to meet network adequacy requirements. In doing so, members may utilize any provider in or out of the MCP's network regardless of IPA or medical group affiliation. DHCS prohibits the use of an administrative Subcontractor, including but not limited to, an administrative services organization, to restrict an assigned member to a Network Provider's network if that network fails to meet network adequacy standards. Although DHCS certifies the aggregated MCP network, these network requirements apply.

MCPs must have contractual provisions and policies and procedures for ensuring each Network Provider has an adequate network, including the use of administrative Subcontractors that facilitate the referral and/or utilization management process. MCP policies and procedures must align with DHCS' Annual Network Certification process to assess the network adequacy of all Network Providers that are delegated for the provision of Medi-Cal managed care covered services.

MCPs must also have contractual provisions and policies and procedures for imposing CAPs and monetary sanctions on Network Providers when they are out of compliance with network adequacy requirements. This includes timely access requirements, any subcontractual requirements, State or federal law, or DHCS requirements. MCPs must report all significant instances of non-compliance by its Network Providers and the imposition of CAPs or monetary sanctions on a Subcontractor. MCPs must also report Network Provider non-compliance issues when those issues result in the MCP's non-compliance with contractual and legal requirements.[57] MCPs shall report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions

[55] MCP Contract, Exhibit A, Attachment 9, Out-of-Network Providers.
[56] 42 CFR, Section 438.207.
[57] For more information on Network Provider non-compliance, see APL 16-001, or any future iteration of this APL.

pertaining to their obligations under the contract with DHCS to their Managed Care Operations Division contract managers within three business days of discovery or imposition.[58]

CERTIFICATION OF DOCUMENTS AND DATA CERTIFICATION:
MCPs are required to submit complete, accurate, reasonable, and timely Annual Network Certification attachments and 274 file submissions in compliance with this APL and Title 42 of the CFR, Sections 438.207, 438.68, and 438.206(c)(1). The Annual Network Certification falls within the scope of APL 17-005, or any future iteration of this APL, which requires each MCP to submit its certification statement on MCP letterhead by the final business day of each month to its contract manager. Repeated failure to submit this certification statement may result in the imposition of a CAP. DHCS may also impose a CAP on MCPs that submit data, information, or documentation that fail to meet the requirements outlined in Title 42 of the CFR, Section 438.606 and this APL.

NETWORK CERTIFICATION NON-COMPLIANCE:

Preliminary Findings of Non-Compliance
After receiving MCPs' timely submissions, DHCS will provide technical assistance by supplying a worksheet containing preliminary Annual Network Certification findings. MCPs have one week to correct any findings that were caused by a reporting error and begin to remedy findings that would result in a CAP before DHCS imposes a formal Annual Network Certification CAP. In the event the MCP's submission is untimely, DHCS will be unable to provide technical assistance and will impose a CAP.

Corrective Action Plan Process
MCPs who fail to meet the Annual Network Certification components or rectify findings identified in the preliminary Annual Network Certification findings worksheet may be placed under an Annual Network Certification CAP. Monetary sanctions will be imposed for non-compliance with legal and contractual obligations at the time the MCP is placed on a CAP.[59, 60, 61] DHCS also reserves the right to halt significant changes in a network if the MCP fails to meet network certification or CAP requirements. Finally, DHCS reserves the right to impose additional sanctions for continued failures to comply with all

[58] For more information on subcontractual non-compliance, see APL 17-004, or any future iteration of this APL.
[59] WIC, Section 14304 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14304.
[60] 22 CCR, Section 53872. 22 CCR, Section 53872 is available at: https://govt.westlaw.com/calregs/Document/I71D235005F7811DFBF84F211BF18441D?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
[61] For specific policy information, see APL 18-003, or any future iteration of this APL.

network adequacy requirements under State and federal law and the contract with DHCS.[62, 63]

During the CAP process, MCPs must allow Medi-Cal members to access Medi-Cal services out-of-network if the services are not available in-network until DHCS finds that the deficiency has been corrected, regardless of provider or transportation costs. If an MCP submits an updated or new AAS to rectify a network deficiency, the MCP must continue to provide transportation services for members to any Network Providers for which it has an approved AAS until DHCS has reviewed and approved the updated or new request. DHCS will collaborate with the MCP throughout the Annual Network Certification CAP process and provide technical assistance to ensure the MCP corrects all network deficiencies.

Out-of-Network Monitoring and Oversight
DHCS will monitor MCPs that are under an Annual Network Certification CAP to ensure all CAP mandates are being met, including the requirement to authorize care through out-of-network providers within timely access standards. MCPs are also required to ensure Subcontractors and delegated entities adhere to the CAP mandates and comply with out-of-network access requirements. MCPs must submit a policy or procedure to ensure there is a consistent process for out-of-network access compliance.

MCPs under an Annual Network Certification CAP must demonstrate their ability to effectively provide out-of-network access information to members. MCPs must also submit their out-of-network policies and procedures, staff training materials, and call center scripts related to out-of-network access to DHCS. DHCS will review the submissions to ensure compliance with CAP requirements and provide technical assistance if additional updates are required.

POST NETWORK CERTIFICATION MONITORING ACTIVITIES:

Monitoring and Data Quality Review
MCPs will be subject to a quarterly monitoring process, which include a review of additional activities that include, but are not limited to, the following:

- Timely access surveys;
- Investigation of complaints, grievances, appeals, and issues of non-compliance;[64]
- A random sample of MCP Network Provider annual network assessments;

[62] WIC, Section 14304.
[63] 22 CCR, Section 53872.
[64] WIC, Section 14197(f)(2).

- Quality of care indicators;
- Provider-to-member ratios; and
- Out-of-network access requests.

In conjunction with the quarterly monitoring processes, DHCS will continue its existing data quality review processes. Encounter and provider data quality will continue to be evaluated and verified by MCQMD. Encounter and provider data quality metrics may include, but are not limited to, primary source verification that is conducted by DHCS' EQRO through encounter data validation studies, and provider surveys, respectively. In addition, MCPs are subject to a mandatory network adequacy validation performed by the EQRO. The EQRO will validate the previous 12 months captured by the Annual Network Certification.[65]

DHCS reserves the right to perform an ad hoc network certification when there is a significant change to the network that affects the MCP's ability to meet network adequacy requirements, including but not limited to, network changes in the composition of or payments to the network; changes in services, benefits, or geographic service area; or enrollment of a new member group.

Public Reporting

DHCS will post any AAS that has been requested and approved on its website.[66] Additionally, DHCS will post a report that includes the findings of its evaluation and identify any MCPs that are subject to a CAP due to non-compliance with network adequacy standards, along with the MCPs response to the CAP.[67] In addition, DHCS will submit an annual report on each MCP to CMS.[68]

Delegate Monitoring

MCPs are responsible for ensuring that their delegates comply with all applicable State and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Network Providers and Subcontractors.

[65] 42 CFR, Section 438.358(b)(1)(iv).
[66] WIC, Section 14197(e)(3).
[67] WIC, Section 14197(f)(3).
[68] 42 CFR, Section 438.66(e).

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services