



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



GAVIN NEWSOM
GOVERNOR

DATE: April 27, 2021

ALL PLAN LETTER 21-006
SUPERSEDES ALL PLAN LETTER 20-003

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

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 Annual Network Certification (ANC) requirements 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.^{1, 2}

BACKGROUND:

The ANC provides a prospective look at the MCP's network for the upcoming contract year (CY). MCPs are required to annually submit documentation to the Department of Health Care Services (DHCS) to demonstrate the adequacy of their networks for the upcoming CY.³ DHCS reviews all MCP network submissions and provides an assurance of the MCPs' compliance with ANC requirements to the Centers for Medicare and Medicaid Services (CMS) before the CY begins.⁴

POLICY:

DHCS is required by federal and state law to certify each MCP's aggregate network annually for a prospective review of the MCPs' networks.⁵ For purposes of DHCS' ANC, a network consists of Primary Care Physicians (PCPs), specialists, hospitals, pharmacies, ancillary providers, facilities, and other providers that contract with an MCP, or its subcontractors for the delivery of Medi-Cal covered services.⁶ MCPs are

¹ Title 42, CFR, Part 438 is available here: <https://www.ecfr.gov/cgi-bin/ECFR?SID=d15b0ce81c0ea804f39e129fd7f11a5f&mc=true&page=browse>.

² California Law Code is searchable at: <http://leginfo.legislature.ca.gov/faces/codes.xhtml>.

³ For purposes of this APL, the CY is the MCP's fiscal year. Exceptions to this are AIDS Healthcare Foundation and Senior Care Action Network (SCAN) Health Plan for which the CY is the calendar year.

⁴ 42 CFR section 438.207(d).

⁵ 42 CFR sections 438.68, 438.206, and 438.207; WIC section 14197.

⁶ For more information on networks, network providers and subcontractors, including the definitions and applicable requirements, see the MCP's contract, APL 19-001, and any

required to annually submit ANC documentation to DHCS to demonstrate compliance with network adequacy requirements.

MCPs may also be required to submit additional documentation to DHCS when the MCP's network experiences a significant change.⁷ Significant changes may occur as a result of a contract termination that impacts 2,000 or more members or when the changes cause an MCP to become noncompliant with any of the ANC requirements outlined in this APL.⁸ Significant changes can occur throughout the CY. If a significant change occurs within 90 days prior to the ANC filing due date, the MCP should contact its DHCS contract manager to discuss whether the MCP should make a separate filing for the significant change or include the appropriate documentation for the significant change in its annual ANC filing.⁹

I. MEDI-CAL MANAGED CARE ANNUAL NETWORK CERTIFICATION REQUIREMENTS

A. Annual Network Certification Submission Requirements

1. Annual Network Certification Exhibit Submission

Each MCP must complete and submit accurate data and information to DHCS that reflects the entire makeup of all network providers that are reviewed for ANC requirements, no later than May 1 of the CY. MCPs must submit all required ANC exhibits, as outlined in Attachment B and, if applicable, alternative access standard (AAS) requests in Attachment C, with the correct file labeling conventions through the DHCS Secure File Transfer Protocol site. Additionally, MCPs must include the cover sheet referenced in Attachment B, and provide a detailed overview of the MCP's ANC exhibit submissions.

MCPs that fail to submit all complete and accurate ANC exhibits and required submission information by the deadline are subject to the imposition of a corrective action plan (CAP) and/or potential monetary sanctions.

subsequent revisions to the APL. APLs are searchable at:

<http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

⁷ Submission requirements for significant changes and contract terminations are outlined in APL 21-003.

⁸ Reporting and submission requirements for significant changes and contract terminations are outlined in APL 21-003.

⁹ A separate filing must be submitted in accordance with requirements outlined in APL 21-003.

2. 274 File Submission

DHCS will utilize MCPs' monthly 274 File submission to verify the MCP's compliance with the required provider-to-member ratios, mandatory providers and timely access to appointment standards.¹⁰ For purposes of ANC, MCPs' January 274 File submission will be used. DHCS will also utilize the January 274 File submission to review MCP resubmissions of errors identified during the preliminary review process. If DHCS is unable to access the MCP's January 274 File submission due to the MCP's untimely, incomplete or inaccurate submission, the MCP is subject to imposition of a CAP and/or monetary sanctions.

B. Annual Network Certification Requirements

In order to be in compliance with ANC requirements, MCPs must meet each of the following requirements:

1. Network Providers¹¹

Each MCP must maintain an appropriate network of specific provider types to ensure the MCP's network has the capacity to provide all medically necessary services for current and anticipated membership.^{12,13} Additionally, MCPs operating in County Organized Health Systems or Cal MediConnect counties must have an appropriate network of Managed Long Term Services and Supports (MLTSS) providers to provide all medically necessary MLTSS services for current and anticipated members.¹⁴

¹⁰ Title 22, California Code of Regulations (CCR) section 53853(a)(1)-(2); Managed Care Organization Contract Exhibit A, Attachment 6, Provider Network, 3; State Health Official (SHO) Letter 16-006; 28 CCR 1300.67.2.2. CCR is available at:

<https://govt.westlaw.com/calregs/Search/Index>. SHO Letter No. 16-006 is available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf>.

¹¹ For more information on networks, network providers and subcontractors, including the definition and requirements applicable see the MCP's contract with DHCS, APL 19-001 and any subsequent revisions to the APL.

¹² MCPs must maintain a network of providers including adult and pediatric PCPs, non-physician medical practitioners, adult and pediatric mental health outpatient providers, hospitals, pharmacies and ancillary services.

¹³ MCPs may email MCQMDNAU@dhcs.ca.gov to request its anticipated membership.

¹⁴ MLTSS providers include Community Based Adult Service providers, Long-Term Care providers, providers in the Multipurpose Senior Services Program, Intermediate Care Facilities and Skilled Nursing Facilities.

2. Network Capacity and Ratios

MCPs are required to meet or exceed capacity and ratio requirements as outlined in the MCP contract for their model type.^{15, 16} MCP networks must meet the full time equivalent (FTE) ratios of one FTE PCP to every 2,000 members and one FTE physician to every 1,200 members.¹⁷

MCPs may use non-physician medical practitioners to improve primary care access; however, DHCS will not include non-physician medical practitioners for purposes of calculating the PCP and total physician ratios.^{18, 19}

MCPs are also required to meet provider to member ratios for adult and pediatric outpatient mental health providers to ensure timely access to MCP-covered outpatient non-specialty mental health services. DHCS annually calculates the number of mental health providers necessary to cover the projected mental health needs for anticipated members in each county and provides each MCP with the number of mental health providers needed to meet the minimum required provider-to-member ratio.²⁰ This calculation is based on mental health utilization for the previous year.

Additionally, in order to ensure compliance with mental health parity requirements, MCPs that contract with DHCS to provide specialty mental health services in a county must meet the provider-to-member ratios that the county mental health plan would otherwise be required to maintain for outpatient specialty health services and psychiatry services for its current and anticipated membership.²¹

3. Mandatory Providers

Mandatory provider types (MPT) are specific provider types and facilities that MCPs are required to contract with, or offer to contract with. MPTs include Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC),

¹⁵ MCP Contract, Exhibit A, Attachment 6, Network Capacity.

¹⁶ Network ratios are calculated for each reporting unit.

¹⁷ MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.

¹⁸ Title 22 CCR, sections 51240 and 51241.

¹⁹ MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.

²⁰ MCP Contract, Exhibit A, Attachment 20, Outpatient Mental Health Services Providers.

²¹ For more information, see Behavioral Health Information Notice No. 20-012 at:

<https://www.dhcs.ca.gov/formsandpubs/Pages/2020-BH-Information-Notices.aspx>

Freestanding Birth Centers (FBC), Certified Nurse Midwives (CNM), Licensed Midwives (LM), and Indian Health Facilities (IHF).

Federally Qualified Health Centers and Rural Health Centers

MCPs are required to contract with at least one FQHC and one RHC, where available in each county in which the MCP operates.²² Additionally, pursuant to WIC section 14087.325, Local initiative (LI) health plans are required to offer to contract with all available FQHCs and RHCs in each of their counties.²³ LI MCPs must provide supporting documentation of their contracting efforts with all FQHCs and RHCs, even if they have a minimum of one active contract with an FQHC and RHC in each county. Non-LI health plan models must meet minimum contract requirements, but are not required to offer to contract with all available FQHCs and RHCs in their counties.

Freestanding or Alternative Birthing Centers and Midwife Services

MCPs are required to contract with at least one FBC, one CNM, and one LM where available in each county in which the MCP operates in accordance with state and federal network adequacy requirements.^{24, 25, 26, 27} MCPs that have a FBC in their network are not exempt from the requirement to contract directly with a minimum of one CNM and one LM. MCPs must ensure CNMs and LMs are properly enrolled and credentialed when establishing a direct contract with these providers in addition to other requirements outlined in APL 18-022.²⁸

American Indian Health Services

Federal and state law and regulations provide protections for American Indians and American Indian Health Services providers.²⁹ MCPs are required to offer to contract with all IHFs available in each county in which the MCP

²² SHO Letter 16-006 is available at:

<https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf>.

²³ WIC section 14087.325 places the expanded obligation on LIs. Non-LIs are held to the MPT contracting requirements in SHO Letter 16-006.

²⁴ See SHO Letter No. 16-006.

²⁵ MCP Contract, Exhibit A, Attachment 9, Nurse Midwife and Nurse Practitioner Services.

²⁶ WIC section 14132.39, WIC section 14132.4.

²⁷ 42 United States Code section 1396d(a)(17) is available at: <http://uscode.house.gov/>.

²⁸ For additional information on FBC, CNM, and LM contracting requirements, see APL 18-022.

²⁹ 42 CFR section 438.14; Title 22, CCR section 55120 is available at:

<https://govt.westlaw.com/calregs/Search/Index>.

operates.³⁰ IHFs can voluntarily enter into a contract with an MCP at any time. MCPs that are unable to contract with an IHF must allow eligible members to obtain services from out-of-network (OON) IHFs.³¹

MPT Minimum Contracting Requirements

MCPs must meet the requirements below in order to meet the minimum MPT contracting requirements for ANC:

1. Contract with the minimum number of MPTs for each MPT as described above; or
2. Submit an attestation or justification, and maintain all supporting documentation of the MCP's contracting attempts, including failed contracting efforts with MPTs to be provided to DHCS upon request.

Additionally, MCPs must provide policies and procedures (P&Ps) as instructed in Attachment B of this APL to demonstrate compliance and efforts to improve access to services customarily provided by MPTs.

4. Time and Distance Standards

DHCS established time and distance standards in accordance with state and federal law and regulations to ensure members have adequate access to covered services.³² MCPs must meet time or distance standards based on the population density of the county for designated provider types set forth in Attachment A of this APL.^{33, 34}

Time or distance standards apply to obstetrician-gynecologist (OB/GYN) primary care services only if a member elects to use the OB/GYN as a PCP.³⁵ However, regardless of how the OB/GYN is being utilized, the MCP must ensure timely access to care.

³⁰ 22 CCR section 55120.

³¹ 42 CFR section 438.14.

³² Standards are established for both time and distance; however, in order to be compliant with the standards, MCPs must meet either time or distance.

³³ WIC section 14197(b).

³⁴ Time and distance standards must be met for provider types including adult and pediatric PCPs, adult and pediatric core specialists as outlined in Attachment A, OB/GYN primary and specialty care services, hospitals, adult and pediatric mental health providers and pharmacies.

³⁵ Health & Safety Code section 1367.69.

To demonstrate compliance with time or distance, MCPs must submit accessibility analyses that demonstrate coverage of the MCP's entire county, for all ZIP codes, accounting for all current and anticipated members.^{36,37} Attachment B, Exhibit B explains the submission requirements for accessibility analyses and narratives. MCPs that claim to be exempt from submitting AAS requests through Attachment C may file a delivery system AAS justification for DHCS consideration as explained in Attachment B and in further detail in section C.4. of this APL.³⁸

DHCS accepts the Department of Managed Health Care's 100 representational population points mapping methodology when submitting accessibility analyses to meet time or distance for anticipated members. The methodology uses population density to plot 100 representational population points per ZIP code in habitable areas to account for current members, as well as the farthest points of the ZIP code where an anticipated member could potentially live.

5. Timely Access Survey

DHCS conducts a quarterly retrospective timely access survey that measures network providers' and the MCP's overall compliance with appointment wait time standards. DHCS utilizes the annual survey results for ANC.³⁹

The survey includes a statistically valid random sample of network providers to confirm the first three available times for urgent and non-urgent appointments for pediatric and adult members; the availability of interpreter services; the languages spoken by the network providers, and provider site locations.

Additionally, as part of the survey, DHCS contacts each MCP's call center to confirm:

³⁶ For ZIP codes that cross county borders, MCPs are only responsible for compliance with time or distance for the part of the ZIP code that is within the MCP's service area.

³⁷ Additionally, MCPs are not responsible for ZIP codes of Post Office Boxes, unique ZIP codes, and ZIP codes with special considerations. See Attachment B of this APL for more information.

³⁸ WIC section 14197.

³⁹ For more information on network adequacy standards, see Attachment A of this APL.

- Call center wait times do not exceed ten minutes for a MCP call center representative who is knowledgeable and competent regarding the member's concerns to answer the phone;⁴⁰
- A 24/7 triage line is available and triage or screening wait times do not exceed 30 minutes;⁴¹
- Call center representative awareness of a member's right to receive 24/7 hour access to interpretation services.⁴²

DHCS provides timely access survey results to MCPs on a quarterly basis and annually determines the MCP's compliance rates for purposes of ANC. MCPs must submit a proposed corrective action response to any timely access deficiencies identified in the quarterly survey results and identify any changes or corrections the MCP will take to achieve compliance with timely access requirements.

C. Medi-Cal Managed Care Health Plan Alternative Access Standards

1. Alternative Access Standard Request

MCPs must submit AAS requests to DHCS only if the MCP is unable to demonstrate compliance with meeting either time or distance. Before submitting an AAS request, MCPs must make good faith efforts to exhaust all reasonable contracting options with additional providers within the time or distance standards.⁴³ MCPs must submit AAS requests using Attachment C of this APL for DHCS review and approval.

Additionally, DHCS may authorize MCPs to utilize telehealth and mail order pharmacy(ies) as an AAS when they are unable to meet time or distance standards.⁴⁴ However, a member can refuse a telehealth visit or the mail order pharmacy and the MCP must ensure an in-person provider is available regardless of whether they are in network or OON. If an MCP is unable to arrange for an in-person visit with a contracted provider, the MCP must authorize OON services.

AAS requests must be submitted on an annual basis or any time there is a significant change in the MCP's network that results in the MCP not meeting

⁴⁰ 28 CCR section 1300.67.2.2(c)(10);

⁴¹ 28 CCR section 1300.67.2.2(c)(8)(A).

⁴² 22 CCR section 53853(c)-(d).

⁴³ WIC sections 14197(e)(1)-(2).

⁴⁴ WIC section 14197(e)(4).

time or distance standards. In order for the AAS request to be considered for ANC purposes, MCPs must submit the request with the ANC exhibits no later than May 1 of the CY. However, MCPs can submit AAS requests earlier than the submission deadline which may allow DHCS to provide technical assistance, extend DHCS' review period to ensure the submission is complete and/or correct or determine the need for additional supporting documentation.⁴⁵ DHCS will make a best effort to review and respond to AAS requests received after the deadline but cannot guarantee a decision prior to the CMS assurance of compliance submission deadline.

The AAS request submission must detail the facts and circumstances for each AAS request and provide supporting details as outlined in Attachment B, Exhibit C. MCPs are required to utilize Attachment C provided by DHCS, which includes specific data entry requirements, dropdown cells and other functions that allow for use with DHCS' internal databases. Failure to use the correct Attachment C may result in a rejection of the MCP's entire AAS request submission.

When completing Attachment C, MCPs must utilize the following provider resource lists to identify providers for inclusion in the AAS request:

- MCP Monthly 274 File;
- Fee-for-Service Open Data Portal;
- Health Care Options;
- Office of Statewide Health Planning and Development;
- Health Professional Shortage Areas (HPSA).⁴⁶

DHCS will send an AAS determination letter informing the MCP of AAS approvals and denials.⁴⁷ DHCS approves or denies AAS requests for each county, ZIP code, provider type and population served, including specialty type, and analyzes the information provided by the MCP, information from other MCPs operating in the same county and bordering counties, and DHCS' research of closer providers to validate each request.⁴⁸ Approved AAS requests are contingent on the results of DHCS' AAS validation process.

⁴⁵ WIC section 14197(e)(3).

⁴⁶ More information on HPSA designations is available at: <https://data.hrsa.gov/tools/shortage-area/hpsa-find>.

⁴⁷ WIC section 14197(e)(3).

⁴⁸ WIC section 14197(e)(3).

DHCS may revoke any approved AAS requests if an inaccuracy is discovered or the MCP is unable to provide all required supporting documentation during the validation process. MCPs must review and respond to each AAS denial, by either revising the miles and/or minutes; providing updated justifications and evidence of contracting efforts; or providing additional information to assist DHCS in its review.

MCPs must maintain documentation of all efforts to contract with additional OON providers identified in their AAS requests that are in their county and bordering counties where they have network deficiencies. DHCS encourages MCPs to contract with all available providers, including those outside of time or distance standards, to increase their network capacity. Contracting efforts may not be required in cases in which DHCS agrees that the MCP is contracted with the closest provider but is still unable to meet time or distance standards. In such instances, the MCP must provide additional information in Attachment C.

MCPs must provide all documentation of failed contracting efforts to DHCS upon request, during the AAS validation process or at any time DHCS requests additional documentation. DHCS may request the MCP to perform additional contracting efforts if DHCS identifies additional providers that may correct a network deficiency during the internal review process.

2. Telehealth Providers

MCPs may use telehealth providers as an AAS when they are unable to meet time or distance standards and to increase the network capacity when submitting AAS requests if they are unable to contract with a sufficient number of in-person providers; however, MCPs cannot require members to access telehealth providers in place of in-person services.^{49, 50, 51} Since a member cannot be required to use telehealth, MCPs must provide transportation to a network provider and meet timely access standards for medically necessary services when a member is offered a telehealth visit but requests an in-person visit.⁵² MCPs that request to utilize a telehealth provider as an AAS, must submit supporting documentation and evidence of failed contracting efforts with in-person providers for DHCS review and verification, as detailed in Attachment B of this APL.

⁴⁹ WIC section 14197(e)(1)(A).

⁵⁰ WIC section 14197(e)(4).

⁵¹ WIC section 14132.72(f).

⁵³ WIC section 14197(e)(1)(A).

If MCPs elect to utilize telehealth providers as an AAS, telehealth services must be made available to all members in the county. Telehealth services must be consistent with the criteria outlined in the Medi-Cal Provider Manual and APL 19-009 (Revised), including subsequent revisions to this APL, and be certified and enrolled in the Medi-Cal Program and credentialed by the MCP.

3. Mail Order Pharmacy

MCPs may utilize mail order pharmacies as an AAS when they are unable to meet time or distance standards after they have made reasonable attempts to contract with a pharmacy with a physical location.⁵³ MCPs that request to use a mail order pharmacy as an alternative access to care must submit supporting documentation and evidence of all contracting efforts to DHCS for review and approval as outlined in Attachment B, Exhibit C-3. When using mail order pharmacies, MCPs must have procedures in place to ensure that all medications are delivered in a timely manner, consistent with the member's medical need, even if medications cannot be sent through the mail, the member cannot receive medications through the mail, or the member has confidentiality concerns about receiving medications by mail.⁵⁴

4. Delivery System Alternative Access Standard

In cases where an MCP is unable to meet time or distance due to its delivery system, DHCS is authorized to determine if the MCP is capable of delivering the appropriate level of care and access to members through a delivery system AAS.⁵⁵ In order to be considered for a delivery system AAS justification, the MCP must submit a written request to DHCS following the instructions in Attachment B of this APL.⁵⁶ If accepted, DHCS will provide the requesting MCP a template to submit the formal delivery system AAS justification.

⁵³ WIC section 14197(e)(1)(A).

⁵⁴ WIC section 14185(a) is available at:

https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=5.6

⁵⁵ WIC section 14197(e)(1)(B).

⁵⁶ WIC section 14197(e)(2).

DHCS will review the MCP's submission to determine if the justification for a delivery system AAS meets the needs of the MCPs members and ensures appropriate and timely access to care.⁵⁷ An approved delivery system AAS is valid for one CY; however, if DHCS approved an MCP's delivery system AAS justification for the previous CY, the MCP can submit an attestation certifying it is seeking to utilize the previously approved justification for the current ANC.

5. Additional Medi-Cal Managed Care Health Plan Requirements for Approved Alternative Access Standards

MCPs that receive AAS approvals from DHCS must inform their affected members who reside in the ZIP code where AAS requests were approved by posting all approved AAS on the MCP's website within 30 days after DHCS publishes the statewide results.^{58, 59}

MCPs that have an approved AAS for a core specialist are required to assist any requesting member in obtaining an appointment with an appropriate OON core specialist, in person or via telehealth. When assisting the member, the MCP must make its best effort to establish a member-specific case agreement with an OON core specialist at the Medi-Cal fee-for-service rate or a mutually agreed upon rate, unless the MCP has already attempted to establish a member-specific case agreement with the OON core specialist in the most recent fiscal year, and the core specialist has refused to enter into an agreement.⁶⁰ If this cannot be arranged, the MCP must arrange for an appointment with an in-network specialist. The OON core specialist must be able to provide services to a member within the applicable time or distance and timely access standards and, in cases where the OON specialist is not able to provide services to a member under these standards, the MCP must arrange for non-emergency medical transportation or non-medical transportation.⁶¹

Further, MCPs must continually demonstrate that they have a process in place to arrange services through telehealth (at the member's preference) or to provide transportation for members who need to access services outside of time or distance standards.⁶²

⁵⁷ WIC section 14197(e)(3).

⁵⁸ WIC section 14197.04(c).

⁵⁹ The AAS approvals are posted after the ANC submission to CMS and after CAPs are closed.

⁶⁰ WIC section 14197.04(a).

⁶¹ WIC section 14197.04(b).

⁶² WIC section 14197(f)(1) and (2).

D. Annual Network Certification Validations

DHCS validates MCP submissions by reviewing the 274 File submission, contracts with network providers, mandatory providers and AAS requests. As part of this process DHCS evaluates the MCP's contracting efforts, verifies the authenticity of contract signature pages, and reviews other evidence and supporting documentation and determines the accuracy and completeness of the submission. DHCS may request additional MCP documentation at any time in order to confirm that the information included in the submission is accurate.

An MCP's failure to provide the requested documentation or a determination by DHCS that the information in the submission is invalid or inaccurate will lead to rescission of the ANC approval, implementation of a CAP, and/or imposition of monetary sanctions.

II. NON-COMPLIANCE WITH NETWORK CERTIFICATION REQUIREMENTS

A. Medi-Cal Managed Care Health Plan Preliminary Review of Submission

DHCS will provide technical assistance to all MCPs that submit a complete and accurate ANC submission by the deadline. DHCS may not be able to provide technical assistance to MCPs that do not meet the submission deadline.

Technical assistance will be provided in the form of a worksheet and will contain DHCS' initial review of the quality, accuracy and completeness of the MCP's submission. The MCP will have the opportunity to resubmit a corrected submission for identified errors, incompleteness, and inaccuracies. No additional assistance outside of the technical assistance process will be provided to MCPs, therefore the submission resulting from the technical assistance process will be reviewed for compliance with the requirements.

B. Medi-Cal Managed Care Health Plan Corrective Action Plans and Monetary Sanctions

DHCS will impose a CAP on MCPs that fail to meet ANC requirements, are unable to fully rectify deficiencies identified through technical assistance, or that fail ANC validations. MCPs must submit a detailed plan of action setting forth all steps the MCP will take to correct the ANC deficiencies identified in the CAP notification letter. MCPs will have six months to correct all deficiencies and must comply with all CAP mandates set forth below until the CAP is closed.

Additionally, DHCS is authorized to impose monetary sanctions for failure to comply with network adequacy requirements.⁶³ DHCS may impose sanctions for not meeting ANC requirements at the end of the CAP period and additional sanctions for repeated and continued failures to comply with network adequacy requirements, CAP mandates, or the inability to correct a deficiency within the CAP timeframe.⁶⁴

C. Medi-Cal Managed Care Health Plan Corrective Action Plan Mandates

An MCP under an ANC CAP must comply with the following mandates:

- Provide an initial CAP response no later than 30 days after the issuance of the CAP notification letter;
- Provide DHCS with bi-monthly (once every two months) status updates that demonstrate action steps the MCP is undertaking to correct the CAP deficiency(ies);
- Authorize OON access to medically necessary providers within timely access standards and applicable time or distance standards, regardless of associated transportation or provider costs until the CAP is completed by the MCP and closed by DHCS; and
- Demonstrate its ability to effectively provide OON access information to members and ensure that its member services staff, network providers, and subcontractors are trained on the mandates, including the right for members to request OON access for medically necessary services and transportation to providers where the MCP is unable to comply with ANC requirements.

DHCS will review the CAP submissions and the MCP's deliverables to ensure compliance with CAP mandates. DHCS will provide technical assistance during the CAP timeframe and also if additional corrective action is required.

If an MCP submits an updated or new AAS to address a network deficiency, the MCP must continue to comply with its previously approved AAS until the updated or new AAS is approved by DHCS. Before approval, MCPs must continue to provide transportation services for members to any network providers or OON providers under the terms of the previously approved AAS.

⁶³ WIC section 14197.7.

⁶⁴ WIC section 14197.7.

MCPs are also required to ensure that their network providers and subcontractors are informed of and adhere to the CAP mandates and comply with all OON access authorization and transportation requirements.

III. SUBCONTRACTORS' COMPLIANCE WITH NETWORK ADEQUACY STANDARDS

MCPs are required to have processes in place to ensure subcontractors comply with network adequacy requirements. MCP members who receive care through subcontractors must have the same access to a subcontractor's network as they would through the MCP's provider network. It is the MCPs responsibility to ensure that there are sufficient contracts in place with subcontractors to ensure that MCPs meet all ANC requirements and comply with all ANC requirements outlined in this APL. Additionally, MCPs must have contractual provisions, and P&Ps in place for identifying when a subcontractor's network adequacy is deficient and results in the MCP being out of compliance with any of the ANC requirements. When an MCP finds a subcontractor has a network adequacy deficiency, the MCP must impose a CAP until all deficiencies are corrected. MCPs must report all significant instances of a subcontractor's deficiencies and impositions of CAPs to DHCS.

IV. POST NETWORK CERTIFICATION MONITORING ACTIVITIES

MCPs are subject to quarterly monitoring by DHCS, which may include requests for additional evidence and information, including, but not limited to, timely access surveys; investigation of complaints, grievances, appeals, and issues of non-compliance with contractual requirements and policy guidance; MCP network monitoring and oversight assessments; quality of care indicators; data reviews for utilization capacity and provider-to-member ratios; authorization of OON requests; and the provision of transportation services.⁶⁵

In conjunction with quarterly monitoring processes, DHCS continues its existing data quality review processes by verifying encounter data and provider data quality. Encounter and provider data quality performance metrics include, but are not limited to, primary source verification that is conducted by DHCS' External Quality Review Organization through encounter data validation studies and provider surveys, respectively.

MCPs are ultimately responsible for ensuring members obtain medically necessary covered services from an OON provider if the services cannot be provided by a

⁶⁵ WIC section 14197(f)(2).

network provider in accordance with contractual requirements. MCPs must also ensure that transportation is available when necessary to access OON providers.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCP) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCP contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their subcontractors and network providers 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 subcontractors and network providers.

If you have any questions regarding this APL, please contact your MCP contract manager.

Sincerely,

Original Signed by Nathan Nau

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