Annual Network Certification Instruction Manual
Attachment B

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Purpose:

This Annual Network Certification (ANC) instruction manual (Manual) outlines the specific data and submission requirements that Medi-Cal managed care health plans (MCPs) must submit to the Department of Health Care Services (DHCS) for their ANC to demonstrate compliance with network adequacy standards set forth in APL 21-006.

DHCS will review, validate and certify MCP networks in each county to ensure members have access to appropriate service providers and all medically necessary services.[1]

MCP Resources:

DHCS has created a SharePoint site to house resources for MCPs, including the 274 Provider Directory Companion Guide (Companion Guide), Attachment C, reporting unit designation, the Taxonomy Crosswalk and other resource tools.[2]

DHCS Data Review Process:

MCPs must enter their data in the 274 File as instructed in the Companion Guide and outlined in this Manual in order for a network provider to be counted for ANC.[3] DHCS utilizes 274 File data to determine compliance with ANC, as well as the Timely Access Survey and quarterly monitoring reporting template. Detailed instructions on data entry for the 274 File can be found in the Companion Guide. However, this Manual contains specific ANC data entry requirements to ensure network providers are captured correctly for ANC purposes.

Submission Requirements:

As detailed in this Manual, MCPs may prepare and submit required information about their provider network as earlier than the submission deadline, but all exhibits must be submitted **no later than May 1**, following the guidelines below:

- MCPs with staffing changes will need request access to the Secure File Transfer Protocol (SFTP) site before the due date to ensure a timely submission. Staff who have previously been granted access do not need to re-request SFTP access.[4]
- Complete the Submission Checklist and Cover Sheet and submit with ANC exhibits via the SFTP site. The Cover Sheet can be found on the SharePoint site.

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[1] In accordance with Title 42 of the Code of Federal Regulations (CFR) sections 438.68, 438.207, and 438.206(c)(1) and Welfare and Institutions Code (WIC) section 14197. 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=7edf2ff9bbcb77d617805bcaf451a96a&mc=true&node=pt42.4.438&rgn=div5. WIC Section 14197 is available here: http://leginfo.legislature.ca.gov/faces/codes.xhtml.

[2] To request access to the SharePoint site, email MCQMDNAU@dhcs.ca.gov.

[3] For further information regarding the 274 File, see APL 16-019: Managed Care Provider Data Reporting Requirements, or any subsequent revision to this APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

[4] To request access to the SFTP site, email DHCS-PMU@dhcs.ca.gov

- Submit ANC Exhibits via the SFTP site using the subject title "**ANC Exhibit [XX] [HEALTH PLAN NAME]**".
- Submit complete and labeled ANC Exhibits to DHCS via SFTP using the MCP's specific Provider Network File subfolder.
- Submit ZIP files if there are multiple ANC Exhibits for each MCP's county.
- Send email to MCQMDNAU@dhcs.ca.gov and the MCOD Contract Manager confirming the date on which all required ANC Exhibits are submitted.

Exhibit A: MCP Network Providers

Overview

- DHCS utilizes the MCP's January 274 File to determine compliance with the MCP's required provider to member ratios and mandatory provider contracting requirements. DHCS will utilize an updated 274 File to confirm the MCP's exhibit resubmissions as part of the Corrective Action Plan (CAP).
- MCPs must ensure that all network providers reviewed as part of ANC requirements are entered in the 274 File correctly as instructed in the Companion Guide, including providers that are a part of the MCP's network but may be outside of the county(ies) in which the MCP operates. Provider types reviewed as part of ANC requirements can be found in Attachment A of this APL. However, it does not preclude the MCP's responsibility to ensure that all other contracted network providers who provide medically necessary Medi-Cal covered services to members are entered in the 274 File correctly.

Exhibit A-1: MCP Network Providers
DHCS will review the MCP's 274 File in the following hierarchical order:

1. Provider Group Network Role Code (3G, 3E)'
2. Licensure Type Code (utilizing these as the only accepted entries for purposes of ANC: MD, DO, CSW, MFT, PSY, NP, PA
3. 274 File Format Indicator (Sees Children, HIV/AIDS Specialist, Telehealth or Community-Based Adult Services)
4. Facility Type Code
5. Institutional Facility Type Code
6. Taxonomy[5]

Exhibit A-2: Network Provider to Member Ratios
DHCS calculates Full-Time Equivalent (FTE) provider counts and projected anticipated membership based on the methodology described below.

Specialists that operate as Primary Care Physicians (PCPs), in addition to their specialty type, can be counted towards PCP ratios. However, the provider's contract with the MCP must include the provider's scope of practice to include PCP services. DHCS will verify a provider's scope of practice through its validation process.

FTE Providers
Each network provider has a maximum FTE of 100% for each MCP. DHCS calculates a network provider's FTE by taking the sum of the network provider's FTE divided by 100 for all distinct National Provider Identifiers (NPIs) contracted with the MCP. Telehealth providers may be considered to meet provider to member ratio requirements if they do not provide in-person services.

[5] To request the current DHCS Taxonomy Crosswalk, email DHCS-PMU@dhcs.ca.gov.

Projected Anticipated Membership
DHCS calculates anticipated membership for each MCP based on the contractual capacity requirements or its allotted member assignment, whichever is greater, and predicted coverage through stepwise autoregressive forecast based on the previous 18 months enrollment.[6]

Non-Physician Medical Practitioner Supervision Ratios
MCPs may utilize non-physician medical practitioners to improve access to primary care in their network; however, a licensed physician must supervise all non-physician medical practitioners. MCPs must not exceed the following physician supervision to non-physician medical practitioner ratios:[7, 8]

- Nurse Practitioners: 1:4
- Physician Assistants: 1:4
- Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives (CNM) or two (2) physician assistants.

MCPs must ensure that each FTE non-physician medical practitioner does not have an individual caseload that exceeds 1,000 members. If the MCP contracts with non-physician medical practitioners, the total number of members assigned to a PCP may increase to 1,000 additional members if the non-physician medical practitioner that is practicing with the PCP is a FTE. However, MCPs must continue to ensure that members are assigned in accordance with these ratios and that PCPs do not exceed the network provider to member ratio of 1 FTE PCP to 2,000 members and 1 FTE non-physician medical practitioner to 1,000 members.

Exhibit A-3: MCP Mandatory Providers

Mandatory Providers must meet the following definitions to be considered for ANC review. Instructions on how to enter Mandatory Providers in the 274 File are detailed in the section below.

Facility	Overview	Resources
Federally Qualified Health Center (FQHC)	An entity defined in section 1905 of the Social Security Act (42 U.S. Code (USC) section 1396d(l)(2)(B)) that provides primary care and ambulatory services.[9]	https://npidb.org/organizations/ambulatory_health_care/federally-qualified-health-center-fqhc_261qf0400x/ca/.
Rural Health Center (RHC)	An entity defined in section 1905 of the Social Security Act (42 USC section 1395x(aa)(2)) that provides primary care and ambulatory services.	https://web.carhc.org/Primary-Care.

[6] The previous 18 months of enrollment is provided on the "Medi-Cal Managed Care Enrollment Report" report, available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report.
[7] MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.
[8] Title 22 of California Code of Regulations (CCR), sections 51240 and 51241. Title 22 CCR is available at: https://govt.westlaw.com/calregs/Search/Index.
[9] USC is searchable at: http://uscode.house.gov/browse.xhtml.

Facility	Overview	Resources
Freestanding Birth Center (FBC)[10]	A health facility that is not a hospital where childbirth is planned to occur away from the pregnant woman's residence; that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are in their scope of work as defined in 42 USC section 1396d(l)(3)(B).	The California Health and Human Services (CHHS) Agency provides and maintains the Licensed and Certified Healthcare Facility Listing and the list is available at https://data.chhs.ca.gov/dataset/healthcare-facility-locations.
Indian Health Facility (IHF)	A tribal or urban Indian organization operating health care programs or facilities with funds from the Department of Health and Human Services, Indian Health Service, appropriated pursuant to the Indian Health Care Improvement Act (25 USC section 1601 et. seq.) and the Snyder Act (25 USC section 13 et. seq.).	The List of American Indian Health Program Providers is available in Attachment 1 of APL 17-020: American Indian Health Programs, or any future iterations of APL 17-020 or this APL and its attachments.
Certified Nurse Midwife (CNM)	A registered nurse who has successfully completed a program of study and clinical experience meeting state guidelines or has been certified by an organization recognized by the State as defined in 42 USC section 1395x(gg).	CHHS provides and maintains the list of CNMs and Enrolled Medi-Cal Fee for Service (FFS) Providers. The list is available at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers
Licensed Midwife (LM)	An individual to whom a license to practice midwifery has been issued to assist a woman in childbirth as long as progress meets criteria accepted as normal as defined in California Business and Professions Code (BPC) 2507.	CHHS provides and maintains the list of LMs and Enrolled Medi-Cal FFS Providers. The list is available at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers .

[10] The FBC must be certified as a Comprehensive Perinatal Services Program (CPSP) provider pursuant to WIC section 14134.5 and meet the standards for certification established by the National Association of Childbearing Centers. The FBC must be located in proximity, in time or distance, to a facility with the capacity for management of obstetrical and neonatal emergencies, including the ability to provide cesarean section delivery, within 30 minutes from time the emergency is diagnosed. WIC section 14134.5 can be found at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14134.5.&lawCode=WIC.

Mandatory Provider Type 274 File Data Entry

MCPs must enter each contracted MPT in the 274 File using the instructions outlined below. MCPs must also consult the Companion Guide for further details on data entry.

Mandatory Provider Types	
FQHC	• Facility Type Code: "17: Non-Individual-Other Service Providers" • Institutional Facility Code: "77: Clinic-Federally Qualified Health Center" • Match the provider information in the resource labeled "FQHC and RHC Current Rates."
RHC	• Facility Type Code: "17: Non-Individual-Other Service Providers" • Institutional Facility Code: "71: Clinic-Rural Health" • Match the provider information in the resource labeled "FQHC and RHC Current Rates."
FBC	• Facility Type Code: "17: Non-Individual-Other Service Providers" • Institutional Facility Code: "84: Free Standing Birthing Center" • Match the provider information in the resource labeled "Licensed and Certified Healthcare Facility Listing."
IHF	• Facility Type Code: "17: Non-Individual-Other Service Providers" • Institutional Facility Code: "70: Clinic-Indian Health Services Facility" • Match the provider information in the resource labeled "List of American Indian Health Program Providers."
CNM	• Licensure Type: "NPA: Nurse Practitioner/Physician Assistant/Advanced/Masters RN" • Taxonomy: "367A00000X" • Associate physician extenders with a physician previously identified. The affiliation must be submitted with the physician extender's data. A physician extender is associated with a physician through the prov_affiliation_type and prov_affiliated_NPI fields
LNM	• Taxonomy: "176B00000X" • Match the provider information in the resource labeled "Enrolled Medi-Cal Fee for Service Providers."

Mandatory Provider Type Documentation

MCPs must also follow the instructions below to submit additional documentation when they are unable to contract with an MPT to meet the requirements outlined above. MCPs must submit an

attestation and/or justification for each applicable county and MPT and all supporting documentation to DHCS upon request.

No Contract due to no active providers in county	No contract due to inability to contract with available providers in county[11]
Attestation stating that no mandatory provider types are available in the county; and **Policies and Procedures** detailing the processes and what protections MCPs have in place a process for members to access services that are customarily provided by the mandatory providers either in or out of the county, including transportation.	**Justification** detailing the scenario and rationale for each mandatory provider that is not in the MCP's network. Each scenario could be the same; however, the rationale should be specific to the identified provider and county since the last ANC submission; [12] and; All Documentation of Failed Contracting Efforts must be submitted to DHCS upon request; and **Policies and Procedures** detailing the process and what protections MCPs have in place for members to access services that are customarily provided by the mandatory providers either in or out of the county.

Local Initiative MCPs

MCPs that operate in a local initiative (LI) health plan model are required to offer to contract with all available FQHCs and RHCs in each of their service area(s).[13] LI MCPs must submit supporting documentation of their contracting efforts with FQHCs and RHCS even if they have a minimum of one active contract with an FQHC and RHC in each service area. Additionally, LI MCPs are subject to the submission requirements above if they do not meet the minimum contract requirement.

Exhibit A-4 Mandatory Provider Validations: Supporting Documentation

MCPs are required to provide documentation to DHCS to confirm they have executed contracts with MPTs.

MCPs may also attest that no changes have occurred since the last ANC submission; however, they will still be required to submit evidence of contracting efforts and the required documentation as outlined above. If the MCP is contracted with a mandatory provider and the most recent 274 File does not accurately reflect this, the MCP must take immediate steps to correct its 274 File in future submissions.

[11] MCPs must submit a justification if they are unable to contract with all available IHFs in each county it services.

[12] Scenarios may include, but are not limited to, provider was unwilling to accept MCP contract or Medi-Cal FFS rates; provider refused to contract with MCP; provider does not meet MCP's professional standards, credentialing requirements, or has a disqualifying quality of care issue; provider is currently in contracting negotiations with the MCP (justification must include rationale and timeframes for execution); or another scenario with a detailed description of the rationale.

[13] WIC Section 14087.325

Exhibit A-5: Network Provider Validations: Supporting Documentation
DHCS will conduct provider validations by requesting contract signature pages for a sample of providers from the MCP's 274 File to directly verify their contracting status with the MCP.

Exhibit B: MCP Time and Distance[14]

MCPs must submit an accessibility analysis for Exhibits B-1 through B-6 to demonstrate compliance with time or distance standards in each county for each provider type.[15,16] MCPs may utilize the Accessibility Analysis Template provided on the SharePoint site or the MCP software that generates the accessibility analysis. However, once generated, the MCP must ensure that the fields of the exported accessibility analyses are in the order they appear on the Accessibility Analysis Template. DHCS may reject an accessibility analysis if it is not submitted on the template provided or if the fields do not follow the order of the template.

Exhibit B-1: Adult and Pediatric PCPs	• Adult PCPs • Pediatric PCPs
Exhibit B-2: Adult and Pediatric Core Specialists[17]	• Adult Core Specialist by specialty type • Pediatric Core Specialist by specialty type
Exhibit B-3: **B-3a: Primary Care Obstetrician-Gynecologist (OB/GYN)** **B-3b: Specialty Care OB/GYNs**	B-3a – Submit Policies and Procedures detailing at a minimum: • Process for OB/GYNs to contract with the MCP as a PCP, if desired, and not requiring OB/GYNs to be PCPs; • Process to ensure timely access to PCPs and OB/GYN specialists if there are no OB/GYN PCPs in the MCP's network; and • Process to provide transportation to an OB/GYN PCP that is outside of time or distance standards, upon the member's request. B-3b – Accessibility Analysis • Adult Specialty Care OB/GYN • Pediatric Specialty Care OB/GYN
Exhibit B-4: Hospitals	• Hospitals
Exhibit B-5:	• Adult Outpatient Mental Health Providers • Pediatric Outpatient Mental Health Providers

[14] Standards are established for both, time and distance; however, in order to be compliant with the standards, MCPs must meet either time or distance.
[15] Time and distance standards vary depending on provider type and county size; see WIC section 14197 and Attachment A of this APL for county classifications.
[16] For information about which providers to report for each provider type, see the current DHCS Taxonomy Crosswalk.
[17] Adult and Pediatric Core specialists are outlined in Attachment A of this APL.

Adult and Pediatric Mental Health Outpatient Providers	
Exhibit B-6: Pharmacies	• Pharmacies

Additional Guidance for Accessibility Analysis Submissions:

MCPs must:

- Demonstrate coverage for all ZIP codes in the entire county. For ZIP codes that cross county borders, the MCPs are only responsible for compliance with time or distance standards for the part of the ZIP code that is within the MCPs service area. . DHCS will accept the 100 representational population points mapping methodology to be applied to MCPs accessibility analyses to meet DHCS' time or distance standards for anticipated members which uses population density to plot 100 representational population points by ZIP code in habitable areas.
- Not add additional columns to the Accessibility Analysis Template.
- Complete separate accessibility analyses for each provider type and population serviced labeling them as Exhibits B-1 through B-6.
- Verify that time or distance standards are met in the ZIP code for current and anticipated membership regardless of whether members currently reside in mapped area.
- Account for all ZIP codes with the exception of Post Office (PO) Boxes, unique ZIP codes, and ZIP codes with special considerations.[18, 19]
- Ensure that analyses are conducted using peak travel time to account for accurate mapping.[20]

[18] DHCS utilizes the United State Postal Services' (USPS) Look Up a ZIP Code™, available at: https://tools.usps.com/go/ZipLookupAction_input.

[19] Unique ZIP codes are assigned to a company, government agency, or entity with sufficient mail volume, based on average daily volume of letter size mail received, availability of ZIP code numbers in the postal area, and USPS cost-benefit analysis.

[20] For purposes of completing the accessibility analyses, peak travel time is defined as "rush hour" between the hours of 7:00AM-10:00AM and 3:00PM-6:00PM.

Exhibit C: MCP Alternative Access Standards

If time or distance is not met for any of the specified provider types outlined in Exhibits B-1 through B-6, the MCP must submit an Alternative Access Standard (AAS) request. MCPs may begin submitting their AAS request for the current ANC on February 1 of each year and are encouraged to submit early to ensure AAS requests are approved or denied before DHCS' ANC submission deadline.

Exhibit C-1: Alternative Access Standard Request Submission (if applicable)

Submission Requirements

MCPs are required to submit all AAS requests using the Attachment C template on the SharePoint site, which includes prepopulated dropdown selections. MCPs submissions must be correctly entered into the AAS request using correct data entry as outlined in the Attachment C instructions. Failure to correctly input the data and all required information may result in requests being rejected.

Each AAS request must identify at least **two** nearest OON providers that the MCP attempted to contract with or a detailed justification of the reason why contracting efforts were not attempted, or the date the MCP contacted the providers to discuss contracting with the MCP and the number of contracting attempts the MCP made for each request.

Contracting efforts may not be required if the OON provider identified for the AAS is not within time or distance standards, **and** the MCP is contracted with the closest provider. In such cases, the MCP must provide additional information for DHCS' consideration in column AK (Additional Information for Consideration) of Attachment C. Additionally, if the MCP's research conflicts with DHCS's findings (i.e., MCP contacted the closer provider and verified that the provide does not practice at the identified location or does not see the population that DHCS identified) the MCP may include an explanation in column AK of Attachment C.

MCPs must maintain documentation of all failed contracting efforts and provide to DHCS upon request. Failure to provide the required information for each request will result in an automatic denial of the AAS request.

Best Practices and Additional Guidance include:

- MCPs must identify and attempt to contract with two nearest OON providers licensed to provide care within California, unless the AAS justification states that the MCP attempted and was unsuccessful in contracting with the providers within California.
- MCPs must ensure that the nearest OON providers are at distinct addresses.
- MCPs cannot list Medical Groups or Independent Physician Associations (IPA) in Attachment C; only individual provider names must be listed, even if the provider belongs to a Medical Group or IPA.
- MCPs must map the proposed miles and minutes for the nearest OON providers to the farthest edge of the ZIP code.
- MCPs should round each AAS request to the nearest five, for both miles and minutes to account for differences in mapping software.

- The proposed alternative standards will need to meet or exceed the actual distance the potential members could be required to travel, but not exceed the measured distance by so much that the standard is no longer tailored to match the real geographic challenges of a particular ZIP Code.
- Do not submit AAS requests for PO Boxes, unique ZIP codes, or ZIP codes with special considerations, such as carved-out ZIP codes.[21]
- Do not add additional columns to Attachment C. Instead, submit a narrative, when applicable, in the Additional Information for Consideration column (column AK). Additionally, when referencing providers in column AK, state the specific provider's name.
- Health Professional Shortage Areas (HPSAs) is only an acceptable justification for an AAS if the request is for PCPs or Mental Health Outpatient Providers. DHCS will deny the AAS for any other provider types submitted.
- If a ZIP code spans across county lines, the MCP is only responsible for the area within that ZIP code that fall inside the county where the MCP is authorized to operate. In these instances, the MCP must notate this in column AK so DHCS can take this into account when reviewing and making its AAS determination.
- If DHCS denies an AAS request, the MCP must update and resubmit Attachment C with correct and accurate data and information using the AAS Helpful Tips document on the SharePoint site.
- MCPs that fail to request a reasonable number of additional miles or minutes beyond the current standards may be denied; therefore, it is in the best interest of the MCP to review and follow the best practices instructions outlined in this Attachment when completing Attachment C to submit AAS requests.

Resources

At a minimum, MCPs must utilize all of the following resources to complete Attachment C.

MCP Monthly 274 File	MCPs should initially review the data for their own 274 monthly File(s) before submitting an AAS request to DHCS. Through internal reviews, DHCS has confirmed in-network providers and denied AAS requests due to the MCP being compliant with time or distance standards in the requesting ZIP code and an AAS was not necessary.
Managed Care Open Data Portal	Listing all MCP provider network submissions to assist with contracting efforts: https://data.chhs.ca.gov/dataset/managed-care-provider-network.
Fee-for-service (FFS) Open Data Portal	Provided and maintained by CHHS that lists all adult providers enrolled in the Medi-Cal program. The FFS Open Data Portal is available at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers.
Health Care Options (HCO)	A listing of PCPs and hospitals that are currently contracted with MCPs throughout the State. HCO is available at: https://www.healthcareoptions.dhcs.ca.gov/choose/find-provider.
Office of Statewide Health Planning and Development (OSHPD)	Lists the facilities (hospitals) located throughout the State that are licensed by OSHPD and the Department of Public Health. OSHPD

[21] MCPs may request a current list of DHCS' ZIP code list.

	is available at: https://oshpd.ca.gov/data-and-reports/data-resources/.
Health Professional Shortage Areas (HPSA)	A resource that delineates health professional shortage areas in primary care and mental health throughout the State: HPSA is available at: https://data.hrsa.gov/tools/shortage-area/hpsa-find.

Exhibit C-2: Telehealth Providers (if applicable)
If the MCP is using telehealth providers to meet network adequacy standards, the MCP must submit evidence of in-person provider contracting efforts, including, but not limited to:

- **Narrative** detailing the name of the in-person provider(s) that the MCP attempted to contract with and the frequency of the contracting efforts; and
- **Documentation** demonstrating contract offers and all related correspondence, scheduled phone calls, good faith negotiations, contract records, marketing materials and advertisements, and follow up attempts after initial contract offer or outreach.

Additionally, the MCP must provide a narrative, attestation and policies and procedures that demonstrate that members who prefer an in-person visit receive one. The MCP must submit the following items related to the use of telehealth services:

- **Narrative** detailing the
  - Name(s) of the telehealth company or individual provider;
  - NPI(s) of the telehealth company/provider;
  - Specialty type of the company/provider (i.e. psychiatry, dermatology);
  - Geographical service area of the company/provider (i.e. county, region);
  - Company/provider availability (i.e. FTE);
  - Explanation of the availability (i.e. additionally an in-person provider);
  - Medical group affiliation;
- **Attestation** that the MCPs cannot require members to utilize a telehealth provider when they prefer to access in-person services; and
- **Policies and procedures** that must at a minimum detail:
  - How the MCP advises its members of their right to access in-person services if that is the member's preference, when the AAS is approved; and
  - How the MCP notifies its members that transportation to a network or out-of-network (OON) provider within timely access standards is provided.

Exhibit C-3: Mail Order Pharmacy (if applicable)
If the MCP is using mail order pharmacy to meet network adequacy standards, the MCP must submit evidence of contracting efforts, including, but not limited to:

- **Narrative** detailing the name of the brick and mortar pharmacy(ies) and the frequency of the contracting efforts; and
- **Documentation** demonstrating contract offers via email/letter, scheduled phone calls, good faith negotiations, contract records, marketing materials and advertisements, and follow up attempts after initial contract offer or outreach.

Additionally, the MCP must provide a narrative, attestation and policies and procedures that detail the mail order pharmacy the MCP will utilize and how members will access pharmacy services:

- **Narrative** detailing the
  - Name(s) of the mail order pharmacy;
  - NPI(s) of the mail order pharmacy;
  - Geographical service area of the company/provider (i.e. county, region);
- **Attestation** that the MCP cannot require members to utilize mail order pharmacy services in place of in-person services; and
- **Policies and procedures** that must at a minimum detail:
  - How the MCP advises its members of their right to fill prescriptions at a network or OON pharmacy with a physical location when the AAS is approved;
  - How the MCP ensures timely delivery of any medication that cannot be sent through the mail; and
  - How the MCP notifies its members that transportation to a network or OON pharmacy within timely access standards for medically necessary medications will be provided.

Exhibit C-4: Delivery System Alternative Access Standard (if applicable)
MCPs may submit a request for DHCS approval if it can demonstrate that its delivery structure is capable of delivering the appropriate level of care and access to their members and meet anticipated utilization outside of ANC requirements. An MCP may request the Delivery System (DS-AAS) and DHCS is authorized to determine if the requesting MCP has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access when making the decision to approve this type of AAS request. [22]

The MCP must submit a request to DHCS by emailing MCQMDNAU@dhcs.ca.gov justifying how its delivery structure is capable of delivering the appropriate level of care and access. If DHCS determines that the initial request is justified, DHCS will provide a template for the MCP to complete that will include questions for the MCP to further provide its justification for approval of an AAS. Questions will include but are not limited to:

1. What is the MCP's delivery system?
2. What makes this delivery system different?
3. Is the MCP's delivery system a Medical Home with a centralized facility?
4. Does the MCP delivery system provide care coordination?

If the DS-AAS is approved by DHCS, the MCP is exempt from submitting AAS requests and an accessibility analysis. MCPs that previously received approval for a DS-AAS can submit an attestation certifying there have been no changes to the MCP's network or delivery structure, and that all information in the approved submission is still accurate.

[22] WIC section 14197(e)(1)(B).

Exhibit C-5 AAS Validations
Through the AAS validation, DHCS will require MCPs to submit evidence of contracting efforts with the two OON providers that are listed on the MCP's AAS approval. MCPs are required to provide the requested documentation on a sample of approved AAS requests to validate the submission**.**

The documentation that the MCP must provide to DHCS should reflect evidence of all attempts to contract with the two OON providers and all documentation of failed contracting efforts, including all correspondence between the MCP and the providers it was unable to contract with. Documentation that DHCS may require, includes, but is not limited to: all correspondence between the MCP and the provider offers via email/letter, scheduled phone calls, evidence of good faith negotiations, marketing materials and advertisements, and follow up attempts after initial contract offer or outreach with the two providers the MCP attempted to contract with. MCPs may submit additional documentation to support the request.

The evidence supplied must reflect contracting efforts conducted since the MCP's last ANC submission. DHCS will focus on validating AAS requests that have potential contracting options. The MCP must submit documentation dated after the previously approved AAS request. However, if an MCP initiates contract negotiations with a closer OON provider during the ANC review process, MCPs may submit documentation that is dated after the initial AAS request submission.

Exhibit D: Corrective Action Plan

If DHCS imposes an ANC Corrective Action Plan (CAP) on an MCP, the MCP must submit an OON access policy and procedure and a member services survey script to DHCS for review and approval. The MCP's initial submission is due 30 days after DHCS issues the CAP letter. Subsequent updates on correcting ANC CAP deficiencies are due every other month, until DHCS closes the CAP.

Exhibit D-1: Out-of-Network Access
MCPs must submit policies and procedures to ensure there is a consistent process for authorizing OON access by the MCP when an MCP is under an ANC CAP. The policy and procedure, at a minimum, must detail:

- The mechanism in which the members services staff are notified of ANC CAP mandates;
- That members are allowed to see a provider that is out of the MCP's network;
- The process for informing members of their right to access an OON provider when there is an ANC CAP;
- The process for members to request OON access due to the ANC CAP; and
- That network providers and subcontractors that are at risk for utilization management functions comply with the requirement to authorize OON services when the MCP is under an ANC CAP.

Exhibit D-2: Member Services Materials
MCPs must submit a call survey script and training material for its member services staff to demonstrate that the CAP mandates are being met and access information is provided to the members. The survey script and/or training materials, at a minimum, must include:

- A list of all provider types that require OON access as mandated by the ANC CAP;

- Members right to OON access for the providers and services that are under a CAP; and
- Members' right to a timely appointment with transportation provided if needed.

The MCP is responsible to ensure that subcontractors and network providers are providing accurate and timely information about OON providers that members can see during the ANC CAP. Failure to provide accurate information may result in additional CAP mandates and the imposition of monetary sanctions.

For questions concerning this Manual or the APL attachments, please contact MCQMDNAU@dhcs.ca.gov.