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

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ALL PLAN LETTER 23-001
SUPERSEDES ALL PLAN LETTER 21-006

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] This APL also advises MCPs of the new requirements pertaining to good faith contracting requirements with certain cancer centers and referral requirements pursuant to WIC section 14197.45, as set forth by Senate Bill (SB) 987 (Portantino, Chapter 608, Statutes of 2022).

BACKGROUND:
The ANC is an assessment of the MCP's Network for the reporting year (RY). MCPs are required to annually submit documentation to the Department of Health Care Services (DHCS) to demonstrate the adequacy of their Networks for the RY.[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) for that RY through the Managed Care Program Annual Report (MCPAR) and Network Adequacy Assurances Tool.[4] Furthermore, SB 987 codified requirements for MCPs to make good faith efforts to contract with at least one National Cancer Institute (NCI)-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), or qualifying academic cancer center (herein referred to as cancer centers) within their contracted Provider Networks and their subcontracted Provider Networks, if applicable, within each county in which the MCP operates.

[1] Title 42, CFR, Part 438. The CFR is searchable at: https://www.ecfr.gov/.
[2] State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml
[3] For purposes of this APL, the RY is the calendar year.
[4] 42 CFR section 438.207(d).

POLICY:
DHCS is required by federal and state law to certify each MCP's full Network annually.[5] For purposes of ANC, the composition of the Network consists of Primary Care Physicians (PCP), core Specialists, hospitals, 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 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 with a Network Provider or Subcontractor for the provision of health care services that impacts 2,000 or more Members or when a Network change causes an MCP to become noncompliant with any of the ANC requirements outlined in this APL.[8] MCPs are required to submit applicable Network certification documentation for only the components impacted by the significant change. Significant changes can occur any time throughout the RY however, if a significant change occurs within 90 days prior to the ANC filing due date, the MCP should include the significant change appropriate documentation as part of that RY ANC filing.[9] If a significant change occurs after ANC filing has a final disposition, the MCP should submit applicable Network certification documents for only the component impacted by the significant change at least 60 days prior to the effective date the significant change.[10]

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[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 subsequent revisions to the APL. APLs are searchable at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[7] See California Code of Regulations (CCR) section 1300.52(f) for Department of Managed Health Care (DMHC) requirements, which are different than those specified by DHCS.
[8] Reporting and submission requirements for significant changes and Contract terminations are outlined in APL 21-003 and any subsequent revisions to the APL.
[9] A filing must be submitted in accordance with requirements outlined in APL 21-003 and any subsequent revisions to the APL.
[10] Note significant change as defined above may also trigger reporting obligations to DMHC pursuant to Health & Safety Code section 1352 and CCR, Rule 1300.52 subd. (e)(2), which is separate and apart from the MCP requirements outlined in this APL.

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 composition of the Network Providers subject to ANC requirements, no later than 30 calendar days after receipt of DHCS' ANC documents package, unless an extension is granted by DHCS. 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, including a list of changes from the last ANC submission and indication of a submission for a significant change filing, if applicable.

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 other enforcement actions pursuant to Welfare and Institutions Code section 14197.7(e) and APL 22-015.[11]

2. 274 File Submission

DHCS will utilize the MCPs' monthly 274 File submission to verify the MCP's compliance with the required Provider-to-Member ratios, Mandatory Provider types and timely access standards for PCPs, core Specialists, Non-Specialty Mental Health providers, hospitals, and ancillary services.[12] DHCS will inform MCPs which monthly 274 file will be used for ANC as part of the ANC documents package. DHCS will also utilize the MCP's 274 File submission to review MCP resubmissions of errors identified during the preliminary review process. If DHCS is unable to access the required 274 File submission due to the MCP's untimely, incomplete or inaccurate submission, the submission of

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[11] For additional information on enforcement actions, see APL 22-015 and any subsequent revisions to the APL.

[12] Title 22, 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.

the Network certification will be considered late and the MCP is subject to imposition of a CAP and/or other enforcement actions.

B. Annual Network Certification Requirements

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

1. Network Providers[13]

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.[14, 15, 16] MCPs operating in County Organized Health Systems or Cal MediConnect counties must have an appropriate Network of Long Term Services and Supports (LTSS) Providers to provide all Medically Necessary LTSS services for current and anticipated Members.[17] Effective January 1, 2023, the Long Term Care (LTC) Skilled Nursing Facility (SNF) benefit will be carved in to all plan models statewide. Subsequently, the LTC Intermediate Care Facility/Developmentally Disabled (ICF/DD) and Subacute (Adult and Pediatric) benefit will be carved in to all plan models statewide on July 1, 2023.

Additionally, effective January 1, 2023, MCPs are required to comply with WIC section 14197.45 as set forth by SB 987 and make good faith efforts to contract with at least one cancer center within their contracted Provider Networks and their subcontracted Provider Networks, if applicable, within each county in which the MCP operates, for provision of services to any eligible Member diagnosed with a complex cancer diagnosis. The cancer

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[13] 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.
[14] MCPs must maintain a Network of Providers including adult and pediatric PCPs, Non-Physician Medical Practitioners, adult and pediatric core specialists, adult and pediatric Non-Specialty Mental Health Providers, hospitals, and ancillary services.
[15] Non-Specialty Mental Health Provider requirements are outlined in State Plan Amendment (SPA) 14-012. SPAs are available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/ApprovedSPA.aspx.
[16] MCPs may email MCQMDNAU@dhcs.ca.gov to request its anticipated membership.
[17] 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.

centers must be Medi-Cal enrolled or meet the standards of participation required to contract with an MCP. The MCP must allow any eligible Member diagnosed with a complex cancer diagnosis to request a referral to receive Medically Necessary services through any in-network cancer centers, unless the Member chooses a different cancer treatment Provider. If the MCP is unsuccessful in its good faith contracting efforts, the MCP must allow the Member to request a referral to receive Medically Necessary services through an out-of-network (OON) cancer center, unless the Member chooses a different cancer treatment Provider. These requirements are applicable only if the MCP and OON cancer center can come to an agreement with respect to payment. DHCS will monitor MCP's progress in making good faith contracting efforts to include cancer centers as in-network providers, and may issue CAPs if MCPs fail to demonstrate that good faith contracting efforts have been made.

2. Network Capacity and Ratios

MCPs are required to meet the minimum Service Area capacity requirements as outlined in the MCP Contract for their model type.[18, 19] Additionally, 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.[20]

MCPs may use Non-Physician Medical Practitioners to improve primary care access; however, DHCS excludes Non-Physician Medical Practitioners for purposes of calculating the PCP and total Physician ratios.[21, 22]

MCPs are also required to meet Provider-to-Member ratios for adult and pediatric Non-Specialty Mental Health Providers to ensure timely access to covered Non-Specialty Mental Health Services. DHCS annually calculates the number of Non-Specialty 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 Non-Specialty Mental Health Providers needed to meet the minimum required Provider-to-Member ratio.[23] This calculation is based on mental health utilization for the previous year.

[18] MCP Contract, Exhibit A, Attachment 6, Network Capacity.
[19] Network ratios are calculated for each reporting unit.
[20] MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.
[21] Title 22 CCR, sections 51240 and 51241.
[22] MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.
[23] MCP Contract, Exhibit A, Attachment 20, Non-Specialty Mental Health Providers.

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 Specialty Mental Health Services and psychiatry services for its current and anticipated membership.[24]

3. Mandatory Providers

Mandatory Provider Types (MPT) are specific Provider types and facilities that MCPs are federally or statutorily required to contract or demonstrate efforts to contract. MPTs include Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Freestanding Birth Centers (FBC), Certified Nurse Midwives (CNM), Licensed Midwives (LM), and Indian Health Care Providers (IHCP). If the MCP does not have a current contract with a specific MPT in any of its service areas, the MCP must ensure processes and protections are in place for Members to access services that are customarily provided by the mandatory Providers either in or out of the county, including the provision of transportation services to assist Members in accessing needed care.

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 as part of the MPT validation process.

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

<u>Federally Qualified Health Centers and Rural Health Centers</u>

[24] For more information, see Behavioral Health Information Notice No. 20-012 at: https://www.dhcs.ca.gov/formsandpubs/Pages/2020-BH-Information-Notices.aspx

MCPs are required to contract with at least one FQHC and one RHC, where available, in each county in which the MCP operates.[25] Additionally, pursuant to WIC section 14087.325, Local Initiative (LI) MCPs are required to offer to contract with all available FQHCs and RHCs in each of their counties.[26] 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.

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.[27, 28, 29, 30] The requirement to have a FBC in their Network is a separate and distinct requirement to contract directly with at least one CNM and one LM that are enrolled and credentialed in accordance with APL 18-022.[31, 32]

Indian Health Care Providers
Federal and state law and regulations provide protections for IHCPs.[33] MCPs are required to offer to contract with all IHCPs available in each county in which the MCP operates.[34] MCPs must provide supporting documentation of their contracting efforts with all IHCPs. IHCPs can voluntarily enter into a contract with an MCP at any time. MCPs that are unable to contract with an IHCP must allow eligible Members to obtain services from OON IHCPs.[35]

4. Time or Distance Standards

[25] SHO Letter 16-006 is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf.
[26] WIC section 14087.325 places the expanded obligation on LIs. Non-LIs are held to the MPT contracting requirements in SHO Letter 16-006.
[27] See SHO Letter No. 16-006.
[28] MCP Contract, Exhibit A, Attachment 9, Nurse Midwife and Nurse Practitioner Services.
[29] WIC section 14132.39, WIC section 14132.4.
[30] 42 United States Code section 1396d(a)(17) is available at: http://uscode.house.gov/.
[31] For additional information on FBC, CNM, and LM contracting requirements, see APL 18-022 and any subsequent revisions to the APL.
[32] MCPs must refer to the available CNMs and LMs resource list on Attachment B.
[33] 42 CFR section 438.14; Title 22, CCR section 55120 is available at: https://govt.westlaw.com/calregs/Search/Index.
[34] 22 CCR section 55120.
[35] 42 CFR section 438.14.

Time or distance standards are established in state and federal law and regulations to ensure Members have reasonable access to Covered Services. 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.[36, 37]

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.[38] MCPs cannot require OB/GYNs to act as PCPs, however, regardless of how the OB/GYN is being utilized, the MCP must ensure timely access to care by submitting P&Ps set forth in Attachment B of this APL to demonstrate compliance.

DHCS assesses the MCP's time or distance compliance based on their 274 Provider file for each of the of the MCP's service areas, for all ZIP codes, accounting for all current and anticipated Members, and provides the MCP with a Time or Distance Analysis Report.[39, 40] DHCS utilizes a representational census population points mapping methodology to align DMHC when producing the report, to determine whether the MCPs meet time or distance for anticipated Members. The methodology uses census data representing 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.

MCPs that meet the requirement for the AAS delivery system exemption are not required to submit AAS requests through Attachment C, but instead must file a delivery system AAS justification for DHCS' consideration as explained in Attachment B and in further detail in section C.2. of this APL.[41]

5. Telehealth

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[36] WIC section 14197(b).
[37] Dental time or distance standards applicable to MCPs that provide dental services.
[38] Health & Safety Code section 1367.69.
[39] 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.
[40] 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.
[41] WIC section 14197.

MCPs are required to cover 100% of the population points in the ZIP code in order to be considered compliant with time or distance standards with any deficiencies accounted for through AAS requests. However, when medically appropriate, if the MCP covers at least 85% of the population points in the ZIP code, DHCS permits MCPs to use the synchronous mode of Telehealth instead of submitting an AAS request. [42] If the MCP is using Telehealth to meet time or distance for 15% of the population points in the ZIP code, it must meet the required Telehealth Provider-to-Member ratio based on the number of the MCP's Members in that ZIP code that are not covered by in-person Providers.

Telehealth Providers can be utilized to meet time or distance standards for any ANC Provider types except for General Surgery, Orthopedic Surgery, Physical Medicine and Rehabilitation and Hospitals.[43] The MCP must submit documentation if using Telehealth as specified in Attachment B, and Exhibits B and C of this APL.

The use of Telehealth Providers to meet time or distance standards does not absolve the MCPs' responsibility to provide Members with access to in-person services if the Member prefers.[44, 45, 46] 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.[47] If an MCP is unable to arrange for an in-person visit with a Network Provider, the MCP must authorize OON services and provide transportation to the appointment as needed. 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. Finally, MCPs must submit documentation as instructed in Attachment B of this APL.

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[42] WIC section 14197(f)(1).
[43] The list of telehealth ANC provider types can be found in Attachment A Table 5 of this APL.
[44] WIC section 14197(e)(1)(A).
[45] WIC section 14197(e)(4).
[46] WIC section 14132.72(f).
[47] For more information on transportation, see APL 22-008 and any subsequent revisions to the APL.

MCPs may use third-party corporate Telehealth Providers. Due to a Member's choice to use Telehealth or in-person services, the MCP cannot auto-assign a Member to a third-party corporate Telehealth Provider.[48]

6. Timely Access

Timely Access Survey
DHCS conducts a quarterly timely access survey that measures compliance with appointment wait time standards for Network Providers and the MCP's call center.

DHCS provides timely access survey results to MCPs on a quarterly basis and annually determines the MCP's compliance rates for purposes of ANC.[49] More information regarding timely access, including new requirements set forth by SB 221 (Wiener, Chapter 724, Statutes of 2021), which codified additional timely access standards that all MCPs must comply with for non-urgent follow-up appointments with non-physician mental health care and substance use disorder (SUD) Providers, referrals to a Specialist by a Primary Care Provider (PCP) or another Specialist, and arrangement of coverage with an OON non-physician mental health care or SUD Provider when timely access standards are not met, will be described in a forthcoming Timely Access Requirements APL.

LTSS
MCPs must ensure timely access of Member placement for LTSS Providers. MCPs must provide P&Ps as instructed in Attachment B of this APL to demonstrate compliance and timely access to services customarily provided by LTSS Providers.

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

1. Alternative Access Standard Request

MCPs must submit AAS requests to DHCS when they are unable to demonstrate compliance with meeting time or distance standards and are not utilizing Telehealth to meet compliance with time or distance standards; or when a significant change in their Network occurs and they no longer meet time or distance standards.

[48] Health & Safety Code section 1374.141(a).
[49] For more information on Network adequacy standards, see Attachment A of this APL.

Before submitting an AAS request, MCPs must make good faith efforts to exhaust reasonable contracting options with additional Providers within the time or distance standards.[50] DHCS requires MCPs to submit the unsuccessful contracting efforts for closer providers as part of the AAS request. DHCS expects MCPs to have completed outreach attempts with the Provider identified in the previous ANC submission prior to the RY submission and will generally not accept contracting efforts with the same Provider ongoing as a rationale in order to ensure that MCPs are actively outreaching to closer providers. DHCS may consider allowing some exceptions for MCPs operating in challenging geographical areas or for Provider types that may be difficult to contract with, and will allow MCPs to submit quarterly progress updates for limited instances where MCPs are unsuccessful in establishing contracts.

AAS requests for the MCP's entire Network must be submitted every three years.[51] In the intervals where AAS is not required to be submitted, MCPs must submit an attestation, which is a DHCS-supplied AAS Analysis Report. For the purposes of the attestation, DHCS will provide MCPs with the AAS Analysis Report prior to the ANC filing date. If no change, the MCPs must submit an attestation. However, if a change is required, the MCP must submit a new AAS Analysis Report, in tandem with AAS requests using an updated Attachment C of this APL for DHCS' review and approval.

In order for the AAS request to be considered for ANC purposes, MCPs must submit the request with the ANC exhibits no later than 30 calendar days after receipt of DHCS' ANC documents package, unless an extension is granted by DHCS. However, DHCS highly encourages MCPs to submit early to allow DHCS sufficient time to provide technical assistance and ensure review for completion.[52] DHCS will not accept any AAS requests after the ANC submissions deadline and MCPs that cannot demonstrate compliance with AAS will be subject to the imposition of a CAP and/or other enforcement actions.

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

[50] WIC sections 14197(f)(1)–(2).
[51] WIC section 14197(f)(3)(C)
[52] WIC section 14197(f)(3).

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:

- Managed Care Open Data Portal
- Fee-for-Service Open Data Portal

DHCS will send an AAS determination letter informing the MCP of AAS approvals and denials.[53] 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.[54] Approved AAS requests are contingent on the results of DHCS' AAS validation process.

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.

[53] WIC section 14197(f)(3).
[54] WIC section 14197(f)(3).

2. 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 an AAS request was approved by posting all approved AAS on their websites within 30 days after DHCS publishes the statewide results.[55, 56] MCPs must also inform their affected Members where DHCS has approved the use of Telehealth to meet time or distance standards in lieu of AAS requests.

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.[57] If this cannot be arranged, the MCP must arrange for an appointment with a 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.[58]

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.[59]

3. Delivery System Alternative Access Standard

[55] WIC section 14197.04(c).
[56] The AAS approvals are posted after the ANC submission to CMS and after CAPs are closed.
[57] WIC section 14197.04(a).
[58] WIC section 14197.04(b).
[59] WIC section 14197(f)(1) and (2).

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.[60] 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.[61] If accepted, DHCS will provide the requesting MCP a template to submit the formal delivery system AAS justification.

DHCS will review the MCP's submission to determine if the justification for a delivery system AAS meets the needs of the MCP's Members and ensures appropriate and timely access to care.[62] An approved delivery system AAS is valid for one RY; however, if DHCS approved an MCP's delivery system AAS justification for the previous RY, the MCP can submit an attestation certifying it is seeking to utilize the previously approved justification for the current ANC.

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 other enforcement actions.

II. NON-COMPLIANCE WITH NETWORK CERTIFICATION REQUIREMENTS

[60] WIC section 14197(f)(2)(B).
[61] WIC section 14197(f)(3).
[62] WIC section 14197(f)(2).

A. Preliminary Review of Submission

DHCS will provide technical assistance to all MCPs that submit a complete 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 preliminary findings 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 within ten (10) business days. 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. Corrective Action Plans

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 (6) months to correct all deficiencies including continually working to improve access in its Provider Networks and comply with all CAP mandates set forth below until the CAP is closed. MCPs must close out any deficiencies identified in the CAP in a timely manner to ensure Member access is adequate and continue to work to improve access in their Networks.[63]

Additionally, DHCS may impose sanctions for failure to comply with Network adequacy requirements at the end of the CAP period.[64, 65] The factor(s) set forth in WIC section 14197.7(g) will be considered by DHCS when assessing and determining the amount of the monetary sanction.[66]

C. Corrective Action Plan Mandates

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

- Provide an initial CAP response no later than thirty (30) days after the issuance of the CAP notification letter;

[63] WIC section 14197(D)
[64] WIC section 14197.7 (e)(6).
[65] WIC sections 14197.7(d-e).
[66] For more information regarding enforcement actions see APL 22-015 and any subsequent revisions to the APL.

- Provide DHCS with monthly 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 specified in the CAP, regardless of associated transportation or Provider costs until the CAP is completed by the MCP and closed by DHCS;
- Demonstrate the 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 or 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.

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 MEMBER ACCESS REQUIREMENTS

MCPs are required to have processes in place to ensure Subcontractors comply with Network adequacy and access requirements as set forth in APL 17-004 and any subsequent revisions.[67] MCP assigned Members who receive care through Subcontractors must have the same access to required Providers as they would through the MCP's Provider Network. To ensure this access, MCPs may permit Subcontractors to supplement their Provider Networks with MCPs' direct Networks.

Additionally, MCPs must have contractual provisions and P&Ps in place for identifying when changes in a Subcontractor's Network results in the MCP being out of compliance with any of the ANC requirements. MCPs are responsible for ensuring

[67] For more information see APL 17-004 and any subsequent revisions to the APL.

that their Subcontractors comply with all contractual obligations and applicable state and federal laws and regulations thus, when an MCP finds a Subcontractor has a Network adequacy deficiency as set forth in APL 17-004 and any subsequent revisions, 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.[68]

In conjunction with quarterly monitoring processes, DHCS continues its existing data quality review processes by verifying 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 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 contractually required P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) 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 MCOD 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

[68] WIC section 14197(f)(2).

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 MCOD contract manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services