Annual Network Certification Instruction Manual
Attachment B

Table of Contents

Purpose: 2
- **MCP Resources:** **2**
- **DHCS Data Review Process:** **2**
- **Submission Requirements:** **2**

Exhibit A: MCP Network Providers 4
- **Exhibit A-1: MCP Network Providers** **4**
- **Exhibit A-2: Network Provider to Member Ratios** **4**
- **Exhibit A-3: Mandatory Providers** **5**
- **Exhibit A-4 Mandatory Providers Validation: Supporting Documentation** **7**
- **Exhibit A-5: Facility Validations: Supporting Documentation** **8**
- **Exhibit A-6: Long-Term Services and Supports (LTSS)** **8**

Exhibit B: MCP Time or Distance 9

Exhibit C: MCP AAS 10
- **Telehealth** **11**
- **Exhibit C-2: Delivery System AAS (DS-AAS) (if applicable)** **14**
- **Exhibit C-3: AAS Validations** **15**

Exhibit D: CAP 16
- **Exhibit D-1: OON Access** **16**
- **Exhibit D-2: Member Services Materials** **16**

ANC Submission Checklist and Cover Sheet 17

Annual Network Certification Instruction Manual
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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 All Plan Letter (APL) 23-001.

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] Additionally, DHCS will review, validate and certify MCP Subcontractor Networks. The Network certification requirements for the MCP Subcontractor Networks are set forth in APL 17-005 and any subsequent revisions.

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. DHCS will inform MCPs which monthly 274 File will be used for ANC purposes as part of the ANC documents package sent to all MCPs. 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 Network earlier than the submission deadline, but all exhibits must be submitted **no later than 30 calendar days after receipt of DHCS' ANC documents package,** unless an extension is granted by DHCS, following the guidelines below:

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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. The CFR is searchable at: https://www.ecfr.gov/cgi-bin/text-idx?SID=7edf2ff9bbcb77d617805bcaf451a96a&mc=true&node=pt42.4.438&rgn=div5. State law is searchable at: http://leginfo.legislature.ca.gov/faces/codes.xhtml.

[2] To request access to the Certification and Provider Network Monitoring - Home 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.

- MCPs with staffing changes will need to 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 Submission Checklist and Cover Sheet can be found on the SharePoint site and are included at the end of this Attachment.
- Submit ANC Exhibits via the SFTP site using the subject title "**ANC Exhibit [XX] [HEALTH PLAN NAME]**" including any supplemental documentation submitted after initial submission.
- 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 by county for each MCP.
- Send email to MCQMDNAU@dhcs.ca.gov and the Managed Care Operations Division contract manager confirming the date on which all required ANC Exhibits are submitted.

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

Exhibit A: MCP Network Providers

Overview

- DHCS utilizes the MCP's 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), if applicable.
- 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.[5] 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[6]

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, PCP services must be included in the Provider's scope of practice for Providers who contract with the MCP. 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 Companion Guide, email MCQMDProviderData@DHCS.ca.gov
[6] The current DHCS Taxonomy Crosswalk is available at: Certification and Provider Network Monitoring - Home (sharepoint.com).

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.[7]

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:[8, 9]

- Nurse Practitioners: 1:4
- Physician Assistants: 1:4
- Four Non-Physician Medical Practitioners in any combination that does not include more than three certified nurse midwives (CNM) or two 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: Mandatory Providers
Mandatory Providers must meet the following definitions to be considered for ANC review.

Mandatory Provider Type (MPT)	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.[10]	https://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider

[7] 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.
[8] MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.
[9] 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.
[10] USC is searchable at: http://uscode.house.gov/browse.xhtml.

Mandatory Provider Type (MPT)	Overview	Resources
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://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider
Freestanding Birth Center (FBC)[11]	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 Care Provider (IHCP)	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/enrolled-medi-cal-fee-for-service-provider

[11] 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 (MPT)	Overview	Resources
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/enrolled-medi-cal-fee-for-service-provider

Mandatory Providers

DHCS will review each MCP's 274 file to determine compliance with the MPT requirements by service area.

Prior to the submission date, DHCS will provide each MCP with an MPT roster based on DHCS' analysis that will include all available MPT Providers within the MCPs' service area(s) and will denote the following:

1. Contracted – MCP must provide contract signature pages and if applicable, Provider rosters.
2. Blank cells – MCP must complete the template by identifying whether they are contracted with the Provider or not and provide DHCS with either contract signature pages or evidence of contracting efforts as supporting documentation.
3. Grayed out cells – No further MCP action is needed for ANC but identifies other contracting options.

If the MCP does not have a current contract with a specific MPT in any of its service areas, the MCP is required to submit policies and procedures (P&P) detailing processes and protections that are in place for Members to access services that are customarily provided by the mandatory Providers either in or out of the county, including transportation.

If the MCP's MPT P&Ps were approved during last year's ANC and have not changed, the MCP may submit an attestation on the MCP's letterhead stating that the P&Ps remains unchanged and must include the previous year's approved P&P document titles.

Exhibit A-4 Mandatory Providers Validation: Supporting Documentation

MCPs are required to provide documentation to DHCS to confirm either executed contracts or evidence of contracting efforts. If the MCP is contracted with a MPT 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 and must notate this in the MPT roster response to DHCS.

If the MCP is in the process of contracting with a MPT Provider or is unable to contract with a MPT Provider, the MCP must submit evidence of contracting efforts including a detailed justification or rationale for the inability to contract with each Provider on the MPT roster.[12]

Exhibit A-5: Facility Validations: Supporting Documentation
DHCS will conduct facility 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 A-6: Long-Term Services and Supports (LTSS)
MCPs must submit their LTSS P&Ps for DHCS to verify there is a process in place to ensure timely access to Skilled Nursing Facility, Intermediate Care Facility and Community-Based Adult Services centers.

If the MCP's LTSS P&Ps were approved during last year's ANC and have not changed, the MCP may submit an attestation on the MCP's letterhead stating the P&Ps remains unchanged and must include the previous year's approved P&P document titles.

[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.

Exhibit B: MCP Time or Distance[13]

DHCS will analyze time or distance compliance using ArcGIS geographic access mapping software utilizing the MCP's 274 File submission. DHCS will provide MCPs a Time or Distance Analysis Report based on the results of that analysis for each of the of the MCP's service areas by each applicable Provider type, including all ZIP codes and accounting for all current and anticipated Members based on United States Postal Service (USPS) representative population location points and population count data created by combining U.S. Census American Community Survey (ACS) data, USPS delivery route data, and other USPS data sources.[14, 15, 16, 17, 18] The Time or Distance Analysis Report will outline MCP actions. If DHCS cannot run an analysis due to the MCPs' untimely 274 File submission, the MCP may be subject to a CAP and/or monetary sanctions.[19]

Time or Distance Analysis Report MCP Actions:

- No Action Required: The ZIP code, Provider type and population served is meeting time or distance standards.
- MCP must submit an Alternative Access Standard (AAS) request(s) as the MCP is not meeting time or distance standards: AAS must be submitted as telehealth is not allowed.
- MCP may utilize telehealth or must submit an AAS request(s), further instructions below.

Required Action for Obstetrician-Gynecologist (OB/GYN)

Submit P&Ps detailing at a minimum with all Member protections as specified in DHCS' review tool.[20] If the MCP's P&Ps were approved during last year's ANC and have not changed, the MCP may submit an attestation on the MCP's letterhead stating that the P&P remains unchanged and must include the previous year's approved P&P document titles.

[13] Standards are established for both, time and distance; however, in order to be compliant with the standards, MCPs must meet either time or distance.
[14] 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.
[15] 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.
[16] Time or distance standards vary depending on provider type and county size; see WIC section 14197 and Attachment A of this APL for county classifications.
[17] For information about which providers to report for each provider type, see the current DHCS Taxonomy Crosswalk.
[18] Dental provider time or distance standards are applicable to plans who cover dental services.
[19] For information on enforcement actions, see APL 22-015 or any subsequent revisions to the APL.
[20] The current OB/GYN P&P Review tool is available at: Certification and Provider Network Monitoring - Home (sharepoint.com).

Exhibit C: MCP AAS

MCP must submit AAS requests by ZIP code, Provider type and population served if time or distance standards are not met or telehealth is not available or being utilized.

In accordance with WIC 14197, MCPs must submit AAS requests for the entire Network every three years.[21] The AAS submission every three years does not preclude the MCP from submitting any significant changes to their network since the previous reporting year.

Table 2: AAS Requests to Meet Time or Distance Based on Time or Distance Analysis Report		
2022 AAS Analysis Result (Column K)	Description	Action Required by MCP
New	Met time or distance in previous ANC year but now not meeting. Indicated in Column K on AAS Analysis Report	• Submit AAS request using Attachment C and indicate "N" in Using Telehealth Allowance, see guidance below. (Column L)
Not Needed	Did not meet time or distance in previous ANC year and had AAS request approval on file (Column J) but now meeting standards, either outright meeting 100% or qualifies for telehealth. Indicated in Column K on AAS Analysis Report	• No action required
Revised	Did not meet time or distance and AAS request is still needed but needs to be revised to account for one of the following reasons: • Change in miles or minutes • Change in closest Network Provider, or • Closer Provider has been identified in the service area that wasn't available the previous year	• Indicate "Revised" in Column K on AAS Analysis Report, submit AAS request using Attachment C and indicate "N" in Using Telehealth Allowance, see guidance below (Column L)
No Change	Time or distance is still not met and the same Network Provider is the closest Provider as was provided in the previous ANC year	• Indicate "No Change" in Column K on AAS Analysis Report

[21] WIC 14197 (f)(3)(C)

Telehealth

Allowance

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. However, if the MCP covers at least 85% of the population points in the ZIP code as noted in the MCP's Time or Distance report, synchronous telehealth may be allowed when medically appropriate to show the MCP is compliant with time or distance standards and thus would not require an AAS. If the MCP is using synchronous telehealth to meet time or distance for 15% of the population points in the ZIP code, it must meet the telehealth Provider to Member ratio utilizing Providers that are noted in the 274 File submission as telehealth only (e.g., Telehealth Indicator = O).

MCPs may use synchronous telehealth to meet time or distance compliance for any ANC Provider type *except* for General Surgery, Orthopedic Surgery, Physical Medicine and Rehabilitation and Hospitals by using the AAS Analysis report as detailed Exhibit C of this Manual. [22]

MCPs are required to contract with in-person Providers that are within time or distance standards of at least 85% of their Member population for all counties regardless of county size standards in order to be considered for the use of telehealth. The use of telehealth Providers to meet time or distance does not eliminate the MCP's responsibility to provide Members with access to in-person Providers if Member preferred.

Provider to Member Ratio

MCPs will find the Provider to Member ratio requirement by ZIP code, provider type and population served in the document provided labeled Telehealth Ratio Requirements Report. The MCP must note in the AAS Analysis Report which telehealth only Provider names they are using to meet the requirement ratio.

DHCS will review and inform the MCP if the telehealth request to meet time or distance is approved, by ZIP code. If an MCP does not choose to use telehealth or does not meet the telehealth Provider to Member ratios for the ZIP code, or the percentage of compliance is less than 85%, AAS requests must be submitted.

[22] The list of ANC provider types can be found in Attachment A Table 2 of APL 23-001.

Table 1: Telehealth to Meet Time or Distance Based on Time or Distance Analysis Report		
2022 AAS Analysis Result (Column K)	Description	Action Required by MCP
New	Met time or distance in previous ANC year but now not meeting. Indicated in Column K on AAS Analysis Report	• Indicate "Y" in Using Telehealth Allowance (Column L), if telehealth is allowed for Provider type • Populate Telehealth Provider Name(s) (Column M) based on the Providers needed to meet the Provider ratio.
Revised	Did not meet time or distance and AAS request is still needed and using telehealth instead of AAS	• Indicate "Y" in Using Telehealth Allowance (Column L), if telehealth is allowed for Provider type • Populate Telehealth Provider Name(s) (Column M) based on the Providers needed to meet the Provider ratio.

If using telehealth, the MCP must submit the required documentation as outlined below to validate Member protections are in place to request to use telehealth for compliance with time or distance standards:

- **Attestation**: Must include that all Members, including those residing in 15% of the ZIP code where the MCP does not meet time or distance, have the right and access to an in-person Provider and will coordinate transportation if necessary to ensure access.
- **P&Ps**: Must include and describe the following:
  - How the MCP advises its Members of their right to access in-person services
  - How the MCP will arrange for in-person Providers and appointments within timely access standards, and
  - What the MCPs ongoing Network assessments are to identify Providers that are available to assist in meeting time or distances in the future.
- **Website Posting**: In addition to listing all approved AAS requests on the MCP's website, MCPs are required to include where they use telehealth in their approved AAS requests web posting.[23]
- **Member Services Call Scripts**: Must include information on Members' rights and access to in-person Providers when telehealth appointments are offered instead of in-person and coordination of transportation.

MCPs must reference the Time or Distance Analysis Report (Columns H and I) and actions required to complete the AAS Analysis Report. Failure to correctly complete the report and all required information will result in requests being rejected.

[23] WIC 14917.04.

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

Submission Requirements

MCPs are required to submit all Alternative Access Standard (AAS) requests using the Attachment C, which includes prepopulated dropdown selections. MCP 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 out-of-network (OON) Providers that are closer than the AAS that the MCP is requesting 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. Prior to the ANC submission, DHCS expects MCPs to have completed outreach attempts if the OON Provider is the same Provider as in the previous ANC submission. DHCS will generally not accept Provider outreach in progress as an acceptable rationale unless it is a new available Provider and contracting efforts are new 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.

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 nearest Provider. In such cases, the MCP must provide additional information for DHCS' consideration in column AL (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 Provider does not practice at the identified location or does not see the population that DHCS identified), the MCP may include an explanation in column AL 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.
- 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 submit the AAS request showing the proposed miles and minutes for the nearest OON Providers based on the DHCS-identified population point that is the farthest distance from the required provider types, i.e. hospital, PCP, etc. within each zip code.
- MCPs should round each AAS request to the nearest five, for both miles and minutes to account for differences in mapping software.
    - i.e. If the miles are mapped at 15.7 or 18.3, the MCPs should round up to 20

- Do not submit AAS requests for PO Boxes, unique ZIP codes, or ZIP codes with special considerations, such as carved-out ZIP codes.[24]
- Do not add additional columns to Attachment C. Instead, submit a narrative, when applicable, in the Additional Information for Consideration column (column AL). Additionally, when referencing Providers in column AL, state the specific Provider's name.
- 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.
- 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.

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/enrolled-medi-cal-fee-for-service-provider.

Exhibit C-2: Delivery System AAS (DS-AAS) (if applicable)

MCPs may submit a request for DHCS approval if they can demonstrate that their 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 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. [25]

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 a DS-AAS. Questions will include but are not limited to:

1. What is the MCP's delivery system?
2. What makes this delivery system different?

[24] MCPs may request a current list of DHCS' ZIP code list.
[25] WIC section 14197(e)(1)(B).

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. 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.

Exhibit C-3: 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 as specified in AAS Validation Letters, includes, but is not limited to: all correspondence between the MCP and the Provider offers via email/letter, phone call logs with all required components, 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.

In the MCP's initial submission, evidence submitted must reflect contracting efforts conducted since the MCP's last ANC submission. If multiple iterations of validations are required, the MCP must submit documentation dated after the previously approved AAS request. If an MCP initiates contract negotiations with a closer OON Provider during the ANC review process, it must submit documentation that is dated after the initial AAS request submission for the current year. DHCS will focus on validating AAS requests that have potential contracting options.

Exhibit D: CAP

If DHCS imposes an ANC 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 thirty (30) days after DHCS issues the CAP letter. Subsequent updates on correcting ANC CAP deficiencies are due every month, until DHCS closes the CAP.

Exhibit D-1: OON Access

MCPs must submit P&Ps to ensure there is a consistent process for authorizing OON access to the specific Provider types when an MCP is noncompliant with Network adequacy standards and is under an ANC CAP. The P&P, at a minimum, must detail the OON process mandated under the ANC CAP noted below:

- The mechanism in which the Members services staff are notified of ANC CAP mandates;
- For the specific Provider types under the ANC CAP, 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 for the specific Provider types 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 their 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 for the specific Provider types that Members can see when an MCP is noncompliant with Network adequacy standards under 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.

ANC Submission Checklist and Cover Sheet

As a requirement for meeting the ANC submission, MCPs must complete and submit the checklist below along with the accompanying ANC exhibits. This cover sheet should reflect the MCP's submission and account for all covered service areas.

MCP Name: _____
Service Area(s): *include all counties MCP has contract with DHCS to operate in*

EXHIBIT A Mandatory Providers

Mandatory Provider Types (MPT) Roster
Completed ANC MPT Roster provided by DHCS
Yes No

MPT P&P
If MCP does not have executed Network Provider and/or Subcontractor Agreement with required MPTs in the service area, or if the MCP's P&Ps were approved during the last ANC submission and have not changed, was this stated in an attestation on the MCP's letterhead with the previous year's document titles and submitted to DHCS?
Yes No

MPT Validations: Supporting Documentation
Contract signature pages:
Yes No

Supporting documentation of evidence of contracting efforts including detailed justification or rationale for inability to contract with each provider on MPT roster:
Yes No N/A

Attestation certifying inability to contract with available MPT in service area:
Yes No N/A

Facility Validations: Supporting Documentation
Contract signature pages:
Yes No

Long-Term Services and Supports (LTSS) P&Ps
If the MCP's P&Ps were approved during the last ANC submission and have not changed, was this stated in an attestation on the MCP's letterhead with the previous document titles and submitted to DHCS?
Yes No N/A

EXHIBIT B: MCP TIME OR DISTANCE

Telehealth Documentation
Yes No N/A

If yes, MCP must provide the following:

- Attestation
- P&Ps
- Website Posting
- Member Services Call Scripts

Primary Care OB/GYN P&Ps
If the MCP's P&Ps were approved during the last ANC submission and have not changed, was this stated in an attestation on the MCP's letterhead with the previous document titles and submitted to DHCS?
Yes No N/A

EXHIBIT C: MCP ALTERNATIVE ACCESS STANDARDS (AAS)

AAS Analysis Report
Completed AAS Analysis Report provided by DHCS
Yes No N/A

MCP AAS – Attachment C
Yes No N/A

Delivery System Alternative Access Standard Request/Justification
Yes No N/A

Submit a list of the changes from the last ANC submission below.

[MCP to add text]

Is significant change documentation being submitted with this submission?
Yes No N/A

If yes, describe below.

[MCP to add text]