



BRADLEY P. GILBERT, MD, MPP
DIRECTOR

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



GAVIN NEWSOM
GOVERNOR

DATE: February 27, 2020

ALL PLAN LETTER 20-003
SUPERSEDES ALL PLAN LETTER 19-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS¹

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.^{2, 3}

BACKGROUND:

The ANC provides a prospective look at the MCP's network for the upcoming contract year (CY).⁴ MCPs are required to annually submit documentation to the Department of Health Care Services (DHCS) to demonstrate the adequacy of their networks. DHCS reviews all MCP network submissions and provides an assurance of the MCPs' compliance with ANC standards to the Centers for Medicare and Medicaid Services (CMS) before the CY begins.⁵

POLICY:

Federal and state law and regulation require DHCS to certify each MCP's aggregate network every year.^{6, 7} MCPs are required to annually submit ANC documentation to

¹ This APL applies to all MCPs and Senior Care Action Network (SCAN).

² 42 CFR Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl.

³ WIC section 14197 is available at:

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14197.

⁴ For purposes of this APL, the CY is the MCP's fiscal year except for the following MCPs: Family Mosaic, AIDS Healthcare Foundation, and SCAN Health Plan. The CY for those MCPs is the calendar year.

⁵ 42 CFR section 438.207(d).

⁶ A network is defined as Primary Care Physicians (PCPs), specialists, hospitals, pharmacies, ancillary providers, facilities, and any other providers that subcontract with an MCP for the delivery of Medi-Cal covered services.

⁷ 42 CFR section 438.207(c)(2); WIC section 14197.

DHCS to demonstrate their capacity to serve the anticipated membership in their service areas.^{8, 9}

Specifically, DHCS must ensure that MCPs:

- Contract with the required number and mix of primary and specialty care providers;
- Provide medically necessary services needed for their anticipated membership and utilization;
- Confirm the geographic location of network providers complies with time and distance standards; and
- Comply with service availability, physical accessibility, out-of-network (OON) access, timely access, continuity of care, and 24/7 language assistance requirements.¹⁰

I. MEDI-CAL MANAGED CARE HEALTH PLANS ANNUAL NETWORK CERTIFICATION

A. Annual Network Certification Components

1. Network Providers¹¹

Each MCP must maintain and monitor an appropriate network that includes the following network provider types to ensure the MCP's network has the capacity to provide all medically necessary services:

- Adult and pediatric PCPs, including non-physician medical practitioners;¹²
- Obstetrician-gynecologists (OB/GYN);
- Adult and pediatric core specialists;¹³

⁸ 42 CFR sections 438.68, 438.206, and 438.207.

⁹ For purposes of this APL, service area and reporting unit have the same meaning. Reporting units are outlined in Attachment B of this APL.

¹⁰ 42 CFR section 438.207(a) - (b); WIC section 14197.

¹¹ For more information on networks and network providers, see APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, or any subsequent revision to this APL. APLs are available at:

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

¹² Non-physician medical practitioners include nurse practitioners, physician assistants, and certified nurse midwives (CNMs).

¹³ Core specialists are listed in Attachment A of this APL.

- Adult and pediatric mental health outpatient providers;¹⁴
- Hospitals;
- Pharmacies; and
- Ancillary services.¹⁵

Additionally, MCPs operating in County Organized Health Systems (COHS) or Cal MediConnect counties must contract with and monitor an appropriate network of Managed Long Term Services and Supports (MLTSS) providers.¹⁶

2. Network Capacity and Ratios

Network Capacity

In order to support current and anticipated membership, MCPs must meet or exceed network capacity requirements as defined in the MCP contract.¹⁷ Imperial, Regional, San Benito, Two-Plan, and Geographic Managed Care plan model MCPs must maintain a network capacity to serve 60% of all eligible members in their service areas or the current member enrollment in the MCP, whichever is higher. COHS plan model MCPs are required to have a network with the capacity to serve 100% of eligible members in the county. MCPs must adjust the number of network providers proportionally to accommodate any changes in enrollment.

Provider to Member Ratios

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.¹⁸ DHCS calculates the network providers' FTE for adult and pediatric PCPs and total physicians as described in Attachment B, Exhibit A-2.¹⁹ MCPs may use non-physician medical practitioners to improve primary care access; however, they must not include them for purposes of calculating the PCP and Total Physician Ratios.

¹⁴ State Plan Amendment (SPA) 14-012. SPAs are available at:

<https://www.dhcs.ca.gov/formsandpubs/laws/Pages/ApprovedSPA.aspx>.

¹⁵ MCP Contract, Exhibit A, Attachment 6, Network Composition. MCP boilerplate contracts are available at: <https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

¹⁶ MLTSS providers include Community Based Adult Service providers, Long Term Care providers, Multipurpose Senior Services Program, Intermediate Care Facilities and Skilled Nursing Facilities.

¹⁷ MCP Contract, Exhibit A, Attachment 6, Network Capacity.

¹⁸ MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.

¹⁹ Attachment B of this APL serves as the ANC Instruction Manual. The ANC Instruction Manual provides MCPs with policy details, ANC checklists, and ANC scenarios.

MCPs are required to meet provider to member ratios for adult and pediatric outpatient mental health providers to ensure access to MCP-covered outpatient non-specialty mental health services. DHCS annually calculates the number of providers necessary to cover each service area by taking into account service utilization, dedicated provider time for providing mental health services, and expected usage by adult and pediatric populations.²⁰ DHCS will provide each MCP with the required number of providers to cover their service areas.

Additionally, in order to ensure consistency amongst delivery systems and compliance with mental health parity requirements, MCPs that contract with DHCS to provide Specialty Mental Health Services (SMHS) must meet the provider to member ratios by which the county mental health plans are held for outpatient SMHS and psychiatry services.

3. Mandatory Providers

In accordance with WIC section 14087.325, MCPs must offer to contract with each of the following mandatory provider types in their service area, where available: Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).²¹ Furthermore, CMS State Health Official letter (SHO) #16-006 mandates that MCPs contract with at least one FQHC, one RHC, and one Freestanding Birthing Center (FBC) in their service areas, where available.²²

Further, MCPs must contract with a minimum of one CNM and one licensed midwife (LM) in their service areas, where available, in accordance with state

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

²¹ WIC section 14087.325 is available at:

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14087.325. <https://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14087-325.html>.

²² SHO Letter #16-006 is available at:

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

and federal network adequacy requirements.^{23, 24, 25} MCPs that have a FBC in their network are not exempted from the requirement to contract directly with a minimum of one CNM and one LM. MCPs must ensure CNMs and LMs are properly enrolled and credentialed when establishing a direct contract with these providers. For additional information on FBC, CNM, and LM requirements, see APL 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services, including subsequent revisions to this APL.

Federal and state laws and regulations provide protections for American Indians and American Indian Health Services.²⁶ Indian Health Facilities (IHF) are not required to contract with MCPs but can voluntarily enter into a contract with an MCP at any time. However, MCPs are required to offer to contract with each IHF in their service area(s).²⁷ MCPs that do not have an IHF in their network must allow eligible members to obtain services from an OON IHF.²⁸

MCPs must annually demonstrate efforts to improve access to services customarily provided by mandatory providers. MCPs that do not have a contract with a mandatory provider must submit documentation to DHCS for review and approval detailing the reasons the MCP was unable to contract, as outlined in Attachment B, Exhibit A-3.

4. Time and Distance Standards

DHCS established network adequacy standards in accordance with state and federal law and regulations to ensure members have adequate accessibility to available services.^{29, 30} These standards require MCPs to meet both time and

²³ MCP Contract, Exhibit A, Attachment 9, Nurse Midwife and Nurse Practitioner Services.

²⁴ WIC section 14132.39 is available at:

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14132.39. WIC section 14132.4 is available at:

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14132.4.

²⁵ 42 of the United States Code (USC) section 1396d(a)(17). The USC is available at:

<http://uscode.house.gov/>.

²⁶ 42 CFR section 438.14; 22 CCR section 55120.

²⁷ Title 22 of the California Code of Regulations (CCR) section 55120. 22 CCR section 55120 is available at: <https://govt.westlaw.com/calregs/Search/Index>.

²⁸ 42 CFR section 438.14.

²⁹ 42 CFR section 438.207.

³⁰ For more information on network adequacy standards, see Attachment A of this APL.

distance standards based on county population density.^{31, 32} Time and distance standards apply to the following provider types:³³

- Adult and pediatric PCPs;
- Adult and pediatric core specialists;
- OB/GYN primary care services;
- OB/GYN specialty care services;
- Hospitals;
- Adult and pediatric mental health providers; and
- Pharmacies.

If a member elects to use an OB/GYN as their PCP and the OB/GYN agrees to act as the member's PCP, the MCP must ensure timely access is met even if time and distance standards are not met for that member.³⁴

MCPs must create and submit accessibility analyses and narratives, if applicable, to demonstrate compliance with time and distance standards. The accessibility analyses must demonstrate coverage of the MCP's entire service area, for all ZIP codes, to account for all current and anticipated membership. Attachment B, Exhibit B details the submission requirements pertaining to the accessibility analyses and narratives.

DHCS may authorize MCPs to use telehealth and mail order pharmacy(ies), where necessary, for purposes of complying with time and distance standards (see Section B-3: "Telehealth" and Section B-4: "Mail Order Pharmacy" of this APL).³⁵

5. Timely Access

Timely Access Survey

DHCS conducts a timely access survey that measures compliance with appointment time standards.³⁶ DHCS includes the annual results of the retrospective timely access survey as a component of the ANC. The survey includes a statistically valid random sample of network providers to confirm the first three available times for urgent and non-urgent appointments for

³¹ WIC section 14197(b).

³² For more information on county populations, see Attachment A of this APL.

³³ 42 CFR section 438.68(b).

³⁴ Health & Safety Code section 1367.69.

³⁵ WIC section 14197(e)(4).

³⁶ For more information on network adequacy standards, see Attachment A of this APL.

pediatric and adult members; the availability of interpreter services; and the languages spoken by the network providers or provider site locations.

Additionally, as part of the timely access survey, DHCS contacts each MCP call center to confirm call center compliance with wait time standards and call center awareness of a member's right to receive interpretation services.^{37, 38}

DHCS provides the results of its timely access survey to MCPs on a quarterly basis and annually determines the rate of compliance. MCPs must submit a response to any timely access deficiencies found in the quarterly survey results and identify any changes or corrections necessary to achieve compliance with timely access requirements.

Audits & Investigations Timely Access Verification Study

DHCS' Audits and Investigations Division (A&I) routinely performs medical review audits of MCPs. A&I reviews the MCPs' infrastructure to assess compliance with all access to care requirements, including but not limited to, the following:

- Service availability;
- Physical accessibility;
- OON access;
- Timely access;
- Continuity of care; and
- 24/7 language assistance.

If there are non-compliant findings in Category 3 – Access and Availability of the A&I medical audit, those findings are noted in the MCP's ANC Corrective Action Plan (CAP).

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

1. Alternative Access Standard Request

MCPs must submit an Alternative Access Standard (AAS) request to DHCS for review and approval if the MCP is unable to meet time and distance standards and has exhausted all reasonable contracting options with nearer

³⁷ 28 CCR section 1300.67.2.2(c)(10).

³⁸ 22 CCR section 53853(c).

providers.^{39, 40} MCPs must submit all AAS requests, even if they were previously approved, on an annual basis or any time a network change results in the MCP not meeting time and distance standards.

In order for the request to be considered for the ANC, MCPs must submit the AAS request to DHCS with the ANC exhibits no later than 105 days before the CY begins (or the next business day if the due date occurs on a weekend or holiday). DHCS will make best efforts to approve any AAS requests received after the deadline but cannot guarantee a decision prior to the CMS submission deadline.

Attachment B, Exhibit C, details the submission requirements for AAS requests. MCPs must explain the facts and circumstances for each AAS request and detail at a minimum, the following:

- Name and address of nearest network provider;
- Driving time/distance to the nearest network provider;
- Name and address of at least two of the nearest OON provider(s) utilizing provider resource lists;
- Driving time/distance to at least two of the nearest OON provider(s) utilizing provider resource lists;
- Number of members residing in the impacted ZIP code;
- Reasons for inability to contract with nearer providers; and
- Description of contracting efforts.

At a minimum, MCPs must utilize the following provider resource lists and identify the providers on the AAS request:

- Health Care Options.
- Fee for Service Open Data Portal.
- Office of Statewide Health Planning and Development.

DHCS approves or denies AAS requests on a ZIP code and provider type basis, including specialty type.⁴¹ DHCS reviews the AAS request and all supporting documentation to assess the facts and circumstances provided by the MCP. The AAS request is evaluated in relation to other MCP's AAS requests for the same service area, and considers the Health Professional

³⁹ WIC sections 14197(e)(1)–(2).

⁴⁰ The AAS request template is available in Attachment C.

⁴¹ WIC section 14197(e)(3).

Shortage Area (HPSA) designation of the requested service area, where applicable.⁴²

MCPs must maintain documentation of their efforts to contract with nearer providers and must provide all documentation to DHCS upon request. DHCS may request additional evidence of contracting efforts if DHCS identifies more than two nearer OON providers during the review process. Following DHCS' review, DHCS will send an AAS determination letter informing MCPs of AAS approvals and denials in each service area.⁴³ An AAS approval is valid for one CY and must be approved every year thereafter if the MCP still needs an AAS.

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 of all approved AAS through the MCP's Member Handbook and post all approved AAS, specified by county, on the MCP's internet website.⁴⁴ Each MCP must post the approved AAS on its website no later than 30 days after DHCS publishes the statewide AAS approvals on the DHCS website.⁴⁵

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. 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. Either that, or the MCP must arrange for an appointment with an in-network specialist, unless the MCP has already attempted to establish a member-specific case agreement with the core specialist in the most recent fiscal year and the core specialist has refused to enter into an agreement.⁴⁶ The OON core specialist must be within the MCP's applicable time and distance and timely access standards and, in cases where the OON specialist is not within time and distance standards, the MCP must arrange for non-emergency medical transportation or non-medical transportation.⁴⁷

⁴² More information on HPSA designations is available at: <https://data.hrsa.gov/tools/shortage-area/hpsa-find>.

⁴³ WIC section 14197(e)(3).

⁴⁴ WIC section 14197.04(c).

⁴⁵ The AAS approvals are posted after the ANC submission to CMS and after CAPs are closed.

⁴⁶ WIC section 14197.04(a).

⁴⁷ WIC section 14197.04(b).

3. Telehealth

MCPs may use telehealth to meet time and distance standards if they are unable to contract with an in-person provider.^{48, 49} MCPs cannot require members to access services via telehealth in place of in-person services.⁵⁰ MCPs that request to utilize a telehealth provider as an alternative access to care must submit supporting documentation and evidence of contracting efforts to DHCS for review and approval as described in Attachment B, Exhibit C-1.

If a MCP elects to utilize telehealth for compliance with time and distance standards, the telehealth services must be available to all members in the defined service area. This applies regardless of whether the member is assigned to a network provider or subcontractor, or which network provider or subcontractor the member is assigned to. MCPs may have telehealth providers that are only available to members assigned to a subcontractor as long as other members have access to telehealth services through other means. Telehealth providers and telehealth services must also meet the telehealth criteria outlined in the Medi-Cal Provider Manual and APL 19-009 (Revised): Telehealth Services Policy, including subsequent revisions to this APL.⁵¹ In addition, telehealth providers must be certified and enrolled in the Medi-Cal program and credentialed by the MCP.⁵²

Since MCPs cannot require a member to access services via telehealth, MCPs must provide transportation to a network provider within time and distance and timely access standards for medically necessary services, when requested by a member.⁵³

⁴⁸ WIC section 14197(e)(1)(A).

⁴⁹ WIC section 14197(e)(4).

⁵⁰ WIC section 14132.72(f) is available at:

https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14132.72.

⁵¹ The Medicine: Telehealth section of the Medi-Cal Provider Manual is available at:

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc.

⁵² For more information on provider certification and enrollment, see APL 19-004: Provider Credentialing/Recertification and Screening/Enrollment, including subsequent revisions to this APL.

⁵³ For more information on transportation service, see APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services, including subsequent revisions to this APL.

4. Mail Order Pharmacy

MCPs may utilize mail order pharmacies to meet time and distance standards if they make reasonable attempts to contract with a pharmacy with a physical location before utilizing a mail order pharmacy.⁵⁴ MCPs that request to use a mail order pharmacy as an alternative access to care must submit supporting documentation and evidence of all contracting efforts to DHCS for review and approval as outlined in Attachment B, Exhibit C-2.

When using mail order pharmacies, MCPs must have procedures in place to ensure that all medications are delivered in a timely manner, consistent with the member's medical need, even if medications cannot be sent through the mail, the member cannot receive medications through the mail, or the member has confidentiality concerns about receiving medications by mail.⁵⁵

5. Delivery Structure Alternative Access Standard

In cases where an MCP is unable to meet time standards or distance standards due to its delivery structure, DHCS is authorized to determine if the MCP is capable of delivering the appropriate level of care and access to members through an AAS.⁵⁶ In order to be considered for an AAS, the MCP must provide a written request to DHCS following the instructions in Attachment B, Exhibit C-3.⁵⁷

DHCS will provide the requesting MCP a template to submit its formal AAS justification.⁵⁸ DHCS will review all information submitted by the MCP to determine if the MCP's formal justification for AAS meets the needs of its members and ensures appropriate and timely access to care.⁵⁹ An approved AAS is valid for one CY. MCPs must submit an updated AAS justification if the MCP still requires the specified AAS at the end of the CY.

⁵⁴ WIC section 14197(e)(1)(A).

⁵⁵ WIC section 14185(a) is available at:

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

⁵⁶ WIC section 14197(e)(1)(B).

⁵⁷ WIC section 14197(e)(2).

⁵⁸ MCPs must request the AAS justification template by following the instructions in Attachment B.

⁵⁹ WIC section 14197(e)(3).

C. Annual Network Certification Submission Requirements

1. Annual Network Certification Exhibit Submission

Each MCP must submit complete and accurate ANC data and information to DHCS that reflects the MCP's network for each service area no later than 105 days before the CY begins (or the next business day if the due date occurs on a weekend or holiday). MCPs must submit all required ANC exhibits, as outlined in Attachment B and, if applicable, Attachment C, with the correct file labeling conventions through the DHCS Secure File Transfer Protocol site. MCPs that do not submit ANC exhibits by the deadline may be subject to corrective action and/or monetary sanctions. Additionally, if DHCS receives multiple revised submissions from an MCP, DHCS may not accept the submission and the MCP may be subject to corrective action and/or monetary sanctions due to non-compliance with the submission requirements specified in this APL and its attachments.

2. 274 File Submission

MCPs must upload network providers in the 274 file submission in accordance with this APL and APL 16-019: Managed Care Provider Data Reporting Requirements, including subsequent revisions to these APLs. DHCS utilizes only the most current month's 274 file submission at the time of the ANC submission to determine compliance with the MCP's contractual provider to member ratios and mandatory providers. If DHCS is unable to access the required monthly 274 file submission due to an MCP's untimely submission, a corrective action and/or monetary sanctions may be applied for data submission timeliness.

3. Certification of Documents and Data

MCPs are required to submit complete, accurate, reasonable, and timely ANC exhibits and 274 file submissions in compliance with state and federal law and this APL. MCPs must submit their certification statement on MCP letterhead by the final business day of each month to their contract manager. Repeated failure to submit this certification statement may result in the imposition of a CAP and monetary sanctions.⁶⁰

⁶⁰ For more information, see APL 17-005: Certification of Document and Data Submissions, including subsequent revisions to this APL.

D. Annual Network Certification Validations

1. Provider Validation

DHCS validates a statistically valid sample of each MCP's network of adult and pediatric PCPs, OB/GYNs, adult and pediatric core specialists, adult and pediatric mental health outpatient providers, hospitals, and pharmacies to ensure network providers included in the MCP's 274 file submission are currently contracted with the MCP. As part of the validation process, DHCS may request signed contract pages confirming there is a current executed contract with the provider or facility.

2. Mandatory Provider Validation

DHCS validates a statistically valid sample of each MCP's network of FQHCs, RHCs, IHFs, FBCs, CNMs and LMs to ensure the mandatory providers included in the MCP's 274 file submission are currently contracted with the MCP. As part of the validation process, DHCS will review the evidence of contracting efforts and any additional documentation necessary to ensure compliance. DHCS may rescind the approval if the MCP cannot provide sufficient evidence and documentation of contracting efforts.

3. Alternative Access Standard Validation

If an MCP submits an AAS request using the templates in Attachment C, the MCP must describe all contracting efforts to support the AAS request. Through the AAS validation process, DHCS will request evidence of contracting efforts, including evidence of why the MCP was unable to contract, which must include supporting documentation as described in Attachment B, Exhibit C-4.

DHCS' AAS validation process includes a comparison of the MCP's narrative submitted through Attachment C with that of other MCPs serving the same service area and a review of the evidence on contracting efforts that support each AAS request.⁶¹ DHCS may rescind an approved AAS if the MCP cannot provide sufficient evidence of contracting efforts.

⁶¹ WIC Section 14197(e)(3).

II. NETWORK REQUIREMENTS FOR MEDI-CAL MANAGED CARE HEALTH PLAN SUBCONTRACTORS

MCPs are permitted to contract with network providers and subcontractors to fulfill their obligations to arrange for and deliver health care services under the MCP contracts. If an MCP delegates the responsibility to deliver Medi-Cal covered services from the MCP to a subcontractor, including but not limited to, a health plan partner, medical group, Independent Physician Association (IPA), or clinic, the subcontractor must have an adequate network that meets the requirements set forth in this APL. MCPs must allow members to access OON providers if the subcontractor does not have an adequate network. This requirement applies to any deficient network component(s), as required by state and federal law, the MCP contract, and DHCS guidance, including any applicable APLs.^{62, 63}

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

MCPs must have contractual provisions and policies and procedures for ensuring each subcontractor has an adequate network including the use of administrative subcontractors that facilitate the referral and/or utilization management process. MCPs' contractual provisions and policies and procedures must align with DHCS' ANC process to assess the network adequacy of all subcontractors that are contracted to provide Medi-Cal covered services.

MCPs must also have contractual provisions and policies and procedures for imposing CAPs and monetary sanctions on subcontractors when they are out of compliance with network adequacy requirements. This includes timely access requirements under state and federal law, any subcontractual requirements, and or DHCS contract requirements. MCPs must report all significant instances of non-compliance to DHCS, including CAPs or monetary sanctions imposed on subcontractors.

⁶² MCP Contract, Exhibit A, Attachment 9, Out-of-Network Providers.

⁶³ 42 CFR section 438.207.

MCPs must also report network provider or subcontractor non-compliance issues when those issues result in the MCP's non-compliance with contractual and legal requirements.⁶⁴ MCPs must report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their Managed Care Operations Division (MCO) contract manager within three business days of discovery or imposition.⁶⁵

III. NON-COMPLIANCE WITH NETWORK CERTIFICATION REQUIREMENTS

A. Medi-Cal Managed Care Health Plan Preliminary Findings of Non-Compliance

If an MCP's ANC submission is timely, DHCS will provide technical assistance by supplying a worksheet containing preliminary ANC findings. MCPs have two weeks to correct any findings that were caused by a reporting error and must begin to remedy findings that would result in a CAP before DHCS imposes a formal ANC CAP. MCPs may request an extension for meeting the ANC submission deadline by providing a justification, including the reason(s) why the MCP requires additional time. In the event the MCP's ANC submission is untimely, DHCS will be unable to provide technical assistance and will impose a CAP.

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

DHCS will place MCPs who fail to meet the ANC components or rectify findings identified in the preliminary ANC findings worksheet under an ANC CAP. As part of the CAP process, MCPs must submit a plan of action detailing the steps the MCP will take to remedy the ANC deficiency findings. MCPs have six months to correct all deficiencies and must comply with all CAP mandates set forth below until DHCS closes the CAP.

Additionally, DHCS has authority to impose monetary sanctions for failure to comply with network adequacy requirements⁶⁶ DHCS will impose sanctions for not meeting the ANC components at the end of the CAP period. Finally, DHCS

⁶⁴ For more information on network provider or subcontractor non-compliance, see APL 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations, and Decertifications, including subsequent revisions to this APL.

⁶⁵ For more information on subcontractual non-compliance, see APL 17-004: Subcontractual Relationships and Delegation, including subsequent revisions to this APL.

⁶⁶ WIC section 14197.7.

reserves the right to impose additional sanctions on an MCP for continued failures to comply with all network adequacy requirements, CAP mandates, or the inability to correct a deficiency within the CAP timeframe.

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

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

- Authorize OON access to medically necessary providers within timely access standards and applicable time and distance standards, regardless of associated transportation or provider costs until the CAP is closed by DHCS;
- Provide status updates that demonstrate action steps the MCP is undertaking to correct the CAP deficiency(ies) bimonthly (once every two months); and
- Demonstrate its ability to effectively provide OON access information to members and ensure that its MCP member services staff, network providers, and subcontractors are trained on the mandates.

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

If an MCP submits an updated or new AAS to rectify a network deficiency, the MCP must continue to provide transportation services for members to any network providers for which it has an approved AAS and approve requested OON access until DHCS has reviewed and approved the updated or new request.

MCPs are also required to ensure network providers and subcontractors adhere to the CAP mandates and comply with OON access requirements.

IV. POST NETWORK CERTIFICATION MONITORING ACTIVITIES

A. Ongoing Monitoring

MCPs are subject to a quarterly monitoring process by DHCS that reviews additional activities, including but not limited to:

- Timely access surveys;

- Investigation of complaints, grievances, appeals, and issues of non-compliance;⁶⁷
- A random sample of the MCP network provider annual network assessments;
- Quality of care indicators;
- Provider to member ratios; and
- OON requests.

In conjunction with the quarterly monitoring processes, DHCS continues its existing data quality review processes by verifying encounter and provider data quality. Encounter and provider data quality metrics include, but are not limited to, primary source verification that is conducted by DHCS' External Quality Review Organization (EQRO) through encounter data validation studies and provider surveys, respectively. In addition, MCPs are subject to a mandatory network adequacy validation performed by the EQRO. The EQRO will validate the previous 12 months of MCP compliance with network adequacy requirements.⁶⁸

B. Public Reporting

DHCS posts all requested and approved AAS on its website.⁶⁹ Additionally, DHCS posts CAP reports, which include the findings of DHCS' ANC evaluation and identifies all MCPs that are under a CAP for failure to comply with network adequacy standards. The MCP's response to the CAP will be posted on the DHCS website.⁷⁰ In addition, DHCS submits an annual compliance report to CMS and makes it available on the DHCS website.⁷¹

C. Policies and Procedures

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures, the MCP must submit its updated policies and procedures to its MCO contract manager within 30 days of the release of this APL. If an MCP determines that no changes to its policies and procedures are necessary, the MCP must submit an email confirmation to its MCO contract manager within 30 days of the release of this APL attesting that the MCP's policies and procedures 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.

⁶⁷ WIC section 14197(f)(2).

⁶⁸ 42 CFR section 438.358(b)(1)(iv).

⁶⁹ WIC section 14197(e)(3).

⁷⁰ WIC section 14197(f)(3).

⁷¹ 42 CFR section 438.207.

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 are also required to ensure that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities, network providers and subcontractors.

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

Sincerely,

Original signed by Nathan Nau

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