Purpose:

This Annual Network Certification (ANC) instruction manual (manual) outlines the specific data and information submission requirements that Medi-Cal managed care health plans (MCPs) must submit to the Department of Health Care Services (DHCS) for their Annual Network Certification (ANC). This manual outlines the various components and requirements for the ANC process. MCPs must submit required documentation to DHCS to demonstrate compliance with all ANC requirements.

DHCS Data Review Process:

DHCS will review, validate and certify MCP networks in each service area to ensure members have adequate access to appropriate service providers 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.[1]

MCPs must enter their data in the 274 file submission as described below in order for a network provider to be counted for ANC, the timely access survey, and quarterly monitoring. Refer to the 274 Provider Directory Companion Guide for further details on the 274 file submission data elements.[2, 3]

DHCS will review the 274 file submissions in this specific hierarchical order:

- Provider Group Network Role Code (3G, 3E)
- Licensure Type Code (MD, CSW, MFT, PSY, NP)
- 274 File Format Indicator (Sees Children, HIV/AIDS Specialist, Telehealth or CBAS)
- Facility Type Code
- Institutional Facility Type Code
- Taxonomy[4]

Submission Overview:

As outlined in this manual, MCPs must prepare and submit required information about the MCP's network by completing and submitting all exhibits outlined below. **No later than 105 days before the start of the contract year**, MCPs must submit the completed exhibits to DHCS and follow the submission requirements below:

☐ Request permission to the Secure File Transfer Protocol (SFTP) before the due date to ensure a timely submission.[5]

☐ Submit ANC information using the subject title "**ANC Exhibit [...]**" and indicate the MCP's name and service area.

☐ Submit complete and labeled ANC exhibits to DHCS via SFTP using the MCP's specific Provider Network File subfolder.

☐ Submit ZIP files if there are multiple ANC Exhibits for each MCP service area.

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[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=7edf2ff9bbcb77d617805bcaf451a96a&mc=true&node=pt42.4.438&rgn=div5

[2] For further information regarding the 274 file submission, 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.

[3] The DHCS 274 Provider Directory Companion Guide is available upon request.

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

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

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Exhibit A: MCP Network Providers

To ensure network providers[6] are considered for ANC, MCPs must enter network providers in their 274 file submission following the guidance below and must include the following:

☐ All network providers who provide medically necessary Medi-Cal covered services to members regardless of where the provider or facility is located. Providers who practice outside of the MCPs' service areas should still be included as long as they are, by definition, network providers or subcontractors.

☐ All network providers and subcontractors with any of the following contracting arrangements:[7]

☐ Full Scope Network Provider – Provides services to all members
☐ Limited Service Network Provider – Provides a subset of services to all members
☐ Limited Member Network Provider – Provides services to a subset of members
☐ Limited Service/Limited Member Network Provider – Provides a subset of services to a specific subset of members

☐ Taxonomies that reflect the services the network provider delivers for the MCP from the DHCS Taxonomy Crosswalk.

☐ Current network provider contact information that a member can use to make an appointment.

☐ Network providers that serve both adult and pediatric populations. Those providers will count in the "Both" category.

☐ Network providers that have more than one specialty type. They can be counted in multiple specialty provider types as long as they are categorized following the instructions below.

MCPs must **not** include in their 274 file submission non-network providers who are under single case agreements, such as letter of agreements, continuity of care agreements, or memorandums of understanding.

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 contractually required provider to member ratios and mandatory provider contracting requirements.[8] If DHCS is unable to access the required monthly 274 file submission due to the MCP's failure to submit timely, a Corrective Action Plan (CAP) and monetary sanctions may be imposed for failure to timely submit 274 file data.

Exhibit A-1: MCP Network Providers

MCPs must enter all network providers in their 274 file submission. DHCS utilizes the data based on the instructions below for ANC, timely access surveys, and quarterly monitoring.

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[6] For further information regarding network providers, see APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, or any future iteration of this APL.

[7] This does not apply to the provider directory. See provider directory mandates in the MCP contract. MCP contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

[8] The most current month will be the 274 file submission due the month of the MCP's ANC submission that is submitted after the ANC submission date.

- **PCPs (Adult, Pediatric or Both):** Enter adult, pediatric <u>and, where applicable,</u> PCPs that treat both adult and pediatric populations in the 274 file submission following the instructions below. If applicable, enter any supervising PCPs.

  If a PCP is assigned to a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Facility (IHF) services, enter all PCPs at the clinic in the 274 file submission.

  - **Adult PCPs:** Enter "3E" for the individual's Provider Group Network Role Code <u>and</u> identified with a MD licensure type <u>and</u> enter "N" for the Sees Children 274 file format indicator <u>and</u> an appropriate adult taxonomy.
  - **Pediatric PCPs**: Enter "3E" for the individual's Provider Group Network Role Code <u>and</u> identified with a MD licensure type <u>and</u> enter "O" for the Sees Children 274 file format indicator <u>and</u> an appropriate pediatric taxonomy.
  - **Both Adult and Pediatric PCPs**: Enter "3E" for the individual's Provider Group Network Role Code <u>and</u> identified with a MD licensure type <u>and</u> enter "B" for the Sees Children 274 file format indicator <u>and</u> an appropriate taxonomy.
  - **Supervising Adult or Pediatric PCPs**: If a PCP is also a supervising physician of Nurse Practitioners (NP), Physician Assistants (PA), or Certified Nurse Midwives (CNM), enter data in the prov_affiliation_type and prov_affiliated_NPI fields with the NPIs of the NPs, PAs, or CNMs they supervise. Each PCP may only supervise the ratios allowed within the contract, which specifies no more than four non-physician medical practitioners.[9]

- **Non-Physician Medical Practitioners**: Enter non-physician medical practitioners in the 274 file submission following the instructions below.[10]

  - **Nurse Practitioners/Physician's Assistant:** Enter a licensure type NPA: Nurse Practitioner/Physician Assistant/Advanced/Masters RN <u>and</u> associate physician extenders with a physician previously identified <u>and</u> "O", "B", or "N" for the Sees Children 274 file format indicator. The affiliation must be submitted with the physician extender's data. A physician extender is associated with a physician through the prov_affiliation_type and prov_affiliated_NPI fields.
  - **Certified Nurse Midwives**: Enter a licensure type NPA: Nurse Practitioner/Physician Assistant/Advanced/Masters RN <u>and</u> CNM taxonomy "367A00000X" <u>and</u> associate physician extenders with a physician previously identified. The affiliation must be submitted with the physician extender's data. A physician extender is associated with a physician through the prov_affiliation_type and prov_affiliated_NPI fields.

- **OB/GYNs Primary and Specialty Care:** Enter primary, specialty care <u>and, if applicable,</u> OB/GYNs that treat both adult and pediatric populations in the 274 file submission following the instructions below. If applicable, enter any supervising OB/GYNs following the instructions below.

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[9] MCP Contract, Exhibit A, Attachment 6, Physician Supervisor to Non-Physician Medical Practitioner Ratios.
[10] Non-Physician Medical Practitioners include Nurse Practitioners, Physician Assistants and Certified Nurse Midwives.

- **OB/GYN Primary Care:** Enter "3E" for the individual's Provider Group Network Role Code and identified with a MD licensure type and an appropriate taxonomy.[11]
- **OB/GYN Specialty Care**: Enter "3G" for the individual's Provider Group Network Role Code and identified with a MD licensure type and an appropriate taxonomy.
- **Supervising OB/GYNs**: If an OB/GYN is also a supervising physician of NPs, PAs, or CNMs, MCPs must enter data in the prov_affiliation_type and prov_affiliated_NPI fields with the NPIs of the NPs, PAs, or CNMs they supervise. Each physician may only supervise the ratios allowed in the MCP's contract, which specifies no more than four non-physician medical practitioners.

- **Core Specialists (Adult, Pediatric or Both):** Enter adult, pediatric and, where applicable, core specialists that treat both adult and pediatric populations in the 274 file submission following the instructions below.[12]

  For a specialist to be counted as an HIV/AIDS specialist, the MCP must indicate they have completed additional qualifications in the HIV/AIDS qualification list and enter "Y" for the HIV/AIDS 274 file format indicator.[13]

  - **Adult Core Specialists:** Enter "3G" for the individual's Provider Group Network Role Code and enter "N" for the Sees Children 274 file format indicator and identified with a MD licensure type and an appropriate adult taxonomy.
  - **Pediatric Core Specialists:** Enter "3G" for the individual's Provider Group Network Role Code and enter "O" for Sees Children 274 file format indicator and identified with a MD licensure type and an appropriate pediatric taxonomy.
  - **Both Adult and Pediatric Core Specialists**: Enter "3G" for the individual's Provider Group Network Role Code and enter "B" for Sees Children 274 file format indicator and identified with a MD licensure type and an appropriate taxonomy.
  - **Supervising Core Specialists**: If a core specialists is also a supervising physician of NPs, PAs, or CNMs, MCPs must enter data in the prov_affiliation_type and prov_affiliated_NPI fields with the NPIs of the NPs, PAs, or CNMs they supervise. Each physician may only supervise the ratios allowed in the MCP's contract, which specifies no more than four non-physician medical practitioners.

- **Mental Health Outpatient Providers (Adult, Pediatric or Both):** Enter adult, pediatric and, where applicable, mental health outpatient providers that treat both adult and pediatric populations in the 274 file submission following the instructions below. Only include State Plan-approved providers: psychologists, licensed clinical social workers (LCSWs), licensed marriage and family therapists (LMFTs), and LCSW and LMFT interns are permitted to be Mental Health Outpatient Providers.

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[11] Only required to be reported if an OB/GYN is assignable.
[12] The list of core specialist types is available in Attachment A.
[13] The HIV/AIDS qualification list is available in the DHCS 274 Provider Directory Companion Guide.

- **Adult Psychologists, LCSW and LMFT's**: Enter "N" for the Sees Children in the 274 file submission an appropriate taxonomy and licensure codes: MFT: Marriage and Family Therapist/Licensed Marriage and Family Therapist; or CSW: Master of Social Work/Licensed Clinical Social Worker; or PSY: Psychologist- PhD- Level.
  - **Pediatric Psychologists, LCSW and LMFT's**: Enter "O" for Sees Children 274 file format indicator and an appropriate taxonomy and licensure type codes: MFT: Marriage and Family Therapist/Licensed Marriage and Family Therapist; or CSW: Master of Social Work/Licensed Clinical Social Worker; or PSY: Psychologist- PHD- Level.
  - **Both Adult and Pediatric Psychologists, LCSW and LMFT's**: Enter "B" for Sees Children 274 file format indicator and an appropriate taxonomy and licensure type codes; MFT: Marriage and Family Therapist/Licensed Marriage and Family Therapist; or CSW: Master of Social Work/Licensed Clinical Social Worker; or PSY: Psychologist- PhD- Level.

- **Telehealth Providers:** Enter telehealth providers in the 274 file submission following the instructions below:

  - **Telehealth Company**: Enter facility type code 17: other service provider and "Y" for the 274 file format telehealth indicator.
  - **In State Telehealth Provider:** Enter "Y" for the 274 file format telehealth indicator and the providers' physical location.
  - **Out of State Telehealth Provider:** Enter "Y" for the 274 file format telehealth indicator and the providers' physical location and utilize 99 for Site County Code.

- **Facilities:** Enter hospitals, pharmacies and, if applicable, mail order pharmacies and community based adult service facilities (CBAS) that meet the definitions below in the 274 file submission following the instructions below.

  - **Hospital** means an institution which is primarily engaged in providing health care services in an inpatient setting, by or under the supervision of physicians in accordance with 42 USC section 1395x(e)(1).
  - **Pharmacy** means an area, place, or premises licensed by the board in which the profession of pharmacy is practiced and where prescriptions are compounded.[14]
  - **Community Based Adult Services** means an outpatient, facility-based service program that delivers Skilled Nursing Care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the Medi-Cal 2020 Waiver, to members who meet applicable eligibility criteria.

- **Hospitals:** Enter the facility type code 28: Hospitals and an appropriate taxonomy.

- **Pharmacies:** Enter pharmacies into the 274 file submission following the instructions below:

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[14] Business and Professions Code section 4037

☐ **Brick and Mortar Pharmacies:** Enter "3P" <u>and</u> an appropriate taxonomy, excluding the mail order taxonomy, 3336M002X.

☐ **Mail Order Pharmacies**: Enter "3P" <u>and</u> taxonomy: 3336M0002X <u>and, if applicable</u>, "99" for Site County Code if the mail order pharmacy is outside of California.

☐ **CBAS:** Enter "Y" for the CBAS provider 274 file format indicator.

☐ **Ancillary Providers:** Enter the following ancillary providers and sites in the 274 file submission following the instructions below:[15]

☐ **Physical Therapists:** Enter an appropriate taxonomy.
☐ **Mammography Providers:** Enter an appropriate taxonomy.
☐ **MRI Providers:** Enter an appropriate taxonomy.

☐ **Managed Long Term Services and Supports (MLTSS):** If applicable, enter Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF) that meet the definitions below in the 274 file submission following the instructions below.

- **Skilled Nursing Facility** means any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home," or "nursing facility."

- **Intermediate Care Facility** means a facility which is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in Title 22 CCR section 51212 and has been certified by DHCS for participation in the Medi-Cal program.

☐ **SNF:** Enter an appropriate facility type code <u>and</u> one of the institutional facility type codes using one of the codes below in the 274 file submission.

- Institutional Facility Type Code:
  - 21: SNF Inpatient (Including Medicare Part A)
  - 22: SNF Inpatient (Medicare Part B only)
  - 23: SNF Outpatient
  - 28: SNF Swing Beds

☐ **ICF:** Enter an appropriate facility type code <u>and</u> one of the institutional facility type codes using one of the codes below in the 274 file submission.

Institutional Facility Type Code:
  - 65: Intermediate Care – Level I

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[15] If the ancillary provider is in a hospital-based setting, enter the phone number that can be used to make an appointment in the 274 file submission.

▪ 66: Intermediate Care – Level II

Exhibit A-2: Network Provider to Member Ratios

DHCS calculates the full-time equivalent (FTE) PCP and Total Physician provider to member ratios utilizing the MCP's 274 file submission. MCPs may replicate the ratios calculated by DHCS for FTE provider counts and projected anticipated membership based on the methodology described below.

- 1 FTE PCP to 2,000 members
- 1 FTE Physician to 1,200 members

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 providers FTE divided by 100 for all distinct NPIs at the MCP. Telehealth providers may be counted as an additional provider to meet provider to member ratio requirements if they do not provide in-person services.

Projected Anticipated Membership

DHCS calculates membership based on the MCP's network capacity percentage by plan model, or its allotted member assignment, whichever is greater, and a predicted coverage requirement to determine anticipated membership with a stepwise autoregressive forecast based on the previous 18 months enrollment.[16]

Non-Physician Medical Practitioner Supervision Ratios

MCPs may utilize non-physician medical practitioners to improve access to primary care in their network; a licensed physician must supervise non-physician medical practitioners. In accordance with state law and MCPs contractual requirements, MCPs must not exceed the following physician supervision to non-physician medical practitioner ratios:

- Nurse Practitioners: 1:4
- Physician Assistants: 1:4
- Four (4) Non-Physician Medical Practitioners in any combination that does not include more than three (3) Certified Nurse Midwives or two (2) Physician Assistants.

MCPs must ensure that each FTE non-physician medical practitioner does not have an individual caseload that exceeds 1,000 members. If the MCP utilizes 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 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.

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[16] 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

Exhibit A-3: MCP Mandatory Providers

Mandatory Provider Requirements

- MCPs must offer to contract with each Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) in their service area, where available.
- MCPs must contract with at least one FQHC, one RHC, and one Freestanding Birthing Center (FBC) in their service area, where available.[17]
- MCPs must offer to contract with each Indian Health Facility (IHF) in their service area.
- MCPs must contract directly with a minimum of one certified nurse midwife (CNM) and one licensed midwife (LM) in their service area, where available.

Mandatory providers are defined below and must match all the linked resources in the footnotes below when reporting the mandatory provider in the 274 file submission. If the MCP uses a resource that is not provided by DHCS the MCP must provide a link of the resource to DHCS.

- **FQHC**: an entity defined in section 1905 of the Social Security Act (42 USC section 1396d(I)(2)(B)) that provides primary care and ambulatory services.[18]
- **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.[19]
- **FBC**: 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(I)(3)(B).[20]
- **IHF**: a tribal or urban Indian organization operating health care programs or facilities with funds from the Department of Health and Human Services, Indian Health Service, appropriated pursuant to the Indian Health Care Improvement Act (25 USC section 1601 et. seq.) or the Snyder Act (25 USC section 13 et. seq.).[21]
- **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).[22]
- **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.[23]

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[17] State Health Official (SHO) Letter #16-006 is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf.

[18] A list of the FQHCs and RHCs is available by selecting the "FQHC and RHC Current Rates" link on the "DHCS Data & Statistics Reports" web page, available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/default.aspx.

[19] Ibid.

[20] 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.

[21] 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 this APL and/or Attachment.

[22] CHHS provides and maintains the list of CNMs and Enrolled Medi-Cal Fee for Service Providers. The list is available at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017/resource/d7cd2c98-3454-46c5-810b-b5436b54de3a.

[23] CHHS provides and maintains the list of LMs and Enrolled Medi-Cal Fee for Service Providers. The list is available at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017/resource/d7cd2c98-3454-46c5-810b-b5436b54de3a.

Scenario 1 – MCP <u>DOES</u> have a contract with a mandatory provider:
MCPs must enter the mandatory provider in the 274 file submission following the instructions below.

- ☐ **FQHC:** Enter a facility type code, 17: Non-individual-Other service providers <u>and</u> the institutional facility code, 77: Clinic- Federally Qualified Health Center (FQHC), <u>and</u> match the provider information in the resource labeled "FQHC and RHC Current Rates."
- ☐ **RHC:** Enter a facility type code, 17: Non-individual-Other service providers, <u>and</u> the institutional facility code, 71: Clinic- Rural Health, <u>and</u> match the provider information in the resource labeled "FQHC and RHC Current Rates."
- ☐ **FBC:** Enter a facility type code, 17: Non-individual-Other service providers, <u>and</u> the institutional facility code, 84: Free Standing Birthing Center, <u>and</u> match the provider information in the resource labeled "Licensed and Certified Healthcare Facility Listing."
- ☐ **IHF:** Enter a facility code, 17: Non-individual-Other service providers, <u>and</u> the institutional facility code, 70: Clinic - Indian Health Services Facility, <u>and</u> match the provider information in the resource labeled "List of American Indian Health Program Providers."
- ☐ **CNM:** Enter taxonomy "367A00000X" <u>and</u> must be associated with a provider previously identified as a physician and the affiliation must be submitted with the CNM's data. A CNM is associated with a provider through the prov_affiliation_type and prov_affiliated_NPI fields <u>and</u> match the provider information in the resource labeled "Enrolled Medi-Cal Fee for Service Providers."
- ☐ **LM:** Enter taxonomy "176B00000X" <u>and</u> match the provider information in the resource labeled "Enrolled Medi-Cal Fee for Service Providers."

If the MCP is contracted with the mandatory provider and the most recent 274 file does not accurately reflect this, the MCP must take immediate steps to correct or provide a detailed timeline for correction.

Scenario 2 – MCP <u>DOES NOT</u> have a contract with a mandatory provider and no mandatory provider is available in the service area(s):
MCPs must submit the following documentation for review and approval.

- ☐ **Attestation** stating that no mandatory provider types are available in the service area; and
- ☐ **Policies and Procedures** detailing the processes and what protections MCPs have in place for members to access services that are usually provided by the mandatory providers either in or out of the service area, including transportation.

Scenario 3 – MCP <u>DOES NOT</u> have a contract with each of the required mandatory providers in the service area(s):
MCP must submit the following documentation for review and approval.

- ☐ **Justification** detailing the scenario and rationale for each mandatory provider that is not in the MCP's network. Each scenario could be the same; however, the rationale should be specific to the identified provider and service area(s) <u>since the last ANC submission.</u>

Scenarios may include, but are not limited to:

- ☐ Provider was unwilling to accept MCP contract or Medi-Cal fee-for-service 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[24]; or
- ☐ Another scenario with a detailed description of the rationale.

☐ **Policies and Procedures** detailing the process and what protections MCPs have in place for members to access services that are usually provided by the mandatory providers either in or out of the service area.

Exhibit A-4 Required Information for Mandatory Provider Validations

MCPs are required to provide documentation to DHCS to validate the ANC justification submitted by the MCP. All documentation submitted must show the MCP's contracting efforts since the last ANC submission and must include one of the following:

- ☐ **Evidence of Contracting Efforts** documenting that the provider is unwilling to accept the MCP or Medi-Cal fee-for-service rates; the provider refused to contract with the MCP; or the provider is currently in contracting negotiations with the MCP via email/letter, scheduled phone calls, good faith negotiations, contract records, marketing materials and advertisements, and follow up attempts after initial contract offer or outreach; or
- ☐ **Documentation** demonstrating that the provider does not meet the MCP's professional standards, credentialing requirements, or has a disqualifying quality of care issue, including but not limited to documentation showing an inactive license or NPI, lack of accreditation, or adverse actions.

DHCS may request other documentation and information if DHCS cannot validate the MCPs justification with the evidence of contracting efforts or additional documentation.

Exhibit A-5: Required Information for Network Provider Validations

MCPs must provide DHCS with all necessary network provider contact information needed for the provider validations. This information includes but is not limited to:

- ☐ Physical address;
- ☐ Telephone number; and
- ☐ Current email address;

The network provider validations sample size will be at a 90% confidence level with a 10% margin of error. Once DHCS determines the sample size and the providers, DHCS will request contract signature pages for each provider from the MCP. DHCS will conduct additional validations unless DHCS determines the MCPs' have demonstrated compliance with confirming the network providers' contracting status in the timely access survey.

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[24] If applicable, the rationale must detail the targeted timeframe for execution

Exhibit B: MCP Time and Distance

MCPs must submit an accessibility analysis for Exhibits B-1 through B-6 to demonstrate that the MCP has met time and distance standards in each service area for each provider type.[25, 26, 27] The accessibility analysis must demonstrate coverage for all ZIP codes in the service area and show that time and distance requirements are met, regardless of whether members currently reside in the ZIP code of the service area. All ZIP codes must be accounted for except Post Office (PO) Boxes and unique ZIP codes.[28, 29] MCPs must provide a separate accessibility analysis for each provider type and population served, labeling them as Exhibits B-1 through B-7, as outlined below.

If the MCP's reporting unit includes counties with different population densities, the MCP must provide accessibility analyses separated by county instead of service area to delineate the different time and distance standards. For MCPs that have carved-out ZIP codes, Exhibit B-7 must be submitted, as described below. [30] The MCP's accessibility analyses must be submitted in PDF and compatible Excel formats.

All accessibility analysis charts must include:

- Name of the Exhibit (B-1 through B-7)
- Name of the MCP
- Name of the service area
- Name of the City
- ZIP code
- Provider Type
- Population Served (adult or pediatric), when applicable
- Distance standard (miles)
- Time standard (minutes)
- Total Number of Members
- Number of members with access
- Number of members without access
- Percentage of members with access
- Percentage of members without access
- Max travel time (minutes)
- Max distance (miles)

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[25] Time and distance standards vary depending on provider type and county size; see Attachment A of this APL for county classifications.

[26] For the purpose of this instruction manual, the MCP's service area is the MCP's reporting unit. Reporting units are outlined in Table 2 of this instruction manual.

[27] For information about which providers to report for each provider type, see the current DHCS Taxonomy Crosswalk.

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

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

[30] For more information about carved-out ZIP codes, see Table 1 of this document.

- **Exhibits B-1 through B-6:** Submit an accessibility analysis that shows coverage of the entire service area by ZIP code for each provider type as entered in the 274 file submission. If necessary, include network providers in neighboring service areas to meet time and distance standards. If a provider serves both adults and pediatric, they can be included on both accessibility analyses.
- **Exhibit B-7:** For MCPs with carved-out ZIP codes, the MCP must submit a geographic access map of the entire service area, which delineates boundaries, ZIP codes, carved-out ZIP codes, and non-ZIP coded areas.[31]

Exhibit B-1: Adult and Pediatric PCPs

Provide an accessibility analysis showing time and distance for adult <u>and</u> pediatric PCPs.

- Adult PCPs
- Pediatric PCPs

Exhibit B-2: Adult and Pediatric Core Specialists[32]

Provide an accessibility analysis showing time and distance for adult <u>and</u> pediatric core specialists per specialty.

- Adult Core Specialist by specialty type
- Pediatric Core Specialist by specialty type

Exhibit B-3: Primary and Specialty Care OB/GYNs

Provide an accessibility analysis showing time and distance for Specialty Care OB/GYNs.

- Specialty Care OB/GYN

MCPs must allow members to select their OB/GYN as their PCP, as long as the provider agrees to serve as a PCP. Since OB/GYN PCPs are subject to time and distance standards, the MCPs must provide policies and procedures detailing at a minimum:

- Process for OB/GYNs to contract with the MCP as a PCP, if desired, and not requiring OB/GYNs to be PCPs;
- Process to ensure timely access to PCP's and OB/GYN specialists if there are no OB/GYN PCPs in the MCP's network; and
- Process to provide transportation to an OB/GYN PCP that is outside of time and distance standards, upon the member's request.

Exhibit B-4: Hospitals

Provide an accessibility analysis showing time and distance for hospitals.

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[31] If the overview map cannot show carved-out ZIP codes, the MCP must provide a narrative or accessibility analysis stating that the MCP is not responsible for time and distance standards in these ZIP codes.
[32] Adult and Pediatric Core specialists are outlined in Attachment A of this APL.

☐ Hospitals

Exhibit B-5: Adult and Pediatric Mental Health Outpatient Providers

Provide an accessibility analysis time and distance for adult <u>and</u> pediatric State Plan approved mental health providers.

☐ Adult Mental Health Outpatient Providers
☐ Pediatric Mental Health Outpatient Providers

Exhibit B-6: Pharmacies

Provide an accessibility analysis time and distance for pharmacies, including pharmacies located in hospital settings.

☐ Pharmacies

Exhibit C: MCP Alternative Access Standards (AAS) – Attachment C

If neither time nor distance standards are met for any of the specified provider types outlined in Exhibits B-1 through B-6, the MCP must submit an AAS request. Instructions on how to submit an AAS request are outlined in Attachment C.

If the MCP is unable to contract with a specific provider due to a quality of care issue, the MCP must submit **supporting documentation** detailing the MCP's concern with the provider's quality of care. A quality of care issue may include, but is not limited to, a provider having insufficient credentials or being suspended from participation in the Medi-Cal program by DHCS, CMS or the Office of the Inspector General for Health and Human Services.

Notes
- MCPs must not submit AAS requests for PO Boxes or unique ZIP codes.[33]
- During the review process, if an MCP needs to submit a new or revised request, the MCP must submit it on a new Attachment C.
- Certain columns on Attachment C have enabled drop down menus. MCPs must email MCQMDNAU@dhcs.ca.gov if they need an enabled attachment.

Resources
MCPs must utilize the following resources to complete Attachment C.

1. Health Care Options (HCO) is a resource that contains a listing of Primary Care Physicians and hospitals that are currently contracted with MCPs throughout the State.[34]
2. Fee for Service (FFS) Open Data Portal is a resource that is provided and maintained by CHHS that lists all providers enrolled in the Medi-Cal program.[35]
3. Office of Statewide Health Planning and Development (OSHPD) is a resource that lists the facilities located throughout the State that are licensed by OSHPD and the Department of Public Health.[36]
4. Health Professional Shortage Areas (HPSA) Primary Care is a resource that delineates health professional shortage areas throughout the State.[37]

Exhibit C-1: Telehealth Providers (if applicable)

If an MCP is requesting to utilize telehealth to meet network adequacy standards, the MCP must submit evidence of contracting efforts, including but not limited to:

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

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[33] To list an appropriate ZIP code, MCPs should use USPS' Look Up a ZIP Code™.
[34] HCO is available at: https://www.healthcareoptions.dhcs.ca.gov/choose/find-provider
[35] FFS Open Data Portal is available at: https://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider-file
[36] OHSPD is available at: https://oshpd.ca.gov/data-and-reports/data-resources/
[37] HPSA is available at: https://data.hrsa.gov/tools/shortage-area/hpsa-find

Additionally the MCP must provide a narrative, attestation and policies and procedures that detail the telehealth company or provider the MCP will utilize and processes for members who prefer to access in-person services, including but not limited to:

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

Exhibit C-2: Mail Order Pharmacy (if applicable)

If the MCP is requesting to utilize a mail order pharmacy to meet the network standards, MCPs must submit evidence of contract efforts, including but not limited to:

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

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

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

Exhibit C-3: Delivery System Alternative Access Standard (if applicable)

Upon request of an MCP, 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.[38]

- ☐ The MCP must make a formal request to DHCS through the SFTP site detailing the reasons why it has determined that its delivery structure is capable of delivering the appropriate level of care and access.
- ☐ If DHCS determines that the request is appropriate, DHCS will send a template for the MCP to complete. The template will include questions for the MCP to further provide its justification for approval of an AAS. Questions include but are not limited to:

  - ☐ What is the MCP's delivery system? What makes this delivery system different?
  - ☐ Is the MCP's delivery system a Medical Home with a centralized facility?
  - ☐ Does the MCP delivery system provide care coordination?

Exhibit C-4 AAS Validations

In Attachment C, MCPs must detail the name of the **two** nearest identified OON providers, the date the MCP contacted the providers to discuss contracting with the MCP and the number of contracting attempts the MCP made. Through the AAS validation, DHCS will request **evidence of contracting efforts**, which must include supporting documentation demonstrating contract offers via email/letter, scheduled phone calls, good faith negotiations, contract records, marketing materials and advertisements, and follow up attempts after initial contract offer or outreach. The evidence of contracting efforts must reflect contracting efforts conducted since the MCP's last ANC submission. DHCS will focus on validating AAS requests that have potential contracting options. The documentation submitted must be dated prior to the AAS request being requested.

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[38] Welfare and Institutions Code section 14197(e)(1)(B)

Exhibit D: Corrective Action Plan (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.

Exhibit D-1: OON Access

MCPs must submit a policy or procedure to ensure there is a consistent process for authorizing OON access by the MCP and its delegates. The policy and procedure, at a minimum, must detail:

- The mechanism in which the members services staff are notified of ANC CAP mandates;
- That Members are allowed to see a provider that is out of the MCP's network;
- The process for informing members of their right to access an OON provider when there is an ANC CAP; and
- The process for members to request OON access due to the ANC CAP.

Exhibit D-2: Member Services Materials

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

- A list of all provider types that require OON access as mandated by the ANC CAP;
- Members right to OON access for the providers and services that are under a CAP; and
- Members right to a timely appointment with transportation provided if needed.

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

For questions concerning this manual or the APL attachments, please contact your Managed Care Operations Division Contract Manager.

Table 1: Carved-Out ZIP Codes

County	Type of Carve-Out	Affected ZIP Codes
Amador	Carved-Out to Kaiser	95642, 95685, 95629, 95689, 95665, 95666
El Dorado	Carved-Out to Kaiser	95709, 95684, 95726, 95720, 95636, 95735, 95721, 96150, 96142
Kern	Carved-Out to Fee for Service	93558
Los Angeles	Carved-Out to Fee for Service	90704
Placer	Carved-Out to Kaiser	95713, 95631, 95717, 95714, 95701, 95715, 95724, 96146, 96140, 96145, 96141, 96148, 96143
Riverside	Carved-Out to Fee for Service	92225, 92226, 92239
San Bernardino	Carved-Out to Fee for Service	92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 93592

Table 2: Reporting Units

MCP Name	Reporting Unit
Aetna Better Health	Sacramento County
Aetna Better Health	San Diego County
AIDS Healthcare Foundation	Los Angeles County
Alameda Alliance for Health	Alameda County
Anthem Blue Cross Partnership Plan	Alameda County
Anthem Blue Cross Partnership Plan	Contra Costa County
Anthem Blue Cross Partnership Plan	Fresno County
Anthem Blue Cross Partnership Plan	Kings County
Anthem Blue Cross Partnership Plan	Madera County
Anthem Blue Cross Partnership Plan	**Region 1:** Butte, Colusa, Glenn, Plumas, Sierra, Sutter and Tehama Counties
Anthem Blue Cross Partnership Plan	**Region 2:** Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne and Yuba Counties
Anthem Blue Cross Partnership Plan	Sacramento County
Anthem Blue Cross Partnership Plan	San Benito County
Anthem Blue Cross Partnership Plan	San Francisco County
Anthem Blue Cross Partnership Plan	Santa Clara County
Anthem Blue Cross Partnership Plan	Tulare County
CalOptima	Orange County
CalViva	Fresno County
CalViva	Kings County
CalViva	Madera County
California Health & Wellness Plan	Imperial County
California Health & Wellness Plan	**Region 1:** Butte, Colusa, Glenn, Plumas, Sierra, Sutter and Tehama Counties
California Health & Wellness Plan	**Region 2:** Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne and Yuba Counties
Care1st Partner Plan	San Diego County
CenCal Health	San Luis Obispo County
CenCal Health	Santa Barbara County
Central California Alliance for Health	Merced County
Central California Alliance for Health	Monterey/Santa Cruz Counties
Community Health Group Partnership Plan	San Diego County
Contra Costa Health Plan	Contra Costa County
Family Mosaic	San Francisco County

MCP Name	Reporting Unit
Gold Coast Health Plan	Ventura County
Health Net Community Solutions, Inc.	Kern County
Health Net Community Solutions, Inc.	Los Angeles County
Health Net Community Solutions, Inc.	Sacramento County
Health Net Community Solutions, Inc.	San Diego County
Health Net Community Solutions, Inc.	San Joaquin County
Health Net Community Solutions, Inc.	Stanislaus County
Health Net Community Solutions, Inc.	Tulare County
Health Plan of San Joaquin	San Joaquin County
Health Plan of San Joaquin	Stanislaus County
Health Plan of San Mateo	San Mateo County
Inland Empire Health Plan	Riverside/San Bernardino Counties
Kaiser NorCal (KP Cal LLC)	**KP North:** Amador, El Dorado, Placer and Sacramento Counties
Kaiser SoCal (KP Cal LLC)	San Diego County
Kern Family Health Care	Kern County
LA Care Health Plan	Los Angeles County
Molina Healthcare of California Partner Plan, Inc.	Imperial County
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino Counties
Molina Healthcare of California Partner Plan, Inc.	Sacramento County
Molina Healthcare of California Partner Plan, Inc.	San Diego County
Partnership Health Plan of California	**Northeast:** Lassen, Modoc, Shasta, Siskiyou and Trinity Counties
Partnership Health Plan of California	**Northwest:** Del Norte and Humboldt Counties
Partnership Health Plan of California	**Southeast:** Napa, Solano, Yolo Counties
Partnership Health Plan of California	**Southwest:** Lake, Marin, Mendocino, and Sonoma Counties
Rady Children's Hospital	San Diego County
San Francisco Health Plan	San Francisco County
Santa Clara Family Health Plan	Santa Clara County
SCAN Health Plan	Los Angeles County
SCAN Health Plan	Riverside/San Bernardino Counties
United Healthcare	San Diego County