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Approving Committee: Member Provider Committee		Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025		

Purpose:

To describe how the Health Plan ensures complete provider networks are in place and maintained according to required access standards and regulatory requirements for all provider types and services.

Policy:

1. The Health Plan shall develop and maintain a network of appropriate providers, that is sufficient to provide covered services to health plan enrollees, in accordance with regulatory requirements. The network is expected to adequately serve 75% of all eligible beneficiaries.
2. The Health Plan shall develop and maintain a provider network that includes, but is not limited to, Primary Care Providers (PCP); specialists; professional, allied, and supportive paramedical personnel; ancillaries; hospitals; laboratories; pharmacies; and dentists.
3. The Health Plan shall adhere to the following provider-to-enrollee ratios:
 - a. Primary care physicians 1:2,000
 - b. Total physicians 1:1,200
 - c. If non-physician medical practitioners (nurse practitioners and/or physician assistants) are included in the provider network, each individual shall not exceed an FTE provider/patient caseload of 1:1,000 patients.
4. The Health Plan shall adhere to the following physician-to-non-physician-medical-practitioner supervision ratios:
 - a. Nurse Practitioners 1:4
 - b. Physician Assistants 1:4

A physician serving in a supervising capacity for non-physician medical practitioners may not supervise more than four (4) non-physician medical practitioners in any combination (e.g., combination can include but is not limited to supervising no more than three (3) certified midwives or two (2) physician assistants.
5. The Health Plan shall contractually require that network providers employing non-physician medical practitioners follow the appropriate regulations pertaining to physician supervision of non-physician

medical practitioners, including 22 CCR Sections 1399.545, 51240 and 51241; and Business and Professions Code Sections 3516 and 2836.1.

6. The Health Plan shall ensure that network providers are geographically accessible to enrollees and are within the following Geo Access standards. The calculations completed for each Geo map reflect the penetration of that specialty or service, and time and distance compliance.

Provider Type	Time and Distance Std.
Acute Care Hospital	15 miles 30 minutes
Adolescent Medicine	15 miles 30 minutes
Allergy Provider	15 miles 30 minutes
Anesthesiology	15 miles 30 minutes
Birth/Delivery Facility	15 miles 30 minutes
Cardiology	15 miles 30 minutes
Chiropractic	15 miles 30 minutes
Community Based Adult Services	15 Miles 30 Minutes
Dermatology	15 miles 30 minutes
DME/HME Providers	n/a n/a
Emergency Service Fac.	15 miles 30 minutes
Facility with Birth/Del. Services	15 miles 30 minutes
Gastroenterology	15 miles 30 minutes
General Dentists	15 miles 30 minutes
General Surgery	15 miles 30 minutes
Home Health Agency	15 miles 30 minutes
Hospice	15 miles 30 minutes
Hospitals (Acute Care)	15 miles

	30 minutes
Intermediate Care Facility	15 Miles
	30 Minutes
Long Term Services and Supports (LTSS)	T&D not established for MSSP, SNF, or ICF.
Nephrology	15 miles 30 minutes

Neurology	15 miles 30 minutes
Non-Specialty Mental Health Providers <small>Within 10 business days of the request for appointment</small>	15 miles
	30 minutes
Obstetrics/Gynecology Primary Care	10 miles
	30 minutes
Obstetrics/Gynecology Specialty Care	15 miles
	30 minutes
Oncology	15 miles 30 minutes
	30 minutes
Ophthalmology	15 miles 30 minutes
	30 minutes
Optometry	15 miles 30 minutes
	30 minutes
Orthopedic Surgery	15 miles 30 minutes
	30 minutes
Otolaryngology	15 miles 30 minutes
	30 minutes
Pharmacy	10 miles 30 minutes
	30 minutes
Pathology	15 miles 30 minutes
	30 minutes
Primary Care Providers	10 miles 30 minutes
	30 minutes
Pediatrics	10 miles



	30 minutes
Podiatry	15 miles
	30 minutes
Psychiatrists	15 miles
	30 minutes
Psychiatric Comm. Hosp.	15 miles
	30 minutes
Inpatient Substance Abuse	15 miles

Detox Units	30 minutes
Skilled Nursing Facility	15 Miles
	30 Minutes
Therapist (Occupational)	15 miles
	30 minutes
Therapist (Physical)	15 miles
	30 minutes
Urology	15 miles

7. The Health Plan has established alternative access (time and distance) standards for identified specialists. Please see attachment entitled T&D Specialty; these standards have been approved by Department of Health Care services via response to Plan's Annual Network Certification.
8. The Health Plan assess cultural, ethnic, racial and linguistic needs for Plan enrollees on an annual basis to ensure accessibility and availability of in network providers meets the then current needs of Plan enrollees.
9. The Health Plan shall include at least one designated emergency service facility that provides care on a 24 hour/day/7 days per week basis at a minimum. This designated facility will have one or more physicians and one nurse on duty at the facility at all times.
10. The Health Plan shall contract with specialists in sufficient numbers to meet or exceed adequate numbers and types of specialists within the network to accommodate the need for specialty care, as outlined in State rules. Specialists include all core specialties of:
 - Cardiology/Interventional Cardiology
 - Dermatology
 - Endocrinology
 - ENT/Otolaryngology
 - Gastroenterology
 - General Surgery
 - Hematology/Oncology
 - HIV/AIDS Specialists/Infectious Disease
 - Nephrology
 - Neurology
 - Ophthalmology
 - Orthopedic Surgery
 - Physical Medicine & Rehabilitation
 - Psychiatry
 - Pulmonology
 - a. The Health Plan shall meet federal requirements for enrollee access to Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) services as a mandatory service and benefit. The Health Plan shall include at least one FQHC and one RHC in the provider network to the extent that the FQHC and RHC providers are licensed and recognized under state law and they are available within the service area and the RHC meets the California Association of Rural Health Clinics and California Department of Health Care Services Primary, Rural and Indian Health Division's (PRIHD) standards. In the event a contract is not completed for one of each of these services, non-contracted facilities may also be utilized.
11. In accordance with Department of Healthcare Services (DHCS) All Plan Letter (APL) Cost Avoidance and Post-Payment Recovery for Other Health Coverage (APL 22-027), the Plan will review written disputes received from in network providers and/or subcontractor



12. The Health Plan shall ensure that all in network specialists contracted with the Plan comply with Department of Healthcare Services (DHCS) Provider Credentialing/Re-credentialing and Screening/ Enrollment requirements (DHCS APL 17-019).
- a. The Health Plan requires all specialists to complete the Medi-Cal Screening and Enrollment Provider Attestation during the initial contracting process. Existing providers are required to confirm current enrollment during the re-credentialing process outlined in Plan’s Provider Screening and Enrollment Program (ref: Policy CR. 1).
13. The Health Plan shall ensure enrollees have access to American Indian Health Services Program services, provided IHS facilities in the service area meet the California Association of Rural Health Clinics and California Department of Health Care Services Primary, Rural and Indian Health Division’s (PRIHD) standards.
- a. As of January 1, 2024, there are no IHCPs in Los Angeles County, where the Health Plan operates. In the event an IHCP becomes available in the Health Plan’s service area, the plan will seek to execute a contract with the provider and adopt requirements of DHCS APL 24-002 concerning contracting and credentialing with IHCPs.
 - b. An IHCP does not have to contract with the Health Plan as a Network Provider, nor does the IHCP have to contract with any Health Plan subcontractor, in order to be reimbursed by either the plan or the subcontractor for services provided to an American Indian enrollee.
 - c. The Health Plan will ensure that any IHCP providing Medi-Cal covered services to an American Indian MCP enrollee, is enrolled in the Medi-Cal program.
 - i. The Health Plan will inform the IHCP that the facility must enroll through the state-level enrollment pathway in order to receive reimbursement at the All-Inclusive Rate (AIR) or Prosepctive Payment System (PPS), and to receive Medi-Cal FFS reimbursement for carved out services, such as dental services.
 - ii. The HealthPlan will alert an IHCP to the DHCS enrollment time frames and processing requirements when directing them to enroll through DHCS.
 - iii. The Health Plan will ensure that individual practitioners who provide services at an IHCP facility are enrolled in Medi-Cal as ordering, referring, and prescribing (ORP) providers.
 - d. The Health Plan does not apply any requirement that a Tribal Health Program, including an Indian Health Service-Memorandum of Agreement or Tribal Federally Qualified Health Center provider, be licensed.
 - e. The Health Plan does not require the licensure of a health professional employed by a Tribal Health Program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state.



14. The Health Plan shall have a plan or contracted physician available twenty-four (24) hours a day, seven (7) days/week to coordinate the transfer of care of an enrollee whose emergency condition is stabilized, to authorize medically necessary post-stabilization service, or for general communication with emergency room personnel.
15. The Health Plan shall ensure that network providers offer hours of operation to enrollees that are no less than the hours of operation offered to other patients, or to Medi-Cal FFS beneficiaries, if the provider is exclusively providing care to only Medi-Cal beneficiaries.
16. The Health Plan shall ensure that that the composition of the provider network meets cultural, ethnic and linguistic needs of its Members on a continuous basis.
17. The Health Plan shall include in its network any traditional and Safety-Net Providers that are willing to contract under the same terms and conditions that the Plan offers to any other similar Provider.
18. The Health Plan monitors its provider network for changes that are 10 percent or greater. If a change of ten (10) percent or greater occurs, the Health Plan will file an amendment with the Department of Managed Health Care (DMHC) pursuant to Section 1367.27(r); Rule 1300.52(f); Rule 1300.67.2.2(d)(2).
19. Annual Network Certification
 - a. The Health Plan shall adhere to all network adequacy requirements outlined by State of California regulatory agencies. These standards including but not limited to Department of Health Care Services Network Certification Requirements pursuant to All Plan Letter (APL) 23-001 Title 42 of the Code of Federal Regulations (CFR) sections 438.68, 432.206 and 438.207, and Welfare and Institutions Code (WIC) section 14197.
 - b. DHCS is required by federal and state law to certify each Plan's full Network annually. For purposes of ANC, the composition of the Network consists of Primary Care Physicians (PCP), core Specialists, hospitals, ancillary Providers, facilities, and other Providers that contract with the Plan, or its Subcontractors for the delivery of Medi-Cal Covered Services. The Plan is required to annually submit ANC documentation to DHCS to demonstrate compliance with Network adequacy requirements.
 - c. The Plan may also be required to submit additional documentation to DHCS when the Plan Network experiences a significant change.
 - i. Significant changes may occur as a result of a contract termination with a Network Provider or Subcontractor for the provision of health care services that impacts two thousand (2,000) or more Members or when a Network change causes the Plan to become noncompliant with any of the ANC requirements outlined in DHCS APL 23-001.
 - ii. The Plan is required to submit applicable Network certification documentation for only the components impacted by the significant change. Significant changes can occur any time throughout the RY (Reporting Year). However, if a significant change occurs within ninety



(90) days prior to the ANC filing due date, the Plan should include the significant change appropriate documentation as part of that RY ANC filing.

- iii. If a significant change occurs after ANC filing has a final disposition, the Plan should submit applicable Network certification documents for only the component impacted by the significant change at least sixty (60) days prior to the effective date the significant change.

d. Annual Network Certification Submission Requirements

i. Annual Network Certification Exhibit Submission

1. The Plan must complete and submit accurate data and information to DHCS that reflects the composition of the Network Providers subject to ANC requirements, no later than thirty (30) calendar days after receipt of DHCS' ANC documents package, unless an extension is granted by DHCS.
 - a. The Plan must submit all required ANC exhibits, as outlined in [Attachment B](#) and, if applicable, alternative access standard (AAS) requests in [Attachment C](#), with the correct file labeling conventions through the DHCS Secure File Transfer Protocol site.
 - b. Additionally, The Plan must include the cover sheet referenced in [Attachment B](#), including a list of changes from the last ANC submission and indication of a submission for a significant change filing, if applicable.
2. If the Plan fails to submit all complete and accurate ANC exhibits and required submission information by the deadline are subject to the imposition of a corrective action plan (CAP) and/or other enforcement actions pursuant to Welfare and Institutions Code section 14197.7(e) and DHCS APL 22-015.

ii. 274 File Submission

1. DHCS will utilize the Plans' monthly 274 File submission to verify the Plan's compliance with the required Provider-to-Member ratios, Mandatory Provider types and timely access standards for PCPs, core Specialists, Non-Specialty Mental Health providers, hospitals, and ancillary services.
2. DHCS will inform the Plan which the monthly 274 file will be used for ANC as part of the ANC documents package. DHCS will also utilize the Plan's 274 File submission to review Plan resubmissions of errors identified during the preliminary review process.

3. If DHCS is unable to access the required 274 File submission due to the Plan's untimely, incomplete, or inaccurate submission, the submission of the Network certification will be considered late, and the Plan is subject to imposition of a CAP and/or other enforcement actions
- e. Annual Network Certification Requirements – To be compliant with ANC requirements, the Plan must meet each of the following requirements:
- i. Network Providers
 1. Each Plan must maintain an appropriate Network of specific Provider types to ensure the Plan's Network has the capacity to provide all Medically Necessary services for current and anticipated membership. Plans that are operating in County Organized Health Systems or Cal MediConnect counties must have an appropriate Network of Long-Term Services and Supports (LTSS) Providers to provide all Medically Necessary LTSS services for current and anticipated Members.
 - a. Effective January 1, 2023, the Long-Term Care (LTC) Skilled Nursing Facility (SNF) benefit will be carved into all plan models statewide. Subsequently, the LTC Intermediate Care Facility/Developmentally Disabled (ICF/DD) and Subacute (Adult and Pediatric) benefit will be carved into all plan models statewide on July 1, 2023.
 2. Additionally, effective January 1, 2023, the Plan is required to comply with WIC section 14197.45 as set forth by SB 987 and make good faith efforts to contract with at least one (1) cancer center within their contracted Provider Networks and their subcontracted Provider Networks, if applicable, within each county in which the Plan operates, for provision of services to any eligible Member diagnosed with a complex cancer diagnosis.
 - a. The cancer centers must be Medi-Cal enrolled or meet the standards of participation required to contract with the Plan. The Plan must allow any eligible Member diagnosed with a complex cancer diagnosis to request a referral to receive Medically Necessary services through any in-network cancer centers unless the Member chooses a different cancer treatment Provider.
 - b. If the Plan is unsuccessful in its good faith contracting efforts, the Plan must allow the Member to request a referral to receive Medically Necessary services through an out-of-network (OON) cancer center, unless the Member chooses a different cancer treatment Provider.

- c. These requirements are applicable only if the Plan and the OON cancer center can come to an agreement with respect to payment. DHCS will monitor the Plan's progress in making good faith contracting efforts to include cancer centers as in-network providers and may issue a CAP if the Plan fails to demonstrate that good faith contracting efforts have been made.

ii. Network Capacity Ratios

1. The Plan is required to meet the minimum Service Area capacity requirements as outlined in the Plan Contract for their model type. Additionally, Plan Networks must meet the full-time equivalent (FTE) ratios of one FTE PCP to every two thousand (2,000) Members and one (1) FTE Physician to every twelve hundred (1,200) Members.
2. The Plan may use Non-Physician Medical Practitioners to improve primary care access; however, DHCS excludes Non-Physician Medical Practitioners for purposes of calculating the PCP and total Physician ratios.
3. The Plan is also required to meet Provider-to-Member ratios for adult and pediatric Non-Specialty Mental Health Providers to ensure timely access to covered Non-Specialty Mental Health Services. DHCS annually calculates the number of Non-Specialty Mental Health Providers necessary to cover the projected mental health needs for anticipated Members in each county and provides the Plan with the number of Non-Specialty Mental Health Providers needed to meet the minimum required Provider-to-Member ratio. This calculation is based on mental health utilization for the previous year.
 - a. Pursuant to DHCS APL 23-001, the Plan must maintain a Network of Providers including adult and pediatric PCPs, non-physician medical practitioners, adult and pediatric mental health outpatient providers' core specialists, adult and pediatric Non-Specialty Mental Health Providers, hospitals, pharmacies, and ancillary services.
4. Additionally, in order to ensure compliance with mental health parity requirements, If the Plan contracts with DHCS to provide Specialty Mental Health Services in a county must meet the Provider-to-Member ratios that the county mental health plan would otherwise be required to maintain for Specialty Mental Health Services and psychiatry services for its current and anticipated membership.

iii. Mandatory Providers

1. Mandatory Provider Types (MPT) are specific Provider types and facilities that the Plans are federally or statutorily required to contract or demonstrate efforts to contract. MPTs include Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Freestanding Birth Centers (FBC), Certified Nurse Midwives (CNM), Licensed Midwives (LM), and Indian Health Care Providers (IHCP). If the Plan does not have a current contract with a specific MPT in any of its service areas, the Plan must ensure processes and protections are in place for Members to access services that are customarily provided by the mandatory Providers either in or out of the county, including the provision of transportation services to assist Members in accessing needed care.
2. The Plan must meet the requirements below in order to meet the minimum MPT contracting requirements for ANC:
 - a. Contract with the minimum number of MPTs for each MPT as described above; or
 - b. Submit an attestation or justification and maintain all supporting documentation of the Plan's contracting attempts, including failed contracting efforts with MPTs to be provided to DHCS upon request as part of the MPT validation process.
3. The Plan must provide policies and procedures as instructed in [Attachment B](#) of DHCS APL 23-001 to demonstrate compliance and efforts to improve access to services customarily provided by MPTs.
4. Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)
 - a. The Health Plan shall contract with at least one (1) FQHC and one (1) RHC, in the event an RHC becomes available in Los Angeles County where the Plan operates. Additionally, pursuant to W&I Code section 14087.325, Local Initiative (LI), the Plan is required to offer to contract with all available FQHCs and RHCs in its county of operation. The Plan shall provide supporting documentation of its contracting efforts with all FQHCs and RHCs.
 - b. The Health Plan shall offer terms and conditions to FQHCs and RHCs that are the same as those offered to other network providers providing similar services and shall offer contracted rates of reimbursement not less than the level and amount offered to non-FQHC and non-RHC providers. The Health Plan shall certify

its compliance in writing to DHCS within thirty (30) calendar days of DHCS' written request.

- c. The Health Plan shall submit to DHCS, within thirty (30) calendar days of a request and in the form and manner specified by DHCS, documentation of the services provided, the reimbursement level, and amount for any contracted FQHC and RHC providers.
 - d. The Health Plan shall submit all FQHC and RHC network provider agreements to DHCS for approval.
 - e. In the event the Health Plan enters into a financial incentive payment arrangement with an FQHC or RHC network provider, the Plan shall ensure the agreement meets all applicable conditions of federal and state law and DHCS APL 19-005.
5. Freestanding or Alternative Birthing Centers (FBC) and Midwife Services
- a. The Plan is required to contract with at least one (1) FBC, one CNM, and one LM, where available, in Los Angeles County, where the Plan operates, in accordance with state and federal Network adequacy requirements. The requirement to have an FBC in its Network is a separate and distinct requirement to contract directly with at least one CNM and one LM that are enrolled and credentialed in accordance with DHCS APL 18-022.
6. Indian Health Care Providers (IHCP)
- a. Federal and state law and regulations provide protections for IHCPs. The Plan is required to offer contracts with all IHCPs available in Los Angeles County, where the Plan operates. The Plan shall provide supporting documentation of their contracting efforts with all IHCPs.
 - b. IHCPs can voluntarily enter into a contract with the Health Plan at any time. If the Plan is unable to contract with an IHCP, the Plan allows eligible Members to obtain services from out-of-network IHCPs.

iv. Time or Distance Standards

- 1. Time or distance standards are established in state and federal law and regulations to ensure Members have reasonable access to Covered Services. The Plan must meet

time or distance standards based on the population density of the county for designated Provider types set forth in [Attachment A](#) of DHCS APL 23-001.

2. Time or distance standards apply to obstetrician-gynecologist (OB/GYN) primary care services only if a Member elects to use the OB/GYN as a PCP. The Plan cannot require OB/GYNs to act as PCPs, however, regardless of how the OB/GYN is being utilized, the Plan must ensure timely access to care by submitting Policies and Procedures set forth in [Attachment B](#) of DHCS APL 23-001 to demonstrate compliance.
3. DHCS assesses the Plan's time or distance compliance based on their 274 Provider file for each of the of the Plan's service areas, for all ZIP codes, accounting for all current and anticipated Members, and provides the Plan with a Time or Distance Analysis Report. DHCS utilizes a representational census population points mapping methodology to align Department of Managed Health Care (DMHC) when producing the report, to determine whether the Plan meets time or distance for anticipated Members. The methodology uses census data representing population points per ZIP code in habitable areas to account for current Members, as well as the farthest points of the ZIP code where an anticipated Member could potentially live.
4. Plan's that meet the requirement for the AAS delivery system exemption are not required to submit AAS requests through [Attachment C](#), but instead must file a delivery system AAS justification for DHCS' consideration as explained in [Attachment B](#) and in further detail in section C.2. of DHCS APL 23-001.

v. Telehealth

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

2. Telehealth Providers can be utilized to meet time or distance standards for any ANC Provider types except for General Surgery, Orthopedic Surgery, Physical Medicine and Rehabilitation and Hospitals. The Plan must submit documentation if using Telehealth as specified in [Attachment B](#), and Exhibits B and C of DHCS APL 23-001.
3. The use of Telehealth Providers to meet time or distance standards does not absolve the Plans' responsibility to provide Members with access to in-person services if the Member prefers. The Plan must provide transportation to a Network Provider and meet timely access standards for Medically Necessary services when a Member is offered a Telehealth visit but requests an in-person visit. If the Plan is unable to arrange for an in-person visit with a Network Provider, the Plan must authorize OON services and provide transportation to the appointment as needed. Telehealth services must be consistent with the criteria outlined in the Medi-Cal Provider Manual and DHCS APL 19-009 (Revised), including subsequent revisions DHCS APL 23-001, and be certified and enrolled in the Medi-Cal Program and credentialed by the Plan. Finally, the Plan must submit documentation as instructed in [Attachment B](#) of DHCS APL 23-001.
4. The Plan may use third-party corporate Telehealth Providers. Due to a Member's choice to use Telehealth or in-person services, the Plan cannot auto-assign a Member to a third-party corporate Telehealth Provider

vi. Timely Access

1. Timely Access Survey
 - a. DHCS administers a quarterly timely access survey that measures compliance with appointment wait time standards for Network Providers and the Plan's call center.
 - b. The Health Plan ensures its subcontractors, downstream subcontractors (if applicable), and network providers participate in the Timely Access Survey.
 - c. When entering into or amending contract agreements with subcontractors and/or network providers, the Health Plan includes language requiring providers, subcontractors, and downstream subcontractors (if applicable) to fully participate in all Timely Access Surveys administered by or on behalf of DHCS.
 - d. DHCS provides timely access survey results to the Plan on a quarterly basis and annually determines the

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

2. LTSS

- a. The Plan must ensure timely access of Member placement for LTSS Providers. The Plan must provide Policies and Procedures as instructed in [Attachment B](#) of DHCS APL 23-001 to demonstrate compliance and timely access to services customarily provided by LTSS Providers.

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

i. Alternative Access Standards Request

1. The Plan must submit AAS requests to DHCS when they are unable to demonstrate compliance with meeting time or distance standards and are not utilizing Telehealth to meet compliance with time or distance standards; or when a significant change in their Network occurs and they no longer meet time or distance standards.
2. Before submitting an AAS request, the Plan must make good faith efforts to exhaust reasonable contracting options with additional Providers within the time or distance standards. DHCS requires plans to submit the unsuccessful contracting efforts for closer providers as part of the AAS request.
 - a. DHCS expects the Plan has completed outreach attempts with the Provider identified in the previous ANC submission prior to the RY submission and will generally not accept contracting efforts with the same Provider ongoing as a rationale in order to ensure that the Plan is actively outreaching to closer providers.
 - b. DHCS may consider allowing some exceptions for plans that are operating in challenging geographical areas or for Provider types that may be difficult to contract with and will allow the Plan to submit quarterly

progress updates for limited instances where the Plan is unsuccessful in establishing contracts.

3. AAS requests for the Plan's entire Network must be submitted every three (3) years. In the intervals where AAS is not required to be submitted, the Plan must submit an attestation, which is a DHCS-supplied AAS Analysis Report.
 - a. For the purposes of the attestation, DHCS will provide the Plan with the AAS Analysis Report prior to the ANC filing date. If there is no change, the Plan must submit an attestation. However, if a change is required, the Plan must submit a new AAS Analysis Report, in tandem with AAS requests using an updated [Attachment C](#) of DHCS All Plan Letter (APL) 23-001 for DHCS' review and approval.
4. In order for the AAS request to be considered for ANC purposes, the Plan must submit the request with the ANC exhibits no later than thirty (30) calendar days after receipt of DHCS' ANC documents package, unless an extension is granted by DHCS.
 - a. DHCS highly encourages the Plan to submit early to allow DHCS sufficient time to provide technical assistance and ensure review for completion.
 - b. DHCS will not accept any AAS requests after the ANC submissions deadline and the Plan that cannot demonstrate compliance with AAS will be subject to the imposition of a CAP and/or other enforcement actions.
5. The AAS request submission must detail the facts and circumstances for each AAS request and provide supporting details as outlined in [Attachment B](#), Exhibit C. The Plan is required to utilize [Attachment C](#) provided by DHCS, which includes specific data entry requirements, dropdown cells and other functions that allow for use with DHCS' internal databases.
 - a. Failure to use the correct [Attachment C](#) may result in a rejection of the Plan's entire AAS request submission.
6. When completing [Attachment C](#), the Plan must utilize the following Provider resource lists to identify Providers for inclusion in the AAS request:
 - a. Managed Care Open Data Portal
 - b. Fee-for-Service Open Data Portal

7. DHCS will send an AAS determination letter informing the Plan of AAS approvals and denials. DHCS approves or denies AAS requests for each county, ZIP code, Provider type and population served, including specialty type and analyzes the information provided by the Plan, information from other Plans operating in Los Angeles County and bordering counties, and DHCS' research of closer Providers to validate each request. Approved AAS requests are contingent on the results of DHCS' AAS validation process.
 8. DHCS may revoke any approved AAS requests if an inaccuracy is discovered, or the Plan is unable to provide all required supporting documentation during the validation process. The Plan must review and respond to each AAS denial, by either revising the miles and/or minutes; providing updated justifications and evidence of contracting efforts; or providing additional information to assist DHCS in its review.
 9. The Plan must maintain documentation of all efforts to contract with additional OON Providers identified in their AAS requests that are in their county and bordering counties where they have Network deficiencies. DHCS encourages the Plan to contract with all available Providers, including those outside of time or distance standards, to increase their Network capacity. Contracting efforts may not be required in cases in which DHCS agrees that the Plan is contracted with the closest Provider but is still unable to meet time or distance standards. In such instances, the Plan must provide additional information in [Attachment C](#).
 10. The Plan must provide all documentation of failed contracting efforts to DHCS upon request, during the AAS validation process or at any time DHCS requests additional documentation. DHCS may request the Plan to perform additional contracting efforts if DHCS identifies additional Providers that may correct a Network deficiency during the internal review process.
- ii. Additional Medi-Cal Managed Care Health Plan Requirements for Approved Alternative Access Standards
1. If the Plan receives AAS approvals from DHCS, the Plan must inform their affected Members who reside in the ZIP code where an AAS request was approved by posting all approved AAS on their websites within thirty (30) days after DHCS publishes the statewide results.
 - a. The Plan must also inform their affected Members where DHCS has approved the use of Telehealth to meet time or distance standards in lieu of AAS requests.

2. If the Plan receives an approved AAS for a core Specialist, it is required to assist any requesting Member in obtaining an appointment with an appropriate OON core Specialist, in person or via Telehealth.
 - a. When assisting the Member, the Plan must make its best effort to establish a Member-specific case agreement with an OON core Specialist at the Medi-Cal fee-for-service rate or a mutually agreed upon rate, unless the Plan has already attempted to establish a Member-specific case agreement with the OON core Specialist in the most recent Fiscal Year, and the core Specialist has refused to enter into an agreement.
 - b. If this cannot be arranged, the Plan must arrange for an appointment with a Network Specialist. The OON core Specialist must be able to provide services to a Member within the applicable time or distance and timely access standards and, in cases where the OON Specialist is not able to provide services to a Member under these standards, the Plan must arrange for Non-Emergency Medical Transportation or Non-Medical Transportation.
3. Further, the Plan must continually demonstrate that they have a process in place to arrange services through Telehealth (at the Member's preference) or to provide transportation for Members who need to access services outside of time or distance standards.

iii. Delivery System Alternative Access Standard

1. In cases where the Plan is unable to meet time or distance due to its delivery system, DHCS is authorized to determine if the Plan is capable of delivering the appropriate level of care and access to Members through a delivery system AAS.
 - a. In order to be considered for a delivery system AAS justification, the Plan must submit a written request to DHCS following the instructions in [Attachment B](#) of DHCS APL 23-001. If accepted, DHCS will provide the requesting Plan a template to submit the formal delivery system AAS justification.
2. DHCS will review the Plan's submission to determine if the justification for a delivery system AAS meets the needs of the Plan's Members and ensures appropriate and timely access to care.

- a. An approved delivery system AAS is valid for one RY; however, if DHCS approved the Plan's delivery system AAS justification for the previous RY, the Plan can submit an attestation certifying it is seeking to utilize the previously approved justification for the current ANC.

g. Annual Network Certifications

- i. DHCS validates the Plan's submission by reviewing the 274 File submission, contracts with Network Providers, mandatory Providers and AAS requests. As part of this process, DHCS evaluates the Plan's contracting efforts, verifies the authenticity of contract signature pages, and reviews other evidence and supporting documentation and determines the accuracy and completeness of the submission. DHCS may request additional Plan documentation at any time in order to confirm that the information included in the submission is accurate.
- ii. The Plan's failure to provide the requested documentation or a determination by DHCS that the information in the submission is invalid or inaccurate will lead to rescission of the ANC approval, implementation of a CAP, and/or other enforcement actions.

h. Non-Compliance with Network Certification Requirements

i. Preliminary Review of Submission

- 1. DHCS will provide technical assistance to all Plans that submit a complete ANC submission by the deadline. DHCS may not be able to provide technical assistance to Plan's that do not meet the submission deadline. Technical assistance will be provided in the form of a preliminary findings worksheet, and will contain DHCS' initial review of the quality, accuracy and completeness of the Plan's submission.

- a. The Plan will have the opportunity to resubmit a corrected submission for identified errors, incompleteness, and inaccuracies within ten (10) business days. No additional assistance outside of the technical assistance process will be provided to Plans; Therefore, the submission resulting from the technical assistance process will be reviewed for compliance with the requirements.

2. Corrective Action Plans

- a. The Plan must submit a detailed plan of action setting forth all steps the Plan will take to correct the ANC deficiencies identified in the CAP notification letter. The Plan will have six (6) months to correct all deficiencies

including continually working to improve access within its Provider Networks and comply with all CAP mandates set forth below until the CAP is closed.

- i. The Plan must close out any deficiencies identified in the CAP in a timely manner to ensure Member access is adequate and continue to work to improve access within their Networks.
- b. Additionally, DHCS may impose sanctions for failure to comply with Network adequacy requirements at the end of the CAP period. The factor(s) set forth in WIC section 14197.7(g) will be considered by DHCS when assessing and determining the amount of the monetary sanction.

3. Corrective Action Plan Mandates

- a. A Plan under an ANC CAP must comply with the following mandates:
 - i. Provide an initial CAP response no later than thirty (30) days after the issuance of the CAP notification letter;
 - ii. Provide DHCS with monthly status updates that demonstrate action steps the Plan is undertaking to correct the CAP deficiency(ies);
 - iii. Authorize OON access to Medically Necessary Providers within timely access standards and applicable time or distance standards specified in the CAP, regardless of associated transportation or Provider costs until the CAP is completed by the Plan and closed by DHCS;
 - iv. Demonstrate the ability to effectively provide OON access information to Members and ensure that its Member services staff, Network Providers, and Subcontractors are trained on the mandates, including the right for Members to request OON access for Medically Necessary services and transportation to Providers where the Plan is unable to comply with ANC requirements.
- b. DHCS will review the CAP submissions and the Plan's deliverables to ensure compliance with CAP mandates. DHCS will provide technical assistance during the CAP timeframe or if additional corrective action is required.

- c. If the Plan submits an updated or new AAS to address a Network deficiency, the Plan must continue to comply with its previously approved AAS until the updated or new AAS is approved by DHCS. Before approval, the Plan must continue to provide transportation services for Members to any Network Providers or OON Providers under the terms of the previously approved AAS.
 - d. The Plan is required to ensure that their Network Providers and Subcontractors are informed of and adhere to the CAP mandates, and comply with all OON access authorization and transportation requirements.
 - i. Subcontractors' Compliance with Member Access Requirements
 - i. The Plan is required to have processes in place to ensure Subcontractors comply with Network adequacy and access requirements as set forth in DHCS APL 23-006 and any subsequent revisions.
 - 1. Plan assigned Members who receive care through Subcontractors must have the same access to required Providers as they would through the Plan's Provider Network. To ensure this access, Plans may permit Subcontractors to supplement their Provider Networks with Plans' direct Networks.
 - ii. Additionally, the Plan must have contractual provisions and policies and procedures in place for identifying when changes in a Subcontractor's Network results in the Plan being out of compliance with any of the ANC requirements. The Plan is responsible for ensuring that their Subcontractors comply with all contractual obligations and applicable state and federal laws and regulations thus, when the Plan finds a Subcontractor has a Network adequacy deficiency as set forth in DHCS APL 23-006 and any subsequent revisions, the Plan must impose a CAP until all deficiencies are corrected.
 - 1. The Plan must report all significant instances of a Subcontractor's deficiencies and impositions of CAPs to DHCS.
 - j. Post Network Certification Monitoring Activities
 - i. The Plan is subject to quarterly monitoring by DHCS, which may include requests for additional evidence and information, including, but not limited to, timely access surveys; investigation of complaints, Grievances, Appeals, and issues of noncompliance with contractual requirements and policy guidance; Plan Network monitoring and oversight assessments; quality of care indicators; data reviews for

utilization capacity and Provider-to-Member ratios; authorization of OON requests; and the provision of transportation services.

- ii. In conjunction with quarterly monitoring processes, DHCS continues its existing data quality review processes by verifying Encounter and Provider data quality performance metrics include, but are not limited to, primary source verification. At least annually or more frequently as directed by DHCS, the Health Plan shall cooperate with and assist the External Quality Review Organization (EQRO) designed by DHCS in conducting its EQR reviews of the Health Plan. The Health Plan shall participate in the EQRO's validation of the Health Plan's network adequacy representations from the preceding 12 months to comply with the requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358.
 - iii. The Plan is 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. The Plan must also ensure that transportation is available when necessary to access OON Providers.
- k. The Plan is responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.

20. Subcontractor Network Certification (SNC)

a. Circumstances for Submission

- i. DHCS is required by state and federal laws to annually certify the Plan's full Provider Network for compliance with Network adequacy and access requirements and provide an assurance of that compliance to CMS for the RY. As of the 2022 RY, the CalAIM 1915(b) Waiver STCs also require DHCS to provide the same assurances of Network adequacy and access for the Provider Networks of all Plan Subcontractors and Downstream Subcontractors that have assumed risk per their Subcontractor and Downstream Subcontractor Agreements. Henceforth, the Plan is required to undergo a SNC annually that is separate and distinct from the submission process for the Annual Network Certification (ANC).
- ii. SNC is also required (1) when a Subcontractor Network experiences a significant change, and (2) when the Plan enters into a new risk-based Subcontractor Agreement with a Subcontractor that expands the Plan's existing Provider Network. A significant change is (1) an event that impacts the provision of health care services for two thousand (2,000) or more Members or (2) when a Subcontractor Network change causes the Plan to become noncompliant with any of the Network adequacy and access standards outlined in APL 23-001 or any superseding APL.

- iii. In either instance, Plans must submit the applicable SNC documentation for only the Network adequacy and access standards impacted by the significant change or noncompliance. If a significant change occurs within the ninety (90) calendar days prior to the SNC annual submission date, the Plan can document the change as part of that RY SNC filing. For any significant changes that occur after the SNC annual submission date, the Plan should submit the applicable SNC documentation for only the Network adequacy and access standards impacted by the significant change and report the change in the SNC for that RY.

b. Subcontractor Network Criteria

- i. Subcontractors and Downstream Subcontractors can be Plans that are delegated to arrange for the provision of Covered Services on behalf of another Plan, or any other entities that are delegated responsibility by Plans and Subcontractors for specific services and/or populations such as medical groups, independent physician associations, clinics, and community-based organizations. Whether a Subcontractor or Downstream Subcontractor is fully or partially delegated for functions and obligations under their Subcontractor or Downstream Subcontractor Agreement, Subcontractor Networks are only required to meet the Network adequacy and access standards for the Members assigned to the Subcontractor Network, and for Covered Services the Subcontractor or Downstream Subcontractor is contracted to arrange for Members on behalf of the Plan or Subcontractor. Refer to the SNC Instruction Manual (Attachment A) for details on determining which standards each Subcontractor Network must meet based on populations served and services covered.
- ii. For the annual SNC, Plans must include all Subcontractor Networks reported via the 274 Provider Network data file, unless the Subcontractor Network is exempt per the criteria listed below and the requirement documentation provided substantiates the exemption. In addition to Service Areas where Plans only contract directly with individual Providers and no Subcontractor Networks exist, the following describes the Subcontractor Networks that are exempt from SNC:
 - 1. The Plan only contracts with one Subcontractor Network in the Service Area, and no Providers directly contract with the Plan;
 - 2. The Subcontractor Network only provides specialty or ancillary services; or
 - 3. The Subcontractor Network only provides care through single case agreements and is not available to all the Plan's members upon enrollment.

- iii. Plans are to submit exemption requests with their SNC submission per the instructions provided in Attachment A using the Subcontractor Network Exemptions Request template (Attachment B). DHCS will review each exemption request and provide a formal notification of the disposition to the Plan. Approvals are valid for one (1) calendar year until the next annual SNC filing.

c. Submission

- i. Plans must submit the required SNC documentation to DHCS that accurately reflects the Plan's monitoring of Subcontractor Networks, no later than forty-five (45) days following the RY or, if the date falls on a weekend, the next Working Day. The Plan must submit all required SNC documentation as described in Attachment A with the correct file naming conventions through the DHCS Secure File Transfer Protocol site. If the Plan fails to submit complete and accurate SNC documentation by the SNC annual submission date is subject to the imposition of a corrective action plan (CAP) and/or other enforcement actions pursuant to the Plan Contract, Welfare, and Institutions Code (WIC) section 14197.7(e), and DHCS APL 22-015 or any superseding APL.
- ii. The SNC submission consists of three parts: (1) the Subcontractor Network Exemptions Request template (Attachment B), (2) the Network Adequacy and Access Assurances Report (NAAAR) (Attachment C), and (3) verification documents. The NAAAR, Attachment C, is a modified CMS reporting template containing two sections, Sections B and C, that Plans are required to complete. Section A of the template is prepopulated with the state's Network adequacy and access standards for which Plan's must hold their Subcontractors accountable, as applicable per Subcontractor Network. Because these Network adequacies and access standards are the same as those DHCS uses to certify Plans' Provider Networks through the ANC process, please refer to APL 23-001, or any superseding APL, for the specific time or distance, timely access, Provider to Member ratios, and mandatory Provider types of standards Plans must use to monitor the compliance of their Subcontractor Networks.
- iii. In Section B of the NAAAR, Plan's must delineate the types of analyses they use to monitor and determine the Network adequacy and access compliance of Subcontractor Networks. In Section C, Plan's report, in detail, the compliance results and findings of all the Subcontractor Network monitoring analyses conducted within the RY. Refer to Attachment A for detailed instructions on how to fill out the NAAAR.
- iv. The third part of the SNC submission is submission of documents for DHCS' review verify the compliance results and findings reported on the NAAAR. Due to the size of California's Medicaid managed care program and the number of Subcontractor Networks, DHCS will verify



documents for a subset of the Plan's Subcontractor Networks. DHCS will notify Plans of the Subcontractor Networks to be sampled, at a minimum, at least thirty (30) days in advance of the annual SNC submission date of forty-five (45) days after the end of the RY, or the next Working Day if the date falls on a weekend. The Plan is only required to send verification documents for Subcontractor Networks which DHCS notifies are to be sampled per Services Area/county for the specified RY.

- v. A Service Area is the county or counties that the Plan is approved to operate in under the terms of their DHCS Contract. If the Service Area for a Subcontractor or Downstream Subcontractor is otherwise designated differently in the Subcontractor or Downstream Subcontractor Agreement, the Plan must show proof of that definition using the Subcontractor Network Exemptions Request (Attachment B).
- vi. To ensure every Subcontractor Network is verified, DHCS will remove the previously approved Subcontractor Network(s) from the Plan's pool of Subcontractor Networks after every annual SNC until all the Plan's Subcontractor Networks have been sampled and verified. Once all the Plan's Subcontractor Networks have been sampled and verified, the random selection cycle will begin again. Please refer to the Subcontractor Network Certification Instruction Manual (Attachment A) for more information about the required verification documents, including the list of acceptable types of documentation the Plan may submit to DHCS. DHCS may request additional Plan verification documents at any time in order to confirm that the information provided on the NAAAR is accurate. A Plan's failure to provide the requested documentation or a determination by DHCS that the information in the SNC submission is invalid or inaccurate may lead to implementation of a CAP and/or other enforcement actions

d. Non-Compliance

- i. All Subcontractor Network deficiencies impacting Member access to care, as identified by a Plan while monitoring, must result in the Plan, or the Subcontractor (if delegated utilization management), authorizing Covered Services from Out-of-Subcontractor Network (OOSN) Providers for Members in the deficient Subcontractor Network. OOSN Providers used to supplement a deficient Subcontractor Network may include Providers from a Plan's own direct Provider Network or those Out-of-Network when necessary. The Plan, or Subcontractor or Downstream Subcontractor which is delegated utilization management, must authorize Covered Services from OOSN Providers regardless of associated transportation or Provider costs until the deficiency is addressed. A Health Plan or Subcontractor must also ensure that the deficient Subcontractor or Downstream Subcontractor informs Members that OOSN access to services is available, and that the Plan's or Subcontractor's Member

services staff are trained on Members' right to request OOSN access for Covered Services and transportation to Providers where the Subcontractor or Downstream Subcontractor is unable to comply with Network adequacy or access standards.

e. Deficiencies and Corrective Action

- i. Upon completing the review of SNC submissions, DHCS will provide a CAP notification letter to each Plan found non-compliant with the SNC requirements of this APL, outlining the deficiencies and specific issues of noncompliance that the Plan must address. Plan's must provide an initial CAP response, no later than thirty (30) calendar days after the issuance of the CAP notification letter, that details a plan of action and sets forth steps the Plan will take to correct the deficiencies identified.
- ii. Plans have six (6) months to correct all deficiencies during which time Plan's must provide DHCS with monthly status updates that demonstrate action steps the MCP is undertaking to address the CAP. DHCS may impose sanctions, or other appropriate enforcement actions, for failure to comply with Network adequacy and access standards at the end of the six (6) month CAP period. If monetary sanctions are to be imposed, DHCS will consider the factors set forth in WIC section 14197.7(g) when assessing and determining the amount.

Procedure:

Operational Procedure

1. The Director of Contracting and Provider Relations is responsible for recruiting and executing written arrangements with providers in accordance with the Health Plan's provider network needs.
2. The Director of Contracting and Provider Relations is responsible for developing and maintaining PCP panels to ensure enrollees have options when selecting and/or changing their PCP within the Health Plan's network. PCPs are defined as Internal Medicine, Family Practice, OB/GYN or Infectious Disease and must meet the definition of an HIV/AIDS specialist as established by the American Academy of HIV Medicine.
3. The Contracting and Provider Relations staff develops a network of specialists, hospitals, and ancillary providers. *NOTE:* Targeted specialists are preferred to have privileges at a contracted health plan hospital.
4. The Contracting and Provider Relations staff focuses network development on high volume specialists, and other providers specific to a particular specialty or for a specific geographic area of need. The staff makes every effort to utilize non-participating reports as well as requests for specific providers from participating providers when determining recruitment targets.
 - a. The Health Plan identifies high-volume specialists through analysis of encounter and claims data to determine which specialties account for the highest utilization and member demand. High-volume specialties are generally those that provide services to a



large percentage of enrollees or demonstrate significant impact on cost and access to care.

- b. The Health Plan also considers enrollee demographics and chronic disease prevalence to identify specialties with consistent demand, such as cardiology, dermatology, psychiatry, and endocrinology.
 - c. In addition, specialties that are subject to Department of Managed Health Care (DMHC) Timely Access or Annual Network Review reporting requirements are classified as high-volume for oversight purposes. The Health Plan establishes internal thresholds, such as specialties representing five percent or more of total encounters or those appearing in the top ten by utilization volume, to ensure consistent identification. High-volume specialists are prioritized for network adequacy monitoring, credentialing oversight, and quality review activities.
5. The Director of Contracting and Provider Relations assesses the provider network by generating Geo Access reports on a quarterly basis to determine provider network adequacy and compliance with time/distance standards.
6. The Director of Contracting and Provider Relations (P or designee assess cultural, ethnic, racial and linguistic needs for Plan enrollees on an annual basis. The Plan does not require enrollees nor Plan providers to disclose cultural, ethnic, racial or linguistic information thus information is communicated to the Plan on a voluntary basis only.
- a. Following receipt of PHC Enrollee Demographic reporting data from the Plans internal reporting system (BI Portal) or internal Business Analytics (Information Technology) representative(s). PR subsequently generates customized Geo Access Reports utilizing then current access standards. The customized Geo Access Reports provide a comprehensive comparison of in network cultural, ethnic, racial and linguistic information reported from in network providers against the PHC Enrollee Demographic report to identify applicable deficiencies within the Plan's network. The PR department subsequently initiates recruitment plans to identify and contract with targeted providers to resolve identified cultural, ethnic, racial and/or linguistic deficiencies.
 - a. The Health Plan assess cultural, ethnic, racial and linguistic needs for Plan enrollees to ensure accessibility and availability of in network providers meets the then current needs of Plan enrollees.
7. The Contracting and Provider Relations Manager develops and implements a network development plan for network deficiencies identified in the Geo Access assessment.
8. The Contracting and Provider Relations staff arrange for specialty care outside of the provider network when network Providers are unavailable in order to meet an enrollee's medical needs as requested by the UM (Utilization Management) department.
- a. The Contracting and Provider Relations representatives identifies an out-of-network Provider that is geographically accessible to the Member and negotiates a one-time Letter of Agreement, (LOA) with that Provider (see LOA policy).
 - b. The LOA is forwarded to the Credentialing Department for verification of current licensure and to query the Office of Inspector General, (OIG) and excluded parties List.

- c. If the Provider's credentialing check is satisfactory, the PR Manager executes the LOA and notifies the UM department to move forward with the referral.
 - d. If the Provider's credentialing check is not satisfactory, PR does not execute the LOA and seeks another Provider of the same specialty.
9. The Health Plan Administrator files an amendment with DMHC in the event the plan's provider network experiences a change that is 10 percent or greater.

Regulatory Procedure:

1. The Health Plan's Provider Relations staff initiates review of the Annual Network Certification (ANC) submission requirements to the Department of Health Care Services (DHCS) to ensure accurate and timely responses to DHCS.
2. Interdepartmental coordination with internal business analyst representatives occurs to ensure consistency with the Health Plans 274 file submission (January submission) and the Health Plan's ANC submission.
3. The ANC submission includes the prior quarters' Geo Access Reports and corresponding Access Analysis to confirm DHCS network capacity and ratio requirements (i.e. time and distance standards outlined in the table above) are met.
4. The Health Plan's ANC submission includes mandatory provider types and applicable mandatory provider type's exclusion requests in instances where mandatory provider types are not clinically appropriate for Health Plan members.
5. DHCS ANC requires alternative access standard submissions for Health Plans that are unable to demonstrate compliance with DHCS time and distance access standards. Due to the Health Plan's delivery system structure and small Medi-Cal census, the Health Plan will submit an Alternative Access Standards (AAS) request to DHCS for every annual submission.
 - a. Following the Health Plan's receipt of the ANC submission request from DHCS, the Health Plan's Provider Relations Analyst will coordinate with the Health Plan's Medi-Cal Contract Manager to submit an AAS request to DHCS MCMD NAU's mailbox.
 - i. Once the Health Plan receives AAS approval with the corresponding AAS Request Template from DHCS MCQMD NAU, the Health Plan's Provider Relations Analyst will complete the AAS Request Template. This completed template will be submitted internally to the Health Plan's Compliance and Medi-Cal Contract Manager for review and internal approval prior to dissemination to DHCS MCQMD NAU.
6. All remaining requirements associated with the current DHCS ANC are included in the Health Plan's submission. These requirements include but are not limited to the following:
 1. Annual Network Certification Validations
 2. Telehealth Providers (as applicable)

3. Timely Access Survey

Following the Health Plan's receipt of the DHCS ANC approval, the Health Plan uploads approved alternative access standards to the Health Plan's website.

Monitoring:

1. The Director of Contracting and PR generates periodic Geo Access reports to monitor Provider network adequacy in compliance with time and distance standards. Patient ratios are calculated based on Geo mapping and monitored for patient capacity.
 - a. Plan completes and annual analysis of the prior years' Alternative Access submission to the Department of Healthcare Services to identify newly licensed providers and/or providers that have relocated their respective practices to the network deficient areas. As the Plan identifies network recruitment opportunities in the targeted areas, Plan implements an annual recruitment initiative to resolve the prior year's deficiencies.
2. Geo Access reports are submitted to the Member Provider Committee quarterly.
3. The Plan utilizes quantitative and qualitative analysis from out of network (Letter of Agreement) request received from internal stakeholders along with internal grievance data to identify network opportunities for improvement.
4. Ongoing Recruitment: Areas identified on the Health Plan's approved Alternative Access standards are continuously reviewed by the Health Plan's Provider Relations department throughout the year. This review includes identification (based upon specialty need) and subsequent recruitment outreach to all newly licensed providers and/or providers that have relocated to the applicable area(s) of deficiency to aid in resolving deficiencies in the Health Plan's network.
5. This policy is updated, as necessary, reviewed and approved annually by the Member Provider Committee.

Reference(s):

1. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001, [Network Certification Requirements](#) (Supersedes 21-006), dated January 6, 2023.
2. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006 [Delegation and Subcontractor Network Certification \(Supersedes APL 17-004\)](#), dated March 23, 2023.
3. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-027 [Cost Avoidance and Post-Payment Recovery for Other Health Coverage](#) (Supersedes APL 21-002), dated December 6, 2022.
4. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-015 [Enforcement Actions: Administrative and Monetary Sanctions](#) (Supersedes APL 18-003), dated August 24, 2022.
5. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-007-009 (Supersedes APL 19-009) [Telehealth Services Policy](#), dated April 10, 2023.
6. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022 [Access Requirements for](#)

[Freestanding Birth Centers and the Provision of Midwife Services](#) (Supersedes APL 16-017), dated December 19, 2018.

7. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006 [Delegation and Subcontractor Network Certification](#) (Supersedes APL 17-004), dated March 28, 2023.
8. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-005 [Federally Qualified Health Centers and Rural Health Clinics Financial Incentive and Pay For Performance Payment Policy](#), dated June 12, 2019.
9. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002 [Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members](#), dated February 8, 2024.
10. DHCS APL 25-006, Timely Access Requirements, dated April 25, 2025
11. OR Contract #22-20597, Exhibit A, Attachment III, 5.2 Network and Access to Care, and Section 2.2.9 External Quality Review (EQR) Requirements.
12. Title 22 CCR, sections 51240, 51241, 53860(d), and 55120
13. 42 CFR sections 438.310, 438.68, 438.206, 438.207 and 438.14
14. W&I Code sections 14087.325, 14197, 14197(b), 14197(f)(1), 14197(e)(1)(A), 14197(e)(4), 14132.72(f), 14197(f)(1)–(2), 14197(f)(3)(C), 14197(f)(3), 14132.39, 14132.4, 14197.04(a)-(c), 14197(f)(2)(B), 14197(f)(3), 14197(f)(2), 14197(D), 14197.7 (e)(6) and 14197.7(d-e)
15. CCR Section 1399.545
16. California Business and Professions Code Section 2836.1
17. California Health & Safety Code sections 1367.69 and 1374.141(a).
18. 42 United States Code section 1396d(a)(17) and 1396u-2(c)(2)
19. T & D Specialty spreadsheet (Alternative Access) approved by DHCS July 2019.
20. Medi-Cal Screening and Enrollment Provider Attestation
21. Credentialing Policy and Procedure [PHC-CA Provider Screening and Enrollment Program](#)
22. Section 1367.27(r); Rule 1300.52(f); Rule 1300.67.2.2(d)(2).

Regulatory Agency Approvals:

Date	Version	Agency	Purpose	Response
6/21/2023	1.6	Dept. of Health Care Services (DHCS)	2024 Operational Readiness (O/R) Item R.0174	Approved
6/21/2023	1.6	DHCS	O/R R.0176	AIR1
6/21/2023	1.6	DHCS	O/R R.0178	Approved



12/18/2023	1.6	DHCS	O/R R.0183	Approved
8/9/2023	1.7	DHCS	O/R R.0077	Approved
8/22/2023	1.7	DHCS	O/R R.0177	Approved
8/22/2023	1.7	DHCS	O/R R.0179	Approved
10/2/2023	1.9	DHCS	O/R R.0043	AIR1
8/22/2023	1.9	DHCS	O/R R.0176 AIR1	Approved
10/26/2023	1.10	DHCS	O/R R.0043 AIR1	Approved
7/5/2024	1.11	DHCS	APL 24-002	Approved
8/15/2025	1.12	DHCS	APL 25-006	Approved
TBD	1.13	DHCS	MCOD Portal Item D.0383 (updated R.0178)	Pending

