DHCS Medi-Cal Managed Care Manual

California Medi-Cal Managed Care Compliance Requirements

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1. Introduction to DHCS and Medi-Cal Managed Care

The California Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides health coverage to over 14 million Californians. Managed Care Plans (MCPs) contracted with DHCS serve the majority of Medi-Cal beneficiaries and must comply with extensive state and federal requirements.

This manual provides a comprehensive overview of the key compliance requirements for Medi-Cal managed care organizations, covering contractual obligations, operational standards, and quality expectations established by DHCS.

Regulatory Framework

- California Welfare and Institutions Code (W&I Code)
- California Code of Regulations, Title 22
- DHCS Managed Care Contract (Boilerplate and Exhibits)
- All Plan Letters (APLs) - binding policy guidance
- Federal requirements: 42 CFR Part 438 (Medicaid Managed Care)
- CalAIM (California Advancing and Innovating Medi-Cal) initiatives

Key DHCS Oversight Bodies

- Managed Care Quality and Monitoring Division (MCQMD)
- Managed Care Operations Division (MCOD)
- Office of Administrative Hearings and Appeals
- Department of Managed Health Care (DMHC) - for Knox-Keene licensed plans

2. Managed Care Plan Contract Requirements

DHCS contracts with MCPs establish comprehensive requirements covering all aspects of plan operations. These contracts incorporate state law, federal regulations, and DHCS policy directives including All Plan Letters.

Core Contract Obligations

- Provide all Medi-Cal covered benefits to enrolled members
- Maintain sufficient provider networks to ensure timely access
- Process claims within 30 working days (90% of clean claims)
- Maintain quality improvement programs meeting DHCS standards
- Submit encounter data accurately and timely
- Comply with all applicable APLs within specified timeframes
- Maintain cultural and linguistic services programs

Population Health Management

- Health Risk Assessment for new members within 120 days
- Individualized Care Plans for high-risk members
- Care coordination for members with complex needs
- Enhanced Care Management (ECM) for priority populations
- Community Supports (in lieu of services) offerings

CalAIM Requirements

CalAIM represents California's multi-year initiative to transform Medi-Cal. MCPs must implement:

- Population Health Management across all members
- Enhanced Care Management for eligible populations
- Community Supports (formerly ILOS)
- Behavioral Health integration and Specialty Mental Health coordination
- Justice-involved population transition services

3. Enrollment and Eligibility

Enrollment Processing

- Accept all Medi-Cal eligible individuals in the service area
- Process enrollment within DHCS-specified timeframes
- Provide new member materials within 30 days of enrollment
- Conduct Health Risk Assessments (Initial Health Assessments)
- Assign primary care provider within established timelines

Continuity of Care

- Allow continued treatment with out-of-network providers for up to 12 months
- Honor existing authorizations from prior plan for at least 60 days
- Ensure prescription continuity during transitions
- Coordinate care transitions for members changing plans

Disenrollment Protections

- No disenrollment based on health status or utilization
- Involuntary disenrollment only per DHCS-approved reasons
- Member right to change plans during open enrollment or for cause
- Continue services during disenrollment appeal periods

4. Access and Availability Standards

DHCS establishes detailed access and availability standards that MCPs must meet for all Medi-Cal members. These standards cover appointment wait times, geographic access, and after-hours availability.

Appointment Wait Time Standards

- Urgent care (no prior authorization): within 48 hours
- Urgent care (prior authorization required): within 96 hours
- Non-urgent primary care: within 10 business days
- Non-urgent specialist: within 15 business days
- Non-urgent mental health (non-psychiatrist): within 10 business days
- Non-urgent ancillary services: within 15 business days

Geographic Access Standards

- Primary care: within 10 miles or 30 minutes in urban areas
- Hospitals: within 15 miles or 30 minutes
- Specialists: within geographic standards per specialty type
- Pharmacy: within reasonable distance based on county type

After-Hours Requirements

- 24/7 nurse advice line with appropriate language capabilities
- Access to urgent and emergency services at all times
- After-hours triage and referral protocols
- Provider on-call arrangements for enrolled members

Monitoring and Reporting

- Annual access surveys and provider availability studies
- Quarterly network adequacy certifications to DHCS
- Timely access complaints tracking and trending
- Corrective action when standards are not met

5. Quality and Performance Measures

DHCS Quality Requirements

- Quality Assessment and Performance Improvement (QAPI) program
- Annual HEDIS reporting per DHCS specifications
- CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys
- External Quality Review Organization (EQRO) participation
- Performance Improvement Projects (PIPs) as directed by DHCS

Key Performance Measures

- Childhood and adolescent immunization rates
- Well-child visits and preventive screenings
- Prenatal and postpartum care timeliness
- Diabetes and cardiovascular disease management
- Behavioral health follow-up after hospitalization
- Emergency department utilization rates

Auto-Assignment Incentives

DHCS uses quality performance to determine auto-assignment algorithms. Higher-performing plans receive a greater share of members who do not actively choose a plan. Key factors include:

- HEDIS measure performance relative to benchmarks
- CAHPS survey results and member satisfaction
- Network adequacy and access metrics
- Grievance and appeal rates and resolution
- Encounter data completeness and accuracy

6. Grievance and Appeal System

MCPs must maintain a grievance and appeal system that meets both federal (42 CFR 438.400-424) and state (Knox-Keene Act, W&I Code) requirements.

Grievance Requirements

- Acknowledge grievance within 5 calendar days
- Resolve standard grievances within 30 calendar days
- Expedited grievances resolved within 72 hours
- Provide written resolution notice with appeal rights
- Track, trend, and report grievance data to DHCS

Appeal Requirements

- Members have 60 calendar days to file an appeal
- Standard appeals resolved within 30 calendar days
- Expedited appeals resolved within 72 hours
- Continuation of benefits during appeal if requested timely
- Independent Medical Review (IMR) through DMHC as external review

State Fair Hearing Rights

- Members may request State Fair Hearing after exhausting plan appeals
- 120-day filing deadline from notice of appeal resolution
- Aid paid pending during State Fair Hearing if requested within 10 days
- MCP bears burden of proof for service denials

7. Utilization Management Requirements

Prior Authorization Standards

- Standard decisions within 5 business days (extendable by 14 days)
- Expedited decisions within 72 hours
- Written notice to member and provider for all denials
- Clinical criteria based on evidence-based guidelines
- Peer-to-peer review available for providers
- Retroactive authorization for emergency services

Medical Necessity Determinations

- Licensed physician makes all denial decisions
- Use of nationally recognized clinical criteria (MCG, InterQual)
- Consider individual member circumstances
- Document clinical rationale for all adverse decisions
- Provide specific denial reasons citing applicable criteria

Behavioral Health UM

- Comply with Mental Health Parity requirements
- No more restrictive criteria than medical/surgical benefits
- Coordinate with county mental health for specialty services
- Substance use disorder services per ASAM criteria
- Crisis services without prior authorization

8. Provider Network Management

Credentialing Requirements

- Initial credentialing before provider sees members
- Re-credentialing every 3 years minimum
- Primary source verification of licenses and certifications
- NPDB query at initial credentialing and re-credentialing
- OIG/GSA exclusion list checks monthly
- Credentialing committee with physician participation

Provider Relations

- Written provider agreements with required contract provisions
- Provider manual with policies, procedures, and contact information
- Regular provider training on plan requirements
- Provider dispute resolution process (45 days for standard)
- Claims payment within 30 working days for clean claims

Network Monitoring

- Ongoing monitoring of provider performance and quality
- Termination for cause protocols and member notification
- Provider accessibility and availability surveys
- Cultural competency and language capability assessments

9. DHCS Audits and Monitoring

Types of DHCS Oversight

- Annual Medical Audits (comprehensive operational review)
- Financial Audits (annual fiscal solvency review)
- EQRO Technical Reports and Performance Measure Validation
- Focused audits on specific compliance areas
- Encounter data validation studies
- Network adequacy reviews

Medical Audit Focus Areas

- Access and availability compliance
- Utilization management practices
- Quality improvement program effectiveness
- Grievance and appeal system compliance
- Continuity and coordination of care
- Members' rights protections
- Cultural and linguistic services

Monitoring Activities

- Monthly, quarterly, and annual reporting to DHCS
- Encounter data quality reviews
- Network adequacy certifications
- Quality measure dashboards and scorecards
- Compliance with APL implementation deadlines

10. Corrective Action and Sanctions

DHCS Enforcement Tools

- Corrective Action Plans (CAPs) with defined milestones
- Monetary sanctions per contract provisions
- Enrollment freezes for serious deficiencies
- Contract non-renewal or termination
- Referral to other regulatory agencies (DMHC, OIG)

Common Deficiency Areas

- Timely access to care not meeting DHCS standards
- Prior authorization processing delays
- Incomplete or inaccurate provider directories
- Grievance resolution timeliness failures
- Encounter data quality issues
- Inadequate care coordination for complex populations

Ready to strengthen your Medi-Cal managed care compliance? Contact Ginete Healthcare Consulting Group:
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