Policy:	GG.1600
Title:	**Access and Availability Standards**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/ Michael Hunn 12/20/2024*
Effective Date:	12/01/1999
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Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes required access and availability standards, including Provider Network adequacy, for Members to obtain effective, appropriate, and timely access to care and describes the process used by CalOptima Health for annual Network Certification.

II. POLICY

A. General Access

1. CalOptima Health shall evaluate CalOptima Health's and a Health Network's compliance with the standards outlined in this Policy. Unless otherwise stated, each access and availability standard outlined herein shall have a minimum performance threshold of eighty percent (80%).

2. CalOptima Health and its Health Networks shall not discriminate against Members on the basis of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, language, gender identity, identification with any other persons or groups defined in Penal Code, Section 422.56, health status, or physical or mental disability.

3. CalOptima Health and its Health Networks shall provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.

    a. If a Provider cannot meet the minimum access standards for disabled Members, CalOptima Health and its Health Networks shall coordinate a referral to a Provider with the appropriate access standards.

4. CalOptima Health and its Health Networks shall ensure that Providers offer flexibility in scheduling Covered Services for Members with disabilities.

5. In the event a Provider has a religious, moral, or ethical objection to perform or otherwise support the provision of Covered Services, CalOptima Health or Health Network must timely arrange for, coordinate, and ensure Members receive Covered Services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure at, no additional expense to DHCS or the Member.

6. If a Health Network refers a Member to a different Provider pursuant to Section II.A.8. of this Policy, CalOptima Health shall not incur any additional expense as a result of such referral.

7. CalOptima Health shall refer Members to, or assist Members in locating, available and accessible contracted Providers in neighboring service areas or out-of-network Providers for obtaining Covered Services in a timely manner appropriate for the Member's needs.

    a. Out-of-network providers shall be made available to Members if CalOptima Health and its Health Networks are unable to arrange for an in-person visit with a contracted Provider.

8. If Covered Services are unavailable to the Member within the Provider Network, CalOptima Health or a Health Network shall arrange for the provision of specialty services from Specialty Care Providers outside of the Provider Network in a timely manner, and in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

9. CalOptima Health and its Health Networks shall ensure that contracting Providers offer CalOptima Health Members hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medi-Cal Fee-For-Service if the Provider services only Medi-Cal Members.

10. Sensitive Services: Sensitive Services shall be available to a Member within the CalOptima Health plan. A Member may self-refer to an out-of-network Provider to receive Sensitive Services, without Prior Authorization, pursuant to CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

    a. Sexually Transmitted Diseases (STD): Members shall have access to STD services from any CalOptima Health network Provider or out-of-network provider without requiring Prior Authorization or referral.

        i. Members shall have access to out-of-network STD Services through the following:

            a) Local Health Department (LHD) clinics;

            b) Family planning clinics; and

            c) Through other community STD service Providers.

    b. HIV Testing and Counseling Services: Members shall have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any CalOptima Health network Provider without requiring Prior Authorization.

11. Minor Consent Services: Members shall have access to covered services of a sensitive nature which minors do not need parental consent or Prior Authorization to access, in accordance with CalOptima Health Policy GG.1508 Authorization and Processing of Referrals.

12. Immunizations: Members shall have access to immunization services from any CalOptima Health Network Provider or out-of-network provider without Prior Authorization

    a. Member shall have access to Local Health Department (LHD) clinics for immunization services from any CalOptima Health Network Provider or out-of-network provider without Prior Authorization.

13. American Indian Health Service Programs: American Indian Health Services Program shall be available to a Members pursuant to, and in compliance with all requirements of Title 42 United

States Code (USC), Section 1396o(a), and Title V of the American Recovery and Reinvestment Act of 2009, Section 5006.

a. Members shall have timely access to American Indian Health Service Programs by including American Indian Health Service Programs within CalOptima Health's network, to the extent available in the Service Area, for American Indian Members, as well as permitting access to out-of-network American Indian Health Service Programs, in accordance with Title 42 Code of Federal Regulations (CFR), Section 438.14(b).

b. American Indian Health Service Provider, whether in-network or out-of-network, can provide referrals directly to a contracted provider without first requesting a referral from a primary care practitioner (PCP) regardless of the contracting status of the American Indian Health Service Programs.

c. CalOptima Health shall allow for access to out-of-network American Indian Health Service Provider without referral from a network PCP or Prior Authorization.

14. Family Planning Services: Members shall have access to Family Planning Services and sexually transmitted disease services, from a Provider of Member's choice, without referral or Prior Authorization, either in or out-of-network in accordance with CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network.

15. Doula Services: Doula Services shall be available to a Member, pursuant to CalOptima Health Policy GG.1707: Doula Services.

a. Members shall have access to Doula Services when a written recommendation is provided by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

b. CalOptima Health and its Health Networks shall ensure there are no barriers with accessing Doula providers at contracted hospitals/birth centers when accompanying Member for prenatal visits, labor and delivery support and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth).

16. Behavioral Health Care: Behavioral Health Care Services shall be available to a Member, pursuant to CalOptima Health Policy GG.1900: Behavioral Health Services.

17. Behavioral Health Treatment (BHT): BHT services shall be available to a Member pursuant to guidance provided by the Department of Health Care Services (DHCS), by a State Plan-approved provider, and in accordance with the requirements for access to specialty care services as indicated in CalOptima Health Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services.

B. Network Providers

1. CalOptima Health and its Health Networks must maintain an appropriate network of specific provider types, including Doulas to ensure the CalOptima Health network has the capacity to provide all Medically Necessary Covered Services for current and anticipated membership.

2. CalOptima Health shall have an appropriate network of managed long term service and supports (MLTSS) providers to provide all MLTSS Covered Services for current and anticipated membership, in accordance with CalOptima Health Policy EE.1135: Long Term Care Facility and Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Contracting.

3. Community-Based Adult Services (CBAS) Centers:

    a. CalOptima Health shall subcontract with a sufficient number of available CBAS providers that are geographically located within one (1) hour transportation time within the Service Area to ensure timely access for Members who meet CBAS eligibility criteria in the 2020 Waiver Special Terms and Conditions, Section VIII.A.48.d. Subcontracted CBAS providers shall be appropriate for and proficient in addressing CBAS-eligible Members' specialized health care needs, and their acuity, communications, cultural and language needs and preferences.

    b. CalOptima Health may, but is not obligated to, subcontract with CBAS Providers licensed as Adult Day Health Centers (ADHCs) and certified by the California Department of Aging (CDA) to provide CBAS on or after April 1, 2012.

    c. If CalOptima Health determines that Members needs for CBAS exceeds CalOptima Health's CBAS Provider capacity, Contract shall arrange for access to unbundled services in accordance with the 2020 Waiver Special Terms and Conditions, Section VIII.A.48.d, and in CalOptima Health Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes.

    d. CalOptima Health shall provide DHCS with a list of its subcontracted CBAS Providers and its CBAS accessibility standards on an annual basis.

4. Skilled Nursing Facilities (SNFs):

    a. CalOptima Health shall offer to contract with all SNFs within the Service Area that meet the licensing, enrollment and Credentialing requirements.

    b. CalOptima Health shall contract only with SNFs enrolled and licensed by the California Department of Public Health (CDPH) and that are enrolled in Medi-Cal.

5. CalOptima Health shall offer to contract with any Safety-Net Provider that agrees to provide its scope of services in accord with the same terms and conditions that CalOptima Health requires of other similar Providers.

6. CalOptima Health shall make a good faith effort to contract with at least one (1) Medi-Cal enrolled cancer center within the Provider Network and our Health Networks' Provider Networks, if applicable.

7. CalOptima Health shall ensure its Provider Network, Health Networks and downstream Provider Networks shall have adequate networks and staff within the Service Area, including physicians, nurses, Doulas, administrative, and other support staff to ensure that they have sufficient capacity to provide and coordinate care for Covered Services.

8. Within the Service Area, CalOptima Health and its Health Networks shall ensure and monitor an appropriate network of Providers, including but not limited to adult and pediatric PCPs, obstetrician-gynecologists (OB/GYN), adult and pediatric behavioral health Providers, adult and pediatric Core Specialists, Allied Health Care Personnel, supportive paramedical personnel, Doulas, hospitals, ancillary providers, and pharmacies and an adequate number of accessible inpatient facilities and service sites, where applicable. In addition, CalOptima Health and its Health Networks shall ensure and monitor MLTSS providers, American Indian Health Service Programs, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Freestanding Birthing Centers (FBCs), where applicable and where available, in accordance with Title 42 Code of Federal Regulations (CFR), Section 438.207.

a. OB/GYNs may but are not required to contract with CalOptima Health as a PCP, if desired.

b. Members may select an OB/GYN as their PCP, as long as the provider agrees to serve as a PCP.

9. Provider Availability: CalOptima Health and its Health Networks shall maintain a Provider Network adequate to serve 100% of all eligible Members in the Service Area.

a. CalOptima Health and its Health Networks shall maintain an adequate network that includes adult and pediatric specialists, and at a minimum, Core Specialists, as described in Welfare and Institutions Code (WIC), Section 14197(h)(2), within its Provider Networks to accommodate the need for specialty care in accordance with Title 22 California Code of Regulations (CCR), Section 53853(a) and Welfare and Institutions Code (WIC), Sections 14182(c)(2) and 14087.3.

b. CalOptima Health and its Health Networks shall allow Members to access Covered Services out-of-network if the services are not available in network.

c. CalOptima Health shall take into consideration the geographic location of Providers and Members accounting for distance, travel time, and mode of transportation when evaluating adequate access to Covered Services.

d. CalOptima Health shall take into consideration Members and Providers language and gender when evaluating adequate access to Covered Services.

e. CalOptima Health shall take into consideration the number of Providers who are not accepting new patients when evaluating adequate access to Covered Services.

C. Timely Access

1. CalOptima Health and its Health Networks shall have a medical director, or licensed Physician acting on behalf of the medical director, available 24 hours a day, seven days a week to assist with access issues.

2. Emergency Services: Emergency Services shall be available immediately to a Member twenty-four (24) hours a day, seven (7) days a week.

a. CalOptima Health and its Health Networks shall cover emergency medical services without Prior Authorization.

b. CalOptima Health shall have a designated emergency service facility within the Service Area, providing care twenty-four (24) hours a day, seven (7) days a week. This designated emergency service facility will have one (1) or more physicians and one (1) nurse on duty in the facility at all times.

c. CalOptima Health and its Health Networks shall provide adequate follow-up care for those Members who have been screened in the emergency room in accordance with CalOptima Health Policy GG.1122: Follow-up for Emergency Department Care.

d. CalOptima Health and its Health Networks shall ensure that a medical director or licensed physician is available twenty-four (24) hours a day, seven (7) days a week, to authorize Medically Necessary post-stabilization care services, to respond to hospital inquiries within thirty (30) minutes, and to coordinate the transfer of stabilized Members in an emergency

department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

3. CalOptima Health and its Health Networks shall ensure that Members have effective and appropriate access to Covered Services in a timely manner, in accordance with the standards of this policy. CalOptima Health shall evaluate CalOptima Health's and Health Network's compliance with the appointment access standards against a minimum performance threshold of eighty percent (80%), unless otherwise indicated. CalOptima Health shall provide appointment time standards to Health Networks, monitor appointment wait times, and ensure compliance with requirements for follow-up missed appointments.

    a. Primary Care Appointments:

PRIMARY CARE APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointment for services that DO NOT require Prior Authorization	Available within forty-eight (48) hours of the request for appointment	80%
Non-Urgent Primary Care (including Obstetrics/Gynecology Primary Care): Appointments	Available within ten (10) business day of request for appointment	80%
Initial Health Appointment (IHA)	• Available within one-hundred-twenty (120) calendar days of enrollment	80%

*For Members less than 18 months of age within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures. For Adults ages 21 and over in accordance with USPSTF Grade A and B recommendations.

    b. Specialty and Ancillary Care Appointments:

        i. Monitoring of specialty care appointments shall, at minimum, include the monitoring of the following specialty care providers: Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialist/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, Pulmonology, and Urology.

        ii. Monitoring of ancillary appointments shall, at minimum, include the monitoring of the following: physical therapists, mammography providers, and MRI providers.

SPECIALTY AND ANCILLARY APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointment for services that DO NOT require Prior Authorization	Available within forty-eight (48) hours of the request for appointment	80%

SPECIALTY AND ANCILLARY APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointments for services that DO require Prior Authorization	Available within ninety-six (96) hours of the request for appointment	80%
Non-Urgent Specialty Care (including Obstetrics/Gynecology Specialty Care) Appointments	Available within fifteen (15) business days of request for appointment	80%
Non-Urgent Ancillary Services: Appointments for non-urgent Ancillary Services for the diagnosis or treatment of illness, injury, or other health conditions	Available within fifteen (15) business days of request for appointment	80%
Appointment for follow-up routine care with a physician behavioral health care Provider	Members have a follow-up visit with a physician behavioral health care Provider within thirty (30) calendar days of initial visit for a specific condition	80%

c. High-Volume Mental Health (non-physician) Outpatient Service Appointments:

i. Monitoring of timeliness of High-Volume Mental Health (non-physician) Outpatient Services shall, at minimum, include Psychologists, Social Workers, Marriage and Family Therapists, Psychiatric Nurse Practitioners, Mental Health Counselors/Professional Clinical Counselors

HIGH-VOLUME MENTAL HEALTH (NON-PHYSICIAN) OUTPATIENT SERVICES APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Appointment for non-urgent care with a mental health outpatient services provider	Available to a Member within ten (10) business days after the date of the request	80%
Appointment for follow-up routine care with a mental health outpatient services provider	Members have a follow-up visit with a mental health outpatient services provider within ten (10) business days of prior appointment	80%

d. Managed Long Term Support Services (MLTSS): CalOptima Health shall adhere to timely access standards in accordance with Welfare and Institutions Code (WIC), Section 14197(d)(2).

MANAGED LONG TERM SUPPORT SERVICES (MLTSS)		
Provider Type	**Standard**	**Minimum Performance Level**
Skilled Nursing Facility (SNF)	Available to a Member within five (5) working days after the date of the request	80%
Intermediate Care Facility / Developmentally Disabled (ICF-DD)	Available to a Member within five (5) working days after the date of the request	80%

MANAGED LONG TERM SUPPORT SERVICES (MLTSS)		
Provider Type	**Standard**	**Minimum Performance Level**
Subacute Care Facilities	Available to a Member within five (5) working days after the date of the request	80%

e. Exceptions to Timeframes for Appointments

i. Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of their practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.

a) Extension of the applicable wait time is noted in the Member's medical record and is available to DHCS upon request.
b) CalOptima Health shall ensure that Member receives notice of provider's decision to extend the applicable wait time with an explanation of the Member's right to file a Grievance to dispute the extension.

ii. A Provider may offer an appointment for non-urgent Primary Care within the same or next business day from the time the Member requests the appointment, and advance scheduling of an appointment at a later date if the Member prefers not to accept the appointment offered within the same or next business day.

iii. Preventive care services and periodic follow-up care for the services described in Sections II.C.3.a through II.C.3.d of this Policy may be scheduled in advance, consistent with professionally recognized standards of practice, as determined by the treating Provider acting within the scope of their practice.

iv. Subsequent routine appointments: Appointments for subsequent routine appointments for prenatal visits shall be available to a Member and shall be scheduled in advance in accordance with applicable Department of Managed Health Care (DMHC) regulations governing timely access to non-emergency health care services. All Medically Necessary services for pregnant Members will be covered. The most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) will be utilized as the minimum measure of quality for perinatal services by CalOptima Health and its Health Networks.

v. Rescheduling of Appointments: When it is necessary for a Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner appropriate for the Member's health care needs and ensures Continuity of Care consistent with good professional practice.

D. Mandatory Providers

1. CalOptima Health and its Health Networks shall maintain sufficient numbers and types of contracted Mandatory Provider types to ensure access and availability of care to Members where applicable and shall offer to contract with all available Federally Qualified Health Center (FQHCs), Rural Health Clinic (RHCs), and Indian Health Care Providers (IHCPs) within the county and provide supporting documentation of contracting efforts for all three (3) MPTs even if they have a minimum of one active contract per MPT type within the county.

a. FQHC: CalOptima Health shall contract with at least one (1) FQHC in the Service Area, where available

b. RHC: CalOptima Health shall contract with at least one (1) RHC to the extent licensed and recognized in the Service Area, where available.

c. IHCP: CalOptima Health must attempt to contract with each IHCP in its Service Area.

i. CalOptima Health must submit documentation to DHCS of all efforts to contract with IHCPs.

ii. When CalOptima Health receives a provider application from an IHCP, it must provide a written notice acknowledging receipt of the application within fifteen (15) days.

iii. CalOptima Health shall allow IHCPs to voluntarily enter into a contract at any time. If CalOptima Health is unable to contract with an IHCP, CalOptima Health must allow eligible Members to obtain services from OON IHCPs.

iv. If CalOptima Health does not have an IHCPs in the network, CalOptima Health shall allow eligible Members to obtain services from an out-of-network IHFs.

d. Freestanding Birth Center (FBC): CalOptima Health shall contract with at least one (1) FBC to the extent licensed and recognized in the Service Area, where available.

e. Certified Nurse Midwife (CNM) and Licensed Midwife: CalOptima Health shall contract with at least one (1) Certified Nurse Midwife and one (1) Licensed Midwife to the extent licensed and available in the Service Area and that they are properly enrolled and credentialed. When establishing a direct contract with these providers in addition to other requirements outlined in All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services, these provides must also meet the requirements of Title 22 California Code of Regulations (CCR), Sections 51345 and 51345.1.

i. If Licensed Midwife, Certified Nurse-Midwife services, as described in CalOptima Health Policy GG.1713: Certified Nurse-Midwife Practice Guidelines, or Certified Nurse Practitioner services are not available to a Member; a Member may self-refer to an out-of-network Licensed Midwife, Certified Nurse-Midwife or Certified Nurse Practitioner to receive such services.

2. California Children's Services (CCS) Program/Whole Child Model (WCM)

a. CalOptima Health and Health Networks shall ensure that Members have access to all Medically Necessary Covered Services provided by CCS-paneled providers within the Provider Network to the extent required by DHCS, which may require the Member to be seen out-of-network.

i. CalOptima Health shall provide oversight and monitoring of all Health Networks to ensure network certification requirements for WCM are met.

b. As required by DHCS, CalOptima Health and its Health Networks shall demonstrate an adequate Provider Network that includes but may not be limited to the following:

i. Pediatricians, pediatric specialty care providers, and pediatric subspecialty care providers; professional, allied and medical supportive personnel; as well as licensed acute care

hospitals, home health agencies, special care centers, and specialized and customizable durable medical equipment (DME) providers who are CCS-paneled and CCS-approved, as applicable.

ii. An adequate number of hospitals and/or facilities that include neonatal intensive care, CCS-approved pediatric intensive care units, and CCS-approved inpatient facilities.

iii. Licensed acute care hospitals and special care centers approved by the CCS program to treat a CCS-eligible condition.

iv. An adequate provider overlaps with CCS-paneled providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty.

c. CalOptima Health and its Health Networks shall meet DHCS WCM network certification requirements to include twenty-seven (27) network certification components: Twenty-four (24) Core Specialists, tertiary and pediatric community hospitals, and Neonatal Incentive Care Units (NICU) by either meeting the required overlap threshold or having a contract with at least one (1) of that provider/specialty type or facility statewide.

24 CORE SPECIALISTS	
Allergy and Immunology	Neurology
Cardiology	Ophthalmology
Critical Care Medicine	Oral and Maxillofacial Surgery
Pediatric Dermatology	Orthopedics
Pediatric Developmental and Behavioral Medicine	Otolaryngology
Endocrinology	Physical Medicine and Rehabilitation
Gastroenterology	Plastics Surgery
Genetics	Pulmonology
Hematology-Oncology	Rheumatology
Infectious Disease	Surgery
Nephrology	Transplant Hepatology
Neurological Surgery	Urology

d. Health Networks shall meet the overlap threshold for twenty-three (23) of the twenty-seven (27) components. For the remaining four (4) components listed below, CalOptima Health will meet the statewide requirement of a minimum of one (1) of each provider/subspecialty type due to the rarity of the subspecialist statewide. Approved Health Networks will be allowed to participate in WCM while continuing to seek contractual relationships with the following:

RARE SUBSPECIALTIES	
Pediatric Dermatology	Oral and Maxillofacial Surgery
Pediatric Developmental and Behavioral Medicine	Transplant Hepatology

e. CalOptima Health and its Health Networks shall allow out-of-network access to any and all specialists required to cover Medically Necessary CCS services, including but not limited to, the specialists listed above. This includes subspecialists not included as part of the WCM network certification.

f. Members shall be allowed to receive Medically Necessary Covered Services for their CCS-Eligible Condition outside of their assigned Health Network for Continuity of Care purposes or if there are no providers that meet the Member's CCS medical needs within the Health Network's Provider Network, or if in-network Providers are unable to meet timely access standards. Members who are required to select or be reassigned to a new Health Network that

is approved to participate in WCM are permitted through Continuity of Care to continue to receive services from a provider in their previous Health Network, including their assigned PCP.

i. CCS-eligible Members and Providers shall follow CalOptima Health and its Health Network's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider.

ii. CCS-eligible Members requesting services from out-of-network Providers shall be provided accurate information on how to request and seek approval for out-of-network services as provided in the CalOptima Health Medi-Cal Member Handbook.

iii. CCS-eligible Members requesting services from out-of-network Providers shall not be denied out-of-network services based on cost or location.

iv. Transportation shall be provided for Members obtaining out-of-network services in accordance with CalOptima Health Policies GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical and GG.1547: Maintenance and Transportation.

g. For the purposes of the WCM program, to ensure compliance with applicable statutory, regulatory, and contractual requirements, a Health Network shall provide written notice to CalOptima Health immediately after it is known to the Health Network or, by exercising reasonable diligence, would have been known to the Health Network that the Health Network no longer meets the WCM network certification requirements.

h. Health Networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met.

i. CalOptima Health shall request to add a Health Network to participate in the WCM no later than the Annual Network Certification (ANC) submission date provided in All Plan Letter (APL) 23-001: Network Certification Requirements, or any superseding APL.

3. Major Organ Transplant (MOT) Network Requirements

a. CalOptima Health shall contract with hospitals that have approval for a Transplant program that meets DHCS criteria as described in All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative, Attachment 2 - Major Organ Transplants (MOT) Requirements and CalOptima Health Policy GG.1105: Coverage of Organ and Tissue Transplants, for the following organs:

i. Bone Marrow;

ii. Heart;

iii. Intestine;

iv. Liver;

v. Lung; and

vi. Simultaneous kidney-pancreas.

b. Transplant programs that perform corneal, autologous islet cell or kidney Transplants are not required to be a Medi-Cal approved Center of Excellence (COE).

c. CalOptima Health shall have as many active contracts with hospitals as necessary to ensure that an approved Transplant program for each organ listed above is within its network.

d. A hospital that has approval for multiple Transplant programs shall be counted for each organ type, therefore if CalOptima Health contracts with one hospital that has approval for the organs as listed in Section III.D.3.a. of this Policy, the network is deemed sufficient for certification purposes, presuming that the hospital has the capacity to provide all Medically Necessary Transplant services to CalOptima Health's Members.

e. CalOptima Health shall have a contract with as many COEs as needed to cover the above organs for adult Members.

f. CalOptima Health, as a plan participating with WCM, shall be required to contract with hospitals that have approved Transplant programs to serve its adult beneficiaries, as well as with Special Care Centers (SCCs) to serve pediatric Members:

i. Bone Marrow;

ii. Heart;

iii. Intestine; and

iv. Liver.

g. CalOptima Health shall submit the MOT Network Assessment Template that includes all contracted COEs and SCCs to DHCS, as indicated in All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative, Attachment 2 - Major Organ Transplants (MOT) Requirements.

h. CalOptima Health shall be responsible for oversight and monitoring of its MOT network.

i. If CalOptima Health becomes aware that a contracted Transplant program is no longer active, has lost its Medi-Cal approved COE status, or is no longer on DHCS' COE or SCC list, CalOptima Health shall notify a Member and shall coordinate the referral and transfer of beneficiaries to a different approved Transplant program in accordance with CalOptima Health Policy GG.1105: Coverage of Organ and Tissue Transplants.

4. If there are no Mandatory Provider types in the Service Area, CalOptima Health and its Health Networks shall allow Members to obtain services out of network in accordance with CalOptima Health Policies GG.1539: Authorization for Out-of-Network and Out-of-Area Services and EE.1141: CalOptima Health Provider Contracts.

E. Network Capacity and Ratios

1. CalOptima Health and its Health Networks shall meet or exceed the following capacity and full-time equivalent (FTE) ratio requirements.

a. One (1) FTE physician to every one thousand two hundred (1,200) Members.

b. One (1) FTE PCP to every two thousand (2,000) Members.

c. If Non-Physician Medical Practitioners are included in the Provider Network, each individual Non-Physician Medical Practitioners shall not exceed a full-time equivalent network provider/Member caseload of one (1) network provider per one thousand (1,000) Members.

d. CalOptima Health may use non-physician medical practitioners to improve primary care access; however, non-physician medical practitioners will not be used by DHCS to calculate PCP and total physician ratios.

2. CalOptima Health and its Health Networks shall meet or exceed the following PCP capacity and ratio requirements.

NUMBER OF PRIMARY CARE PRACTITIONERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Total Primary Care Practitioners	Primary Care Practitioners to Members	1:2,000
General Practice/Family Practice	General Practitioners/Family Practitioners to Members	1:2,000
Internal Medicine	Internists to Members	1:2,000
Pediatrics	Pediatricians to Members	1:2,000

3. CalOptima Health and its Health Networks shall ensure FTE Physician Supervisor to Non-Physician Medical Practitioner ratios do not exceed the following:

a. Nurse Practitioners1:4

b. Physician Assistants 1:4

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

4. CalOptima Health and its Health Networks shall meet or exceed the following capacity and ratio requirements for high volume specialists.

a. High Volume Specialty Care Practitioners: CalOptima Health shall identify high-volume specialty practitioners by assessing the volume of claims and encounters by specialty type in a previous calendar year. Specialty care providers with the highest utilization shall be determined as a high-volume specialty care practitioner. (Obstetrics/gynecology specialty care practitioners shall be categorized as a PCP and a high-volume specialty care practitioner, in accordance with industry standards.)

NUMBER OF HIGH-VOLUME SPECIALISTS		
Practitioner Type	**Standard**	**Minimum Performance Level**
Obstetrics/Gynecology Specialty Care (OB/GYN)	Obstetrician/Gynecologist to Members	1:2,000
Cardiology	Cardiologists to Members	1:5,000
Hematology /Oncology (includes Oncology)	Hematologists /Oncologist (includes Oncologists) to Members	1:5,000
Gastroenterology	Gastroenterologists to Members	1:5,000
General Surgery	General Surgeons to Members	1:5,000

NUMBER OF HIGH-VOLUME SPECIALISTS		
Practitioner Type	**Standard**	**Minimum Performance Level**
Nephrology	Nephrologists to Members	1:10,000
Neurology	Neurologists to Members	1:5,000
Ophthalmology	Ophthalmologists to Members	1:5,000
Orthopedic Surgery	Orthopedic Surgeons to Members	1:5,000
Psychiatry	Psychiatrists to Members	1:10,000
Pulmonology	Pulmonologists to Members	1:10,000
Urology	Urologists to Members	1:5,000

5. High-Volume Mental Health (non-physician) Outpatient Practitioner: CalOptima Health and its Health Networks shall meet or exceed the following capacity and ratio requirements for High-Volume Mental Health (non-physician) outpatient practitioners to ensure timely access to covered High-Volume Mental Health (non-physician) outpatient services.

    a. CalOptima Health and its Health Network shall meet or exceed the number of adult and pediatric High-Volume Mental Health (non-physician) outpatient practitioners necessary to cover the projected mental health needs for anticipated Members in the county needed to meet the minimum required provider to Member ratio as annually identified by DHCS.

    b. CalOptima Health and its Health Networks shall meet or exceed the following capacity and ratio requirements for High-Volume Mental Health (non-physician) outpatient practitioners.

NUMBER OF HIGH-VOLUME MENTAL HEALTH (NON-PHYSICIAN) OUTPATIENT PRACTITIONERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Psychologist	Psychologists to Members	1:10,000
Licensed Clinical Social Worker	Licensed Clinical Social Workers to Members	1:10,000
Marriage and Family Therapist	Marriage and Family Therapists to Members	1:3,000

F. Time or Distance Standards

1. CalOptima Health and its Health Networks shall meet time or distance standards for adult and pediatric PCPs, adult and pediatric Core Specialists, OB/GYN primary and, specialty care, adult and pediatric mental outpatient health Providers, hospitals, and pharmacies based on county population density, unless CalOptima Health has a DHCS-approved alternative time or distance standard in accordance with Welfare and Institutions Code (WIC), Section 14197 and as decided and modified by DHCS.

2. Standards are established for both time or distance; however, in order to be compliant with the standards, CalOptima Health and its Health Networks must meet either time or distance, where applicable.

3. CalOptima Health and its Health Networks shall meet the following time or distance standards for Primary Care Practitioner (PCP).

GEOGRAPHIC DISTANCE OF PRIMARY CARE PRACTITIONERS	
Practitioner Type	**Measure**
Total Primary Care Practitioners (Adult and Pediatric)	For each practitioner type, there shall be one practitioner within ten (10) miles or thirty (30) minutes from any Member or anticipated Member's residence
General Practice/Family Practice	
Internal Medicine	
Pediatrics	
Obstetrics/Gynecology Primary Care (OB/GYN)	

4. CalOptima Health and its Health Networks shall meet the following time or distance standards where applicable, for CalOptima Health identified specialty care (high volume, high impact, and DHCS core).

GEOGRAPHIC DISTANCE OF SPECIALISTS				
Practitioner Type (Adult and Pediatric)	**High Volume**	**High Impact**	**DHCS Core**	**Standard**
Obstetrics / Gynecology Specialty Care (OB/GYN):	X		X	For each practitioner type, there shall be one Practitioner within fifteen (15) miles or thirty (30) minutes from any Member or anticipated Member's residence
Cardiology /Interventional Cardiology	X		X	
Dermatology			X	
Endocrinology		X	X	
ENT/Otolaryngology			X	
Gastroenterology	X		X	
General Surgery	X		X	
Hematology		X	X	
HIV/AIDS Specialist/Infectious Diseases			X	
Nephrology	X	X	X	
Neurology	X		X	
Oncology	X	X	X	
Ophthalmology	X		X	
Orthopedic Surgery	X		X	
Physical Medicine and Rehabilitation			X	
Psychiatry	X		X	
Pulmonology	X		X	
Urology	X			

5. High Volume Mental Health (non-physician) Outpatient Practitioner: CalOptima Health shall meet the following time or distance standards for High-Volume Mental Health (non-physician) outpatient practitioners.

GEOGRAPHIC DISTANCE OF HIGH-VOLUME MENTAL HEALTH (NON-PHYSICIAN) OUTPATIENT PRACTITIONERS	
Practitioner Type	**Measure**
Psychologist	For each provider type, there shall be one provider within fifteen (15) miles or thirty (30) minutes from any Member or anticipated Member's residence
Licensed Clinical Social Worker	
Marriage and Family Therapist	

6. CalOptima Health shall meet the following time or distance standards for Hospitals.

GEOGRAPHIC DISTANCE OF HOSPITALS	
Practitioner Type	**Measure**
Hospitals	For each practitioner type, there shall be one practitioner within fifteen (15) miles or thirty (30) minutes from any Member or anticipated Member's residence

7. Telephone Triage or Screening Services:

    a. Telephone Triage or Screening Services shall provide or arrange for the provision, twenty-four (24) hours a day, seven (7) days a week, of Triage or Screening Services by telephone and shall ensure that telephone Triage or Screening Services are provided in a timely manner appropriate for the Member's condition, and that the Triage or Screening Waiting Time does not exceed thirty (30) minutes as required by Title 28 California Code of Regulations (CCR), Section 1300.67.2.2(c)(8).

    b. CalOptima Health or a Health Network may provide telephone Triage or Screening Services through:

        i. CalOptima Health or Health Network-operated telephone Triage and Screening Services;

        ii. A telephone medical advice service consistent with Health and Safety Code (HSC), Section 1348.8;

        iii. CalOptima Health or the Health Network's contracted Primary Care or Behavioral health care provider office; or

        iv. Other method that provides Triage or Screening Services.

    c. If CalOptima Health or a Health Network contracts with a primary care or mental health care Provider for the provision of telephone Triage or Screening Services, such Providers shall maintain a procedure for Triaging or Screening Member telephone calls twenty-four (24) hours a day, seven (7) days a week, with a telephone answering machine and/or answering service, and/or office staff, that informs the Member:

        i. Regarding the length of wait for a return call from the Provider; and

        ii. How the caller may obtain urgent or emergency care including, when applicable, how to contact another Provider who has agreed to be on-call, Triage, or Screen by phone, or, if needed, deliver urgent or emergency care.

    d. An unlicensed staff member may perform Triage or Screening on behalf of a licensed staff member in order to assist in determining the Member's condition and refer the Member to a licensed staff member. Such unlicensed staff member shall not use this information obtained from Triage or Screening in an attempt to assess, evaluate, advise, or make any decision regarding the Member's condition, or determine when the Member should see a licensed Provider.

8. Telephone access during business hours:

    a. CalOptima Health and its Health Networks shall ensure that, during normal business hours, the waiting time for a Member to speak by telephone with CalOptima Health or Health Networks

customer service representative who is knowledgeable and competent regarding the Member's questions and concerns shall not exceed ten (10) minutes.

b. Emergency message during business hours: All Members shall be referred to the nearest emergency room. CalOptima Health shall have in its recorded message to include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

9. Telephone access after business hours:

a. After-hours access: A Primary Care Practitioner (PCP) or their Designee, an appropriate licensed professional under their supervision, shall be available twenty-four (24) hours a day, seven (7) days a week, to respond to after-hours Member calls or to a hospital emergency room Practitioner.

b. If a live after-hours attendant answers and the call is an emergency, the attendant shall refer the Member to nine-one-one (911) Emergency Services or instruct the Member to go to the nearest emergency room.

c. If a recorded message answers, it shall include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

G. Cultural and Linguistic Services:

1. Cultural and Linguistic Services Shall be provided in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

III. PROCEDURE

A. CalOptima Health shall participate in the validation of network adequacy from the preceding twelve (12) months to comply with requirements set forth in Title 42 Code of Federal Regulations (CFR), Sections 438.68 and 438.14(b)(1).

B. CalOptima Health shall ensure that all network providers are entered into the monthly 274 File correctly as instructed in the Companion Guide, including Providers that are part of CalOptima Health's network but may be outside of the county in which CalOptima Health operates.

C. CalOptima Health shall submit the monthly 274 File for DHCS to verify CalOptima Health's compliance with Provider to Member ratios, Mandatory Provider types, and timely access to standards for PCPs, Core Specialist, Non-Specialty Mental Health providers, hospitals, and ancillary services.

D. DHCS shall assess CalOptima Health's time or distance, compliance based on CalOptima Health's submission of the 274 Provider file for all ZIP codes within the county, accounting for all current and anticipated Members. DHCS will provide CalOptima Health with a Time or Distance Analysis Report, utilizing a representational census population points mapping methodology to align with DMHC when producing the report, to determine whether CalOptima Health meets time or distance for anticipated Members, indicating 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.

E. If DHCS is unable to access the required 274 File submission due to the CalOptima Health's untimely, incomplete or inaccurate submission, the submission of the Network certification will be considered late and CalOptima Health is subject to imposition of a Corrective Action Plan (CAP) and/or other enforcement action.

F. DHCS may request additional documentation at any time in order to confirm that the original submitted information is accurate.

G. CalOptima Health shall annually conduct the following as a means to collect network adequacy data for monitoring CalOptima Health's Provider Network and health networks, when appropriate:

1. Timely Access Survey;

2. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys and/or other member experience surveys;

3. Behavioral Health Member Experience Survey;

4. Geographic Access Mapping; and

5. Facility Site Reviews (FSRs) data collected in accordance with CalOptima Health Policy GG.1608: Full Scope Site Reviews.

H. CalOptima Health shall analyze performance of CalOptima Health's network adequacy at the plan Provider Network and Health Network, against the standards set forth in this Policy, when available and appropriate.

1. CalOptima Health's Access and Availability Workgroup along with other business areas shall annually monitor a Member's ability to access care by reviewing data that includes but is not limited to the following:

a. Timely access and appointment availability;

b. Members' and Providers' experience as it relates to access;

c. Behavioral health reports on access and availability of contracted Behavioral Health Care Providers;

d. Telephone access, including telephone answer and return call wait time, and triage and screening services; and

e. In-office wait time.

2. The Access and Availability Workgroup along with other business areas shall quarterly monitor a Member's ability to access care by reviewing data that includes but is not limited to the following:

a. Grievances and appeals data;

b. Network adequacy (FTE provider/Member ratio, Mandatory Provider types, and time/distance) data;

c. Encounter/claims data;

d. Potential Quality Issues (PQIs);

e. Initial Health Appointment (IHA) activity;

f. Telephone wait times through reports from the call center; and

g. WCM network adequacy.

I. Access and availability performance against the standards set forth in this policy shall be reported to the Member Experience Sub-Committee by the Access and Availability Workgroup Chair, or Designee, on a quarterly basis to:

1. Analyze and report results in order to:

a. Prioritize opportunities for improvement identified from analyses.

b. Implement interventions on at least one (1) area of opportunity (if applicable) for the following areas:

i. Non-behavioral health care services; and

ii. Behavioral Health Care services.

c. Evaluate the effectiveness of interventions for improving access to non-behavioral and Behavioral Health Care services.

2. CalOptima Health shall annually develop the following:

a. Accessibility analysis (appointment availability and access during and after business hours) report; and

b. Availability analysis (provider/Member ratio and distance/time) report.

J. CalOptima Health shall submit additional documentation, including but not limited to accessibility analyses and alternative access request, to DHCS when CalOptima Health experiences contract terminations that result in a significant change to the Provider Network.

1. A significant change may occur as a result of a contract termination that impacts two thousand (2,000) or more Members or when the changes cause CalOptima Health to be non-compliant with any of the Annual Network Certification (ANC) requirements.

2. If a significant change occurs within ninety (90) calendar days prior to the ANC filing due date, CalOptima Health shall include the significant change appropriate documentation as part of that Reporting Year (RY) ANC filing

3. If a significant change occurs after ANC filing has a final disposition, CalOptima Health shall submit applicable Network certification documents for only the component impacted by the significant change at least sixty (60) calendar days prior to the effective date the significant change.

K. CalOptima Health shall annually submit a complete and accurate Annual Network Certification (ANC) to demonstrate compliance with network adequacy requirements, in accordance with State standards for access and timeliness of care in 42 CFR 438.207(b) and DHCS All Plan Letter (APL) 23-001: Network Certification Requirements.

1. CalOptima Health shall complete and submit accurate data and information to DHCS that reflects the composition of the Network Providers subject to ANC requirements through the DHCS Secure File Transfer Protocol (SFTP) site, no later than thirty (30) calendar days after receipt of DHCS'

ANC documents package, unless an extension is granted by DHCS, in accordance with DHCS All Plan Letter (APL) 23-001: Network Certification Requirements Attachment B.

2. CalOptima Health must submit a written request to DHCS to be considered for a delivery system AAS justification.

    a. If requirements for the AAS delivery system exemptions are met, there is not requirement to submit AAS requests through Attachment C, but instead must file a delivery system AAS justification for DHCS' consideration.

    b. An approved delivery system AAS is valid for one (1) RY; however, if DHCS approved a CalOptima Health's delivery system AAS justification for the previous RY, CalOptima Health can submit an attestation certifying it is seeking to utilize the previously approved justification for the current ANC.

3. DHCS shall offer technical assistance if CalOptima Health submits a complete and accurate ANC submission by the deadline.

    a. Technical assistance will be provided in the form of a preliminary findings worksheet and will contain DHCS's initial review of the quality, accuracy and completeness of CalOptima Health's submission.

    b. DHCS may not be able to provide technical assistance if CalOptima Health does not meet the submission deadline.

4. To demonstrate compliance with time or distance standards, CalOptima Health shall cover 100% of the population points in the zip code, for current and anticipated Members with any deficiencies accounted for through AAS requests.

    a. CalOptima Health may use a synchronous mode of Telehealth instead of submitting an Alternative Access Standard (AAS) request if CalOptima Health covers at least 85% of the population points in the zip code, in accordance with CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services.

    b. If CalOptima Health elects to utilize Telehealth to meet time or distance for 15% of the population in the zip code, CalOptima Health shall:

        i. Ensure the Telehealth services must be available to all Members in the defined service area regardless of whether the Member is assigned to CalOptima Health Community Network (CHCN) or a Health Network, or to which Health Network the Member is assigned.

        ii. Ensure the Telehealth services meet the Telehealth criteria outlined in the Medi-Cal Provider Manual and DHCS APL 23-007 (Revised): Telehealth Services Policy, including subsequent revisions of the APL.

        iii. Ensure the Telehealth services be certified and enrolled in the Medi-Cal program and credentialed by CalOptima Health.

        iv. Meet the required Telehealth provider-to-Member ratio based on the number of MCP Members in the zip code that are not covered by in-person providers.

        v. Not use the following provider types to meet time or distance standards for ANC: General Surgery, Orthopedic Surgery, Physical Medicine and Rehabilitation and Hospitals.

vi. Submit the following required documents to DHCS to validate Member protections:

a) Attestation that all Members have the right and access to an in-person Provider and will coordinate transportation, if necessary, to ensure access.

b) Policies and procedures describing how a Member has a right to in-person services, how to arrange for in-person Providers and appointments within timely access standards, and on-going network assessment to identify Providers that are available to assist in meeting time or distance in the future.

c) Website posting listing all approved AAS requests on the CalOptima Health website, including where Telehealth is used.

d) Member Service Call Scripts to include information on Members' rights and access to in-person Providers when Telehealth appointments are offered instead of in-person and coordination of transportation.

c. CalOptima Health and its Health Networks shall not require Members to access services via Telehealth in place of in-person services.

i. As Members are not required to access services via Telehealth, CalOptima Health shall provide transportation to a network provider within time or distance and timely access standards for Medically Necessary services, when requested by a Member, and in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical.

d. CalOptima Health may use third-party corporate Telehealth Providers if Member choses to use Telehealth or in-person and CalOptima Health cannot auto-assign a Member to a third-party corporate Telehealth Provider.

L. CalOptima Health shall authorize and arrange for Out-of-Network access in the following circumstances:

1. CalOptima Health does not meet Network adequacy requirements set forth in Welfare and Institutions Code (WIC), Section 14197;

2. CalOptima Health does not have an AAS approved by DHCS and fails to meet the Network adequacy standards set forth in Welfare and Institutions Code (WIC), Section 14197;

3. CalOptima Health fails to comply with the requirements for timely access to appointments; or

4. CalOptima Health shall arrange for access to Out-of-Network LTC when Medically Necessary for a Member in cases where CalOptima Health does not have in-network LTC capacity.

M. CalOptima Health shall identify Providers not complying with timely access standards and shall:

1. Communicate to the Provider when they are not compliant with timely access standards;

2. Track and escalate corrective action for Providers with continued non-compliance.

a. Providers with two (2) consecutive instances of non-compliance shall receive a warning.

b. Providers with three (3) consecutive instances of non-compliance shall be referred to the Member Experience Sub-Committee for review and further action in consideration of Member access to appropriate services.

N. If CalOptima Health does not meet the minimum requirements for Mandatory Provider Types, CalOptima Health shall submit an attestation or justification, and maintain all supporting documentation of MPT contracting attempts including failed contracting efforts with MPTs, and provide policies and procedures and a description of what protections CalOptima Health has 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 to DHCS upon request as part of the MPT validation process.

O. If CalOptima Health is unable to meet time or distance standards, CalOptima Health shall make good faith efforts to exhaust all reasonable contracting options with additional providers (two (2) nearest out-of-network providers that are closer than the AAS) within the time or distance standards, an AAS request shall be submitted to DHCS, in accordance with DHCS All Plan Letter (APL) 23-001: Network Certification Requirements, Attachment C.

1. CalOptima Health shall either exhaust all other reasonable options for contracting with Providers such as a Member-specific case agreement with an out-of-network Provider or demonstrate to DHCS that its delivery structure is capable of delivering the appropriate level of care and access as required by Welfare and Institutions Code (WIC), Section 14197 prior to submitting an AAS request to DHCS to meet time or distance standards.

2. CalOptima Health shall submit an AAS request to DHCS when 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 the network occurs and CalOptima Health no longer meets time or distance standards.

3. CalOptima Health shall submit an AAS request for the entire network every three (3) years and shall submit a DHCS – supplied AAS Analysis Report in the intervals where an AAS is not required to be submitted.

4. If no change to the AAS is required, an AAS submission is not required, but an attestation is required.

5. If a change is required, CalOptima Health shall submit a new AAS Analysis Report, in tandem with AAS requests using an updated Attachment C of this APL for DHCS's review and approval.

6. CalOptima Health shall utilize the following Provider resource lists identified in DHCS APL 23-001: Annual Network Certification Requirements, Instructions Manual Attachment B to identify providers for inclusion in the AAS request:

   a. Managed Care Open Data Portal; and

   b. Fee-for-Service Open Data Portal.

7. CalOptima Health shall document all efforts to contract with additional out-of-network providers identified in their AAS requests that are in their county and bordering counties where they have network deficiencies and shall provide all documentation of failed contracting efforts to DHCS.

   a. AAS request submission must detail the facts and circumstances for each AAS request and provide supporting details as outlined in Attachment B, Exhibit C.

b. To ensure continuous active outreach, DHCS expects CalOptima Health to have completed outreach attempts with providers identified in previous ANC submission prior to the RY submission and will generally not accept contracting efforts with the same providers ongoing as rationale.

8. DHCS will not accept any AAS requests after the ANC submissions deadline.

9. DHCS may revoke any approved AAS requests if an inaccuracy is discovered or CalOptima Health is unable to provide all the required supporting documentation during the validation process.

P. Upon receipt of AAS approvals from DHCS, CalOptima Health shall:

1. Inform affected Members who reside in the zip code where AAS requests were approved by posting all approved AAS on the CalOptima Health website within thirty (30) days after DHCS publishes the statewide AAS approvals on the DHCS website. This includes affected Members where DHCS approved the use of Telehealth to meet time or distance standards in lieu of AAS request.

2. Assist any requesting Member in obtaining an appointment with an appropriate out-of-network Core Specialist, in-person or via Telehealth, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services and Welfare and Institutions Code (WIC), Section 14197.

a. CalOptima Health shall make its best effort to establish a Member-specific case agreement with an out-of-network Core Specialist or arrange for an appointment with an in-network Core Specialist in the next closest county within the time or distance standards at the Medi-Cal fee-for-service rate or a mutually agreed upon rate in accordance with CalOptima Health Policy GG.1141: CalOptima Health Provider Contracts, unless CalOptima Health has already attempted to establish a Member-specific case agreement with the out-of-network Core Specialist in the most recent fiscal year, and the Core Specialist has refused to enter into an agreement. If this cannot be arranged, CalOptima Health shall arrange for an appointment with an in-network specialist.

b. The out-of-network Core Specialist must be within time or distance and timely access standards and, in cases where the out-of-network Core Specialist is not able to provide services to a Member under these standards, CalOptima Health shall arrange for non-emergency medical transportation or non-medical transportation, as appropriate, and in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical.

c. CalOptima Health shall continually demonstrate that there is a process in place to arrange services through Telehealth (at the Member's preference) or to provide transportation to Members who need to access services outside of time or distance standards.

Q. CalOptima Health shall have the opportunity to resubmit a corrected submission for identified errors, incompleteness, and inaccuracies within ten (10) business days.

R. If CalOptima Health fails to meet Annual Network Certification components or rectify findings identified by the preliminary Annual Network Certification findings worksheet, an Annual Network Certification CAP may be issued and CalOptima Health shall have six (6) months to correct all deficiencies and comply with the following CAP mandates until the CAP is closed:

1. Provide an initial CAP response no later than thirty (30) calendar days after the issuance of the CAP notification letter;

2. Provide DHCS with monthly status updates that demonstrate action steps CalOptima Health is undertaking to correct the CAP deficiency(ies);

3. Authorize out-of-network access to Medically Necessary providers within timely access standards and applicable time or distance standards, regardless of associated transportation or provider costs until the CAP is completed and closed by DHCS;

4. Demonstrate its ability to effectively provide out-of-network access information to Members and ensure that its Customer Service staff, network providers, and Health Networks are trained in the mandates, include the right for Members to request out-of-network access for Medically Necessary Covered Services and transportation to providers where CalOptima Health is unable to comply with ANC requirements.

5. CalOptima Health shall ensure its Provider Network, Health Networks, and downstream Provider Networks are informed of and adhere to the CAP mandates and comply with all OON access authorization and transportation requirements.

6. DHCS may impose sanctions for failure to comply with Network Adequacy requirements at the end of the CAP period.

7. If an updated or new AAS is submitted to address network deficiency, CalOptima Health shall continue to comply with its previously approved AAS and continue to provide transportation services for Members to any network provider or out-of-network providers under the terms of the previously approved AAS until the updated or new AAS is approved by DHCS.

8. CalOptima Health 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 non-compliance with contractual requirements and policy guidance; Provider Network, Health Networks and downstream Provider 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.

S. CalOptima Health shall provide the Member Experience Sub-Committee and the Health Networks with access and availability results of CalOptima Health and Health Networks' performance, including data results from DHCS and its contracted External Quality Review Organization (EQRO). These results shall include CalOptima Health's assessment results against the access and availability standards as set forth in this Policy.

   1. If the Member Experience Sub-committee identifies access-related deficiencies or non-compliance of standards or requirements set forth in this policy, the Chair of the Member Experience Sub-Committee, or Designee, may take the following steps:

      a. Request that a Health Network submit a Quality Improvement Plan (QIP) or Plan-Do-Study-Act (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant, if applicable.

      b. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request corrective action, if applicable. Such corrective action may include the issuance of a request for a Corrective Action Plan (CAP) and/or the imposition of Sanctions, in accordance with

CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions, respectively; and

c. Report the deficiencies or non-compliance to the Audit and Oversight Committee (AOC) and/or Compliance Committee, as appropriate.

T. CalOptima Health shall ensure that Health Networks comply with network adequacy and access requirements as set forth in DHCS APL 23-006: Delegation and Subcontractor Network Certification and any subsequent revisions.

1. Members who receive care through Health Networks shall have the same access to required Providers as they would through the CalOptima Health Provider Network.

2. CalOptima Health may permit Provider Network, Health Networks and downstream Provider Networks to supplement their Provider Networks with CalOptima Health's direct Network.

3. CalOptima Health has contractual provisions and P&Ps in place for identifying when changes in a Provider Network, Health Network and downstream Provider Network results in CalOptima Health being out of compliance with any of the ANC requirements.

4. If a Health Network has been identified as having a deficient network component(s) and/or fails to meet network adequacy components:

a. CalOptima Health and the Health Network shall authorize services through out-of-network Providers where Members may utilize any Provider in or out of CalOptima Health's network regardless of Health Network affiliation.

b. The Health Network shall submit a Quality Improvement Plan or PDSA, if requested.

c. The Health Network shall submit a CAP to the CalOptima Health Office of Compliance, if necessary. A Health Network shall take all necessary and appropriate action to identify the causes underlying the access-related deficiencies, including but not limited to a review of whether provider hours of operation and/or providers' scheduling practices contributed to the deficiencies, and resolve such deficiencies, to comply with the standards of this Policy and CalOptima Health Policy HH.2005: Corrective Action Plan.

d. CalOptima Health shall report, within three (3) business days, to the DHCS contract manager any significant instances of non-compliance or the imposition of CAPs or financial sanctions on a Health Network when it results in CalOptima Health's non-compliance with contractual requirements, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

U. The Quality Analytics Department shall coordinate performance reviews to assess adherence to access and availability standards, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

1. The Quality Analytics Department shall annually update CalOptima Health's Access and Availability desktop procedures to assess adherence to access and availability standards, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

1. Age Discrimination Act of 1975
2. California Civil Code, §51
3. California Government Code, §11135
4. CalOptima Health Authorization Required List
5. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
6. CalOptima Health Contract for Health Care Services
7. CalOptima Health Operational Audit Tool
8. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
9. CalOptima Health Policy EE.1135: Long Term Care Facility and Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Contracting
10. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
11. CalOptima Health Policy GG.1105: Coverage of Organ and Tissue Transplants
12. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
13. CalOptima Health Policy GG.1122: Follow-up for Emergency Department Care
14. CalOptima Health Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes
15. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical
16. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
17. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
18. CalOptima Health Policy GG.1547: Maintenance and Transportation
19. CalOptima Health Policy GG.1548: Authorization and Monitoring Behavioral Health Treatment (BHT) Services
20. CalOptima Health Policy GG.1608: Full Scope Site Reviews
21. CalOptima Health Policy GG.1619: Delegation Oversight
22. CalOptima Health Policy GG.1707: Doula Services
23. CalOptima Health Policy GG.1713: Certified Nurse-Midwife Practice Guidelines
24. CalOptima Health Policy HH.2002: Sanctions
25. CalOptima Health Policy HH.2005: Corrective Action Plan
26. CalOptima Health Quality Improvement Plan
27. Department of Health Care Services All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (Supersedes APL 16-017)
28. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
29. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised 10/14/2022)
30. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-030: Initial Health Appointment (Supersedes APL 13-017 and Policy Letters 13-001 and 08-003)
31. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements (Supersedes APL 21-006)
32. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
33. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-007: Telehealth Services Policy (Supersedes APL 19-009)
34. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031)
35. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-034: California Children's Services Whole Child Model Program (Supersedes APL 21-005)
36. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-009: Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)

37. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-010: Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
38. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
39. Health and Safety Code (HSC), §1374.73
40. National Committee of Quality Assurance (NCQA) standards
41. Title 22, California Code of Regulations (CCR), §53853(a)
42. Title 28, California Code of Regulations (CCR), §§1300.51(H), 1300.67.2, 1300.67.2.2
43. Title 28, Code of Federal Regulations (CFR), Part 36
44. Title 29, United States Code (USC), §794 (Section 504 of the Rehabilitation Act of 1973)
45. Title 42, Code of Federal Regulations (CFR), §§438.14(b)(1), 438.68, 438.207(b), and 441.20
46. Title 42, United States Code (USC), §2000d
47. Title 45, Code of Federal Regulations (CFR), Part 80, Part 84, and Part 91
48. Title VI of the Civil Rights Act of 1964
49. Title IX of the Education Amendments of 1973
50. Welfare and Institutions Code (WIC), §§14087.3, 14182(c)(2), 14197(d)(2), 14197(h)(2) and 14087.325

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/24/2009	Department of Health Care Services (DHCS)	Approved as Submitted
03/21/2011	Department of Health Care Services (DHCS)	Approved as Submitted
08/28/2014	Department of Health Care Services (DHCS)	Approved as Submitted
06/03/2015	Department of Health Care Services (DHCS)	Approved as Submitted
11/13/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
03/11/2019	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	Approved as Submitted
01/04/2021	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted
10/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
11/29/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/22/2022	Department of Health Care Services (DHCS)	Approved as Submitted
02/22/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/15/2023	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
06/19/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/03/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
04/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
09/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1999	GG.1600	Access to Health Care	Medi-Cal
Revised	02/01/2001	GG.1600	Access to Health Care	Medi-Cal
Revised	10/01/2003	GG.1600	Access and Availability Standards	Medi-Cal
Revised	01/01/2007	GG.1600	Access and Availability Standards	Medi-Cal
Revised	10/01/2008	GG.1600	Access and Availability Standards	Medi-Cal
Revised	01/01/2009	GG.1600	Access and Availability Standards	Medi-Cal
Revised	08/01/2009	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2010	GG.1600	Access and Availability Standards	Medi-Cal
Revised	03/01/2011	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2011	GG.1600	Access and Availability Standards	Medi-Cal
Revised	01/01/2013	GG.1600	Access and Availability Standards	Medi-Cal
Revised	09/01/2014	GG.1600	Access and Availability Standards	Medi-Cal
Revised	01/01/2015	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2015	GG.1600	Access and Availability Standards	Medi-Cal
Revised	05/01/2016	GG.1600	Access and Availability Standards	Medi-Cal
Revised	08/01/2017	GG.1600	Access and Availability Standards	Medi-Cal
Revised	12/01/2017	GG.1600	Access and Availability Standards	Medi-Cal
Revised	09/06/2018	GG.1600	Access and Availability Standards	Medi-Cal
Revised	12/01/2019	GG.1600	Access and Availability Standards	Medi-Cal
Revised	05/01/2020	GG.1600	Access and Availability Standards	Medi-Cal
Revised	11/01/2020	GG.1600	Access and Availability Standards	Medi-Cal
Revised	10/01/2021	GG.1600	Access and Availability Standards	Medi-Cal
Revised	11/01/2021	GG.1600	Access and Availability Standards	Medi-Cal
Revised	03/01/2022	GG.1600	Access and Availability Standards	Medi-Cal
Revised	12/01/2022	GG.1600	Access and Availability Standards	Medi-Cal
Revised	04/01/2023	GG.1600	Access and Availability Standards	Medi-Cal
Revised	12/01/2023	GG.1600	Access and Availability Standards	Medi-Cal
Revised	03/01/2024	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2024	GG.1600	Access and Availability Standards	Medi-Cal
Revised	12/01/2024	GG.1600	Access and Availability Standards	Medi-Cal

IX. GLOSSARY

Term	Definition
Allied Health Care Personnel	For purposes of this policy, Allied Health Care Personnel are specially trained, licensed, or credential health workers other than physicians (e.g., physical therapists, chiropractors).
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders including specialty mental health services. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Behavioral Health Treatment (BHT)	Services and treatment programs for the treatment of Autism Spectrum Disorder (ASD), as specified in the California Medicaid State Plan, including applied behavioral analysis and other evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member less than twenty-one (21) years of age who has been diagnosed with ASD, or for whom a licensed physician, surgeon, or psychologist has determined BHT is Medically Necessary.
Behavioral Health Treatment (BHT) Service Providers	Providers that are State Plan-approved to render Behavioral Health Treatment services, including Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals.
California Children's Services (CCS)-Eligible Conditions	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Certified Nurse Midwife	A registered nurse who has successfully completed a program of study and clinical experience meeting the State guidelines or has been certified by an organization recognized by the State.
Complaint	A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has a pre-existing provider relationship.

Term	Definition
Core Specialist	Adult and pediatric providers as specified in Department of Health Care Services All Plan Letter 23-001: Network Certification Requirements, including Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialists/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, and Pulmonology.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment

Term	Definition
	as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012.

Term	Definition
Cultural and Linguistic (C&L) Services	Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include, but are not limited to: 1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs; 2. Providing twenty-four (24)-hour access to interpreter services at Key Points of Contact for all Members; 3. Providing translations of informational materials in Threshold Languages, providing oral translation for other languages upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and 4. Referring Members to culturally and linguistically appropriate community services, as needed.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Doula Services	Doula Services encompass health education, advocacy, and physical, emotional, and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the Postpartum Period.
Emergency Services	Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

Term	Definition
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Freestanding Birth Center (FBC)	Defined by Title 42, United States Code, Section 1396d(I)(3)(B) as a health facility: 1. That is not a hospital; 2. Where childbirth is planned to occur away from a pregnant woman's residence; 3. That is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and 4. That complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall establish.
Grievance	Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network. For purposes of this policy, a Health Network shall also include the CalOptima Health Community Network.
High Impact Specialty Care Providers	For purposes of this policy, High Impact Specialty Care Providers consist of provider types who treat conditions that have high mortality and morbidity rates, and/or identifying practitioner types where treatment requires significant resources.
High Volume Mental Health (Non-physician) Outpatient Services	For purposes of this policy, High-Volume Mental Health (Non-physician) Outpatient Services include non-specialty mental health services for treatment of mild to moderate impairments provided by psychologists, licensed clinical social workers, marriage, and family therapists.
High Volume Specialty Care Providers	For purposes of this policy, High Volume Specialty Care Providers consist of specialty care providers with the highest utilization as determined by CalOptima Health through assessing the volume of claims and encounters by specialty type in a previous calendar year (Obstetrics/gynecology specialty care providers shall be categorized as a PCP and a high-volume specialty care provider, in accordance with industry standards.)

Term	Definition
Licensed Midwife	An individual to whom a license to practice midwifery has been issued pursuant to Article 24, Chapter 5 of the California Business and Professions Code.
Mandatory Provider	For purposes of this policy, Mandatory Providers are providers who managed care plans must offer to contract with, where available, and include Federally Qualified Health Centers (FQHCs), Rural Health Centers, Freestanding Birthing Center (FBC), Certified Nurse Manager, Licensed Midwife, and Indian Health Facilities (IHFs), as defined in Department of Health Care Services All-Plan Letter23-001: Network Certification Requirements.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Mid-Level Practitioner	A non-physician practitioner who has a professional license and certification. They include but are not limited to Certified Nurse Midwives, Certified Nurse Practitioners, and Physician Assistants.
Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 CCR section 1484.
Prenatal Care	Health care that a pregnant woman receives from a licensed practitioner. Services needed may include physical examinations, dietary and lifestyle advice.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist,

Term	Definition
	pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Licensed Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Prior Authorization	A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Provider Network	For purposes of this Policy, the providers with which an organization contracts or makes arrangements to furnish covered health care services to their members.
Qualified Autism Service Paraprofessional	An unlicensed and uncertified individual employed and supervised by a Qualified Autism Service Provider (QASP), who has adequate education, training, and experience, as certified by a QASP, and provides treatment and implements services pursuant to a treatment plan developed and approved and supervised by a QASP.
Qualified Autism Service Professional	An individual who provides behavioral health treatment, is employed and supervised by a Qualified Autism Service Provider (QASP), provides treatment pursuant to a treatment plan developed and approved by the QASP, and has training and experience in providing services for pervasive developmental disorder or autism.
Qualified Autism Service Provider	Either of the following: 1) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; 2) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.
Qualified Family Planning Practitioner	A qualified provider licensed to furnish family planning services within their scope of practice within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish Family Planning Services to a Member as specified in title 22, Code of California Regulations, Section 51200.
Routine Care	Covered Services that are not urgent in nature and may be pre-planned or scheduled in advance.

Term	Definition
Routine Physical Exams	A well-care visit that usually emphasizes priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.
Rural Health Clinic	An entity defined in Title 22 CCR Section 51115.5
Sanctions	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing and Counseling Services.
Service Area	The county or counties that CalOptima Health is approved to operate in under the terms of the DHCS contract.
Skilled Nursing Facility (SNF)	As defined in Title 22 CCR Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by the California Department of Public Health 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."
Specialty Care Provider (SCP)	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.
Transplant	A non-experimental procedure for human tissue or organ Transplant.
Triage or Screening	The evaluation of a Member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the child's need for care.
Triage or Screening Services	Assessment of a Member's health concerns and symptoms via telephone or other means of communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to perform Triage or Screening Services.
Triage or Screening Waiting Time	The time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.

Term	Definition
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.