Network Adequacy Rules for Medi-Cal Managed Care Plans*

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Introduction

Millions of low-income Californians are enrolled in comprehensive managed care health plans statewide in Medi-Cal.[1] Over the past 30 years, California has increasing moved more beneficiaries into a capitated managed care delivery system. Medi-Cal managed care is now statewide and over 80 percent of Medi-Cal enrollees receive services through a managed care plan, including high-risk and vulnerable groups like seniors, people with disabilities, pregnant women, and children.[2]

In Medi-Cal, managed care is delivered using different models in various counties. Under the Two-Plan model, enrollees have two health plans, one a publicly-run entity, a "local initiative," and a privately-run entity, a "commercial plan," from which to choose their care. Under the Geographic Managed Care (GMC) model, several commercial plans compete to provide services to Medi-Cal beneficiaries. Under the Regional and Imperial Models, two privately-run plans compete to provide services to beneficiaries; these plans cover an entire region of the state as if it were one county. In San Benito County, one commercial plan is available to Medi-Cal beneficiaries who wish to enroll in managed care on a voluntary basis. And under the County Organized Health System (COHS) model, a county forms an agency which contracts with the state Medi-Cal program to provide services to almost all Medi-Cal beneficiaries living in that county.

* This paper does not discuss separate managed care delivery systems for specialty mental health services, or, in some counties, dental and substance use disorder services. For information about network adequacy in Covered California plans, see our companion piece: ABBI COURSOLLE, AT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #2: NETWORK ADEQUACY LAWS IN COVERED CALIFORNIA PLANS. (2014), http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/network-adequacy-laws-in-covered-california-plans-issue-No-2.

Medi-Cal managed care plans are governed by both state and federal law, and are regulated by a number of federal and state agencies. Medi-Cal plans are regulated by the federal Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS). In 2016, CMS made major revisions to the federal regulations that govern Medi-Cal plans; pursuant to the new regulations, California added significant new statutory provisions to implement the new rules in California. In addition, most—but not all—Medi-Cal managed care plans are also licensed by the California Department of Managed Health Care (DMHC) and are subject to a set of consumer protection laws called the California Knox-Keene Act.[3] Because COHS Medi-Cal plans are exempt from DMHC licensure, currently only one COHS, Health Plan of San Mateo, is Knox-Keene licensed.[4]

I. Overview of Network Adequacy

Medi-Cal managed care plans are capitated—i.e. they receive a set payment per enrollee per month in exchange for providing services.[5] The plans contract on a "comprehensive risk" basis, meaning they accept the risk of incurring a loss if they spend more on services than they receives through the capitated payments, but they will make a profit if providing services costs less than the payments.[6] These arrangements give plans an incentive to limit coverage of services for their enrollees in order to maximize profits. Thus, strong legal protections are needed to ensure that enrollees have access to high quality, medically necessary services. Both federal and state laws require Medi-Cal managed care plans to have adequate provider networks. But the rules differ somewhat depending on whether a plan is regulated by DMHC and DHCS, or only DHCS.

Federal Medicaid law requires that each Medi-Cal Managed Care plan ensure that all services covered under the State plan are available and accessible to managed care enrollees.[7] The updated federal Medicaid regulations require states to develop and publish network adequacy standards, including specific time and distance, for certain types of providers, effective July 1, 2018.[8] The regulations further require managed care plans that participate in Medi-Cal to ensure and annually document their capacity to serve the health care needs of their enrollees in each service area in accordance with state access-to-care standards.[9] The regulations require the state to annually certify to CMS that its plans are in compliance with state standards for service availability, after the state's review of each plan's documents.[10] California Medi-Cal law complies with the federal rules in part by requiring plans to "[e]nsure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area."[11] California's specific requirements for Medi-Cal plans are described below.

II. Provider Directories

The first step of ensuring that enrollees have access to an adequate provider network is providing them with information about what providers are included in their plan's network. The revised federal rules

require plans to publish online and in hard copy a provider directory that includes the following information about their contracted physicians, pharmacies, behavioral health providers, LTSS providers, and hospitals: name, group affiliation. street address, telephone number, website, specialty as appropriate, whether the provider is accepting new enrollees, cultural and linguistic capabilities of the provider and provider's office, and whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.[12] The directory must be available to enrollees and potential enrollees, and must be updated at least monthly.[13]

In addition, Knox-Keene licensed plans must comply with a 2015 law that requires plans to publish a publicly-available online provider directory that is updated weekly.[14] Their directories must include, in addition to the information required by the federal Medicaid regulations: the type of practitioner; National Provider Identifier number; California license number and type of license; board certification, if any; the provider's office email address, if available; for physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the plan; and, for federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.[15] They must cover, in addition to the provider types listed in the federal rules, nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, dentists, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice centers, residential care facilities, inpatient rehabilitation facilities, clinical laboratories, imaging centers, and other facilities providing contracted health care services.[16] Knox-Keene-licensed plan directories must also include an email address and telephone number that can be used to notify the plan if a directory listing appears to be inaccurate.[17] They must disclose that language interpreter services are available at no cost with information about how to obtain interpretation services, and that the plan must provide full and equal access to covered services to enrollees with disabilities.[18] Starting January 1, 2018, all Knox-Keene-licensed plans must use a uniform method or reporting information in their provider directories, following guidance issued by DMHC.[19]

III. Numbers and types of providers

Federal Medicaid rules require plans to contract with a number of providers sufficient to provide access to all covered services.[20] In addition, the plan must demonstrate, to the state's satisfaction, that it provides an "appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area."[21] In addition, state law requires plans to "[e]nsure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area."[22] Consistent with federal requirements, Medi-Cal plans must provide female enrollees with direct access to women's health specialists for routine and preventative services.[23] Medi-Cal plans must also contract with any willing safety net provider in the

area.[24] Starting July 1, 2018, Medi-Cal plans must work with the state to ensure that the number of contracted Community-Based Adult Services centers in the state does not fall below the level that existed in April, 2012.[25] Moreover, consistent with the Knox-Keene Act, California requires all Medi-Cal plans to meet a 1:1200 provider-patient ratio overall, and a 1:2000 ratio for primary care providers.[26] Plans must report to the state the capacity of their contracted providers on a monthly basis, or whenever there is a "significant change" to their network capacity.[27]

IV. Geographic Access

The revised federal Medicaid regulations require states to develop geographic access standards for several different provider types, effective July 1, 2018.[28] In calculating the appropriate distance and travel time requirements, plans must account for the means of transportation used by Medicaid enrollees.[29] Plans must also demonstrate to the state that their provider networks offer sufficient "geographic distribution" to provide access to covered services.[30] California enacted legislation in 2017 to comply with the new requirements by mandating that Medi-Cal plans make care available within the following times and distances from the beneficiary's place of residence (effective July 1, 2018), which are also summarized in Appendix A:[31]

- Adult and pediatric primary care: 10 miles or 30 minutes.
- Hospitals: 15 miles or 30 minutes.
- Dental services: 10 miles or 30 minutes.
- Obstetrics and gynecology primary care: 10 miles or 30 minutes.
- Adult and pediatric specialists: dense counties, 15 miles or 30 minutes; medium counties, 30 miles or 60 minutes; small counties: 45 miles or 75 minutes; rural counties, 60 miles or 90 minutes.
    - Specialists for this purpose include practioners in the following specialty areas: cardiology/interventional cardiology; Nephrology; Dermatology;. Neurology; Endocrinology, Ophthalmology; Ear, nose, and throat/otolaryngology; Orthopedic surgery; Gastroenterology; Physical medicine and rehabilitation; General surgery; Psychiatry; Hematology; Oncology; Pulmonology; HIV/AIDS specialists/infectious diseases; Obstetrics and gynecological specialty care.
- Pharmacy services: 10 miles or 30 minutes.
- Outpatient mental health services: dense counties, 15 miles or 30 minutes; medium counties, 30 miles or 60 minutes; small counties: 45 miles or 75 minutes; rural counties, 60 miles or 90 minutes.
- Outpatient substance use disorder services other than opioid treatment programs: dense counties, 15 miles or 30 minutes; medium counties, 30 miles or 60 minutes; small counties: 45 miles or 75 minutes; rural counties, 60 miles or 90 minutes.
- Opioid treatment programs: dense counties, 15 miles or 30 minutes; medium counties, 30 miles or 60 minutes; small counties: 45 miles or 75 minutes; rural counties, 60 miles or 90 minutes.

For purposes of this law, counties are designated as follows:[32]

- Dense counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara. Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

- Medium counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
- Small counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
- Rural counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

Plans must report to the state the locations of their contracted providers on a quarterly basis, or whenever there is a "significant change" to their network.[33]

Knox-Keene-licensed plans must also ensure that ancillary services—that is, "laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider"—are available "within a reasonable distance" of primary care facilities.[34]

V. Timely Access

Federal Medicaid rules require plans to provide enrollees with timely access to services.[35] States' contracts with plans must ensure that plans meet the following requirements: comply with state rules on timely access to care and services, considering urgency of care; provide hours of operation no less than that offered to commercial enrollees or comparable to Medicaid fee-for service; when medically necessary, make services available 24 hours a day, 7 days a week; and, monitor provider compliance and take corrective action if needed.[36]

California has complied with the federal requirements by incorporating the Knox-Keene Act timely access standards to apply to all Medi-Cal managed care plans by statute.[37] The provisions are also incorporated into the contracts for all plans.[38] Those standards require plans to ensure that enrollees have access to services within the following timeframes, which are also summarized in Appendix B: urgent care, where no prior authorization is required, within 48 hours of request;[39] urgent care, where prior authorization is required, within 96 hours of request;[40] non-urgent care and primary care, within 10 business days of request;[41] non-urgent care specialty care, within 15 business days of request;[42] non-urgent non-physician mental health care, within 10 business days of request;[43] and non-urgent ancillary services, within 15 business days of request.[44] These times may be extended if the referring or treating provider determines that a longer wait time will not negatively impact the enrollee's health.[45] Plans must also operate a 24/7 triage screening telephone line, and ensure that enrollees do not wait more than 30 minutes for screening by phone.[46] Knox-Keene-licensed plans must report to DMHC on their compliance with these requirements on an annual basis.[47]

Starting July 1, 2018, California will require plans to meet new timely access standards for two types of long-term care facilities—Intermediate Care Facilities for Individuals with Developmental Disabilities

(ICF-DDs) and Skilled Nursing Facilities (SNFs). Both facility types must be available within plan networks as follows:[48]

- Dense counties: within 5 business days of request;
- Medium counties: within 7 business days of request;
- Small counties: within 14 business days of request; and
- Rural counties: within 14 business days of request.

For this purpose, county categories follow those used for geographic access described above.[49]

VI. Access to Services Out-of-Network

The federal Medicaid regulations and Medi-Cal contracts require that plans provide access to all covered services in a timely and adequate manner, including by providing access to out-of-network providers if no suitable providers are available within a plan's network.[50] In addition, plans must provide access to emergency care out-of-network, without requiring prior authorization.[51] Plans must also provide for or arrange for enrollees to have access to either an in-network or out-of-network provider for second opinions.[52] In California, Medi-Cal plans must also ensure that enrollees may access out-of-network family planning services without prior authorization, and plans must also offer access to out-of-network STD, and HIV testing services (though the plans may require prior authorization for those services).[53] Under California law, new Medi-Cal managed care enrollees also have a right to continue seeing an out-of-network provider from whom they'd previously received care in certain circumstances.[54] In all cases where plans approve out-of-network care, plans must coordinate payment with out-of-network providers to ensure that enrollees do not incur greater costs for seeing an out-of-network provider than they would have incurred in they saw an in-network provider.[55]

VII. Access to Culturally-Competent Care, Including Services in Languages Other Than English

Another facet of access is ensuring that enrollees have access to culturally-competent health care services, that is, services that meet their social, cultural, and linguistic needs.[56] Access to culturally-competent care is important to ensure that groups that experience health care disparities, including people of color, people with disabilities, and LGBTQ people, have access to necessary and quality health care, and utilize services appropriately and effectively.[57] The revised federal rules make some initial steps toward ensuring that Medicaid managed care enrollees have access to culturally-competent care. For example, provider directories must indicate the cultural capabilities of listed providers, and whether the provider has completed cultural competence training.[58] The federal rules do not provide further guidance on how plans should determine what cultural capabilities their contracted providers possess for purposes of listing them in the directory, or what amount of training is required for a provider to be considered to have completed such training. To date, California also has not provided additional guidance to the plans on these subjects. In California, since 2011, Medi-Cal plans have been required to provide cultural sensitivity training to their contracted providers on the particular

needs of people who are older, have disabilities, or have chronic conditions.[59] In addition, state licensing laws mandate that all doctors in California to receive cultural competency training as part of their continuing education requirements.[60]

In terms of the numbers and types of providers in a plan's network, states are required to consider provider cultural competency in developing network adequacy standards, but the federal rules do not prescribe a particular formula for this consideration.[61] States must require contracted plans to participate in the state's "efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds and those with disabilities, regardless of gender, sexual orientation or gender identity."[62] California has long required its plans to identify the cultural and linguistic needs of their members and have a plan in place to meet those needs.[63] Starting in 2017, plans were required to submit their Health Education and Cultural and Linguistic Group Needs Assessments to DHCS for review.[64]

Access to services in other languages is a component of culturally-competent care that is particularly important to ensuring that limited English proficient enrollees have access to the care they need. Federal and state law require plans to ensure that all enrollees have access to interpreter services if the plan does not contract with a provider who speaks the enrollee's language.[65] In addition, to facilitate access, the federal rules require Medi-Cal provider directories to list each provider's linguistic capabilities, including "languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office."[66] Knox-Keene-licensed plan directories must also disclose that language interpreter services are available at no cost with information about how to obtain interpretation services.[67] In terms of the numbers and types of providers in a plan's network, states are required to consider language capacity in developing network adequacy standards, but the federal rules do not prescribe a particular formula for this consideration.[68] As mentioned above, States must also require contracted plans to participate in their efforts to deliver culturally-competent services to enrollees with limited English proficiency.[69]

VIII. Accessibility of Providers and Health Facilities to People with Disabilities

Some people with disabilities need accommodations to access health care services. These may range from wheelchair ramps and accessible exam tables for people who use wheelchairs, to sign-language interpreters for the Deaf, to a separate waiting space for a person with a mental health disability. Federal and state law require health care providers to offer reasonable accommodations for their patients with disabilities.[70] In addition, most health care facilities, including doctors' offices, must comply with building code requirements aimed at ensuring accessibility to people with physical disabilities.[71] Despite these protections, it is important for people with disabilities to know about the accessibility features and accommodations offered by their health care providers in advance. For

example, someone with a wheelchair may prefer to see a provider who offers an accessible exam table, rather than going to a provider that has staff available to lift the person onto an inaccessible table.

Thus, the federal rules require provider directories to notate whether listed providers are accessible to people with physical disabilities in their offices, exam rooms) and equipment.[72] Knox-Keene-licensed plan directories must also disclose that the plan must provide full and equal access to covered services to enrollees with disabilities.[73] In terms of the numbers and types of providers in a plan's network, states are required to consider "the ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities" in developing network adequacy standards, but the federal rules do not prescribe a particular formula for this consideration.[74] California requires Medi-Cal plans to perform a facility site review of contracted health care facilities on an annual basis to evaluate each facilities level of accessibility to people with disabilities.[75]

IX. Options for enrollees when their plan's network does not provide access to needed services

When Medi-Cal managed care enrollees are not able to access a service they need through the managed care plan, or access is not timely, they have several options to seek redress. First, the enrollee may file an appeal with the plan. Each Medi-Cal managed care plan has its own internal appeal process.[76] Plans generally have 30 days to resolve an appeal, but if the appeal concerns potential loss of life or limb, severe pain, or imminent & serious threat to health, the plan must resolve it within three days.[77] Second, if the enrollee's plan is Knox-Keene-licensed she may—after filing an appeal with the plan and either receiving an unfavorable decision, or waiting 30 days without a decision)—seek external review through DMHC.[78] In expedited cases, enrollees may proceed directly to DMHC for external review without waiting for the plan's internal appeal process. Third, after an unfavorable appeal decision by the plan, or after waiting 30 days without a decision (3 days in expedited cases), an individual may also request a Medi-Cal state hearing.[79] The individual may request a hearing up to 120 days after receiving a notice of appeal resolution from the plan.[80] Finally, at any point an enrollee may call or email the Medi-Cal Managed Care Ombudsman Office to report a problem with his or her plan's network.[81]

Conclusion

As more low-income Californians, especially those with disabilities and chronic care needs, are enrolled in Medi-Cal managed care plans, consumer advocates must ensure that the plans' networks are adequate to provide all covered services. Consumer advocates should work with DHCS, DMHC, and policymakers to monitor and enforce California's strong consumer protections that aim to ensure access to services for Medi-Cal enrollees.

Appendix A: Summary of Geographic Access Standards for Medi-Cal Plans (Effective July 1, 2018)

Type	Counties	Primary Care (including OB/GYN)	Specialty Care	Hospitals	Pharmacy	Dental	Behavioral Health (mental health and SUDS)
Dense	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara. Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.	10 miles or 30 minutes	15 miles or 30 minutes	15 miles or 30 minutes	10 miles or 30 minutes	10 miles or 30 minutes	15 miles or 30 minutes
Medium	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.	10 miles or 30 minutes	30 miles or 60 minutes	15 miles or 30 minutes	10 miles or 30 minutes	10 miles or 30 minutes	30 miles or 60 minutes
Small	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.	10 miles or 30 minutes	45 miles or 75 minutes	15 miles or 30 minutes	10 miles or 30 minutes	10 miles or 30 minutes	45 miles or 75 minutes
Rural	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.	10 miles or 30 minutes	60 miles or 90 minutes	15 miles or 30 minutes	10 miles or 30 minutes	10 miles or 30 minutes	60 miles or 90 minutes

Appendix B: Summary of Timely Access Standards for Medi-Cal Plans

Service	Timely Access Standard (measured from time of request)
Urgent care, no PA	48 hours
Urgent care, subject to PA	96 hours
Primary care	10 business days
Non-urgent specialty care	15 business days
Non-urgent, non-physician mental health care	10 business days
Non-urgent ancillary services	15 business days
ICF-DD or SNF*	Dense counties: 5 business days. Medium counties: 7 business days. Small and rural counties: 14 business days.

* Effective July 1, 2018

ENDNOTES

[1] CAL. DEPT. OF HEALTH CARE SERVS., MEDI-CAL MANAGED CARE PERFORMANCE DASHBOARD 3 (2018) (nearly 11 Million beneficiaries receive care from a managed care plan as of September, 2017), http://www.dhcs.ca.gov/services/Documents/MMCD/March212018Release.pdf.
[2] *Id.* at 3 (managed care enrollment at 81% as of September, 2017).
[3] *See generally* CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.
[4] CAL. WELF. & INST. CODE § 14087.95; *see also, e.g.,* CAL. HEALTH BENEFITS REV. PROG., THE CALIFORNIA COST AND COVERAGE MODEL, App'x 13 at 7 (2013), http://www.chbrp.org/other_publications/docs/ap_13.pdf.
[5] In Medi-Cal, the capitation rate is paid by the state to the plans directly. *See* CAL. HEALTH CARE FOUND., MEDI-CAL FACTS AND FIGURES: A PROGRAM TRANSFORMS 26 (2013), https://www.chcf.org/wp-content/uploads/2017/12/PDF-MediCalFactsAndFigures2013.pdf. There are a few very small managed care programs in Medi-Cal for enrollees with particular chronic conditions that are not capitated; this paper will not discuss them. *See* CAL. DEPT. OF HEALTH CARE SERVS., *supra* note 1 at 3. This paper also will not discuss separate managed care delivery systems for specialty mental health services, or, in some counties, dental and substance use disorder services. *See* CAL. DEPT. OF HEALTH CARE SERVS., MEDI-CAL MANAGED CARE QUALITY STRATEGY REPORT 5 (2018 Draft), http://www.dhcs.ca.gov/formsandpubs/Documents/ProposedManagedCareQSR3.28.18.pdf.
[6] *See* 42 C.F.R. § 438.2 (defining "comprehensive risk contract" and "capitation payment" for Medi-Cal plans).
[7] 42 U.S.C. § 1396u-2(b)(5).
[8] 42 C.F.R. § 438.62.
[9] *Id.* § 438.207(a).
[10] *Id.* § 438.207(d).
[11] CAL. WELF. & INST. CODE § 14182(c)(2); *see also, e.g.,* CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COHS COUNTIES, Ex. A, Att. 6 (2014), http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf.
[12] 42 C.F.R. § 438.10(h).
[13] *Id.* §§ 438.10(e)(2)(vi), (h)(3).
[14] CAL. HEALTH & SAFETY CODE § 1367.27(d)(2).
[15] *Id.* § 1367.27(h).
[16] *Id.*
[17] *Id.* § 1367.27(f).
[18] *Id.* § 1367.27(g).
[19] *See* CAL. DEP'T MANAGED HEALTH CARE, UNIFORM PROVIDER DIRECTORY STANDARDS (2016), https://www.dmhc.ca.gov/Portals/0/LicensingAndReporting/upds.pdf.
[20] 42 C.F.R. § 438.206(b)(1).
[21] *Id.* § 438.207(b)(1).
[22] CAL. WELF. & INST. CODE § 14182(c)(2); *see also* CAL. DEP'T OF HEALTH CARE SERVS., *supra,* note 11, at Ex. A, Att. 6 (contract language requiring compliance with these provisions).
[23] *E.g.,* CAL. DEP'T OF HEALTH CARE SERVS., *supra*, note 11, at Ex. A, Att. 14 § 4(D)(17); 42 C.F.R. § 438.206(b)(2).
[24] CAL. WELF. & INST. CODE § 14182(c)(7); CAL. CODE REGS., tit. 22, § 53800(b)(2)(C)(1).
[25] Letter from Nathan Nau, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Feb. 16, 2018) [hereinafter APL 18-005], http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-005.pdf.
[26] CAL. CODE REGS., tit. 22, § 53853(a); *see also, e.g.,* CAL. DEP'T OF HEALTH CARE SERVS., *supra,* note 11, at Ex. A, Att. 6 § 2; APL 18-005, *supra,* note 25, at 3
[27] CAL. DEP'T OF HEALTH CARE SERVS., *supra,* note 11, at Ex. A, at Ex. A, Att. 6 § 10; Margaret Tatar, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Mar. 12, 2014) (APL 14-006), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-006.pdf; *see also* APL 18-005, *supra,* note 25, at 2; Letter from Sarah Brooks, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Dec. 28, 2016) (APL 16-019), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-019.pdf;

Letter from Tanya Homman, Cal. Dep't of Health Care Services to All Two-Plan and Geographic Managed Care Health Plans (Apr. 14, 2011) (APL 11-009), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-009.pdf; CAL. CODE REGS., tit. 22, § 53852.

[28] 42 C.F.R. § 438.68.

[29] *Id.* § 438.68(c)(1)(vi).

[30] *Id.* § 438.207(b)(2).

[31] CAL. WELF. & INST. CODE §§ 14197(b), (c); *see also* APL 18-005, *supra*, note 25, at Attach. A.

[32] CAL. WELF. & INST. CODE §§ 14197(b), (c); *see also* APL 18-005, *supra*, note 25, at Attach. A.

[33] CAL. DEP'T OF HEALTH CARE SERVS., *supra,* note 11, at Ex. A, at Ex. A, Att. 6 § 10; APL 18-005, *supra,* note 25, at 10-11; *see also* CAL. CODE REGS., tit. 22, § 53852.

[34] CAL. CODE REGS, tit. 28, § 1300.51(c)(H)(iv).

[35] 42 C.F.R. § 438.206(c)(1).

[36] *Id.* § 438.206(c)(1).

[37] CAL. WELF. & INST. CODE § 14197(d)(1)(A).

[38] CAL. DEP'T OF HEALTH CARE SERVS., *supra*, note 11, at Ex. A, Att. 9 § 3(A).

[39] CAL. CODE REGS., tit. 28, § 1300.67.2.2(c)(5)(A).

[40] *Id.* § 1300.67.2.2(c)(5)(B).

[41] *Id.* § 1300.67.2.2(c)(5)(C).

[42] *Id.* § 1300.67.2.2(c)(5)(D).

[43] *Id.* § 1300.67.2.2(c)(5)(E).

[44] *Id.* § 1300.67.2.2(c)(5)(F).

[45] *Id.* § 1300.67.2.2(c)(5)(G).

[46] *Id.* § 1300.67.2.2(c)(8).

[47] *Id.* § 1300.67.2.2(g).

[48] CAL. WELF. & INST. CODE § 14197(d)(2).

[49] *Id.*

[50] CAL. DEP'T OF HEALTH CARE SERVS., *supra,* note 11, at Ex. A, Att. 9 § 16; 42 C.F.R. § 438.206(b)(4).

[51] 42 U.S.C. § 1396u-2(b)(2); 42 C.F.R. § 438.114(b)-(c); *see also* CAL. CODE REGS., tit. 22, §§ 53216, 53855; CAL. CODE REGS., tit. 28, § 1300.67(g) (comparable provisions in Knox-Keene Act regulations). Plans must also cover post-stabilization care in certain circumstances. *See* 42 U.S.C. § 1395w–22 (d)(2); 42 C.F.R. §§ 438.114(b), (e); CAL. CODE REGS., tit. 22, § 53855(c).

[52] 42 C.F.R. § 438.206(b)(3); CAL. DEP'T OF HEALTH CARE SERVS., *supra,* note 11, at Ex. A, Att. 5 § 1(C).

[53] CAL. DEP'T OF HEALTH CARE SERVS., *supra,* note 11, at Ex. A, Att. 9 §§ 9(A)-(C).

[54] CAL. WELF. & INST. CODE § 14182(b)(13); *see* ABBI COURSOLLE & SHYAAM SUBRAMANIAN, NAT'L HEALTH LAW PROG., CONTINUITY OF CARE IN MEDI-CAL (2016 ed.), http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/medi-cal-managed-care.

[55] 42 C.F.R. § 438.206(b)(5)); CAL. CODE REGS., tit. 22, §§ 51002, 53855(c). Providers of emergency services to Medicaid managed care enrollees must accept the state's fee-for-service rate for services to Medicaid enrollees. 42 U.S.C. § 1396u-2(b)(2)(D).

[56] JOSEPH R. BETANCOURT, *ET AL.*, THE COMMONWEALTH FUND, CULTURAL COMPETENCE IN HEALTH CARE: EMERGING FRAMEWORKS AND PRACTICAL APPROACHES 3 (2002), http://www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf.

[57] AGENCY HEALTH RES. & QUALITY, IMPROVING CULTURAL COMPETENCE TO REDUCE HEALTH DISPARITIES FOR PRIORITY POPULATIONS 1 (2014), https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/cultural-competence_research-protocol.pdf; *see also* Jean Lau Chin, *Culturally Competent Health Care*, 115 PUBLIC HEALTH REP. 25, 29-30 (2000).

[58] 42 C.F.R. § 438.10(h)(1)(vii).

[59] *See* Letter from Tanya Homman, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (May 11, 2011) (APL 11-010), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-010.pdf.

[60] *See* CAL. BUS. & PROF. CODE § 2190.1(c)(1).

[61] 42 C.F.R. § 438.68(c)(1)(viii).
[62] *Id*. § 438.206(c)(2).
[63] CAL CODE REGS., tit. 22, §§ 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), 53910.5(a)(2); *see also* Letter from Susanne M. Hughes, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Apr. 2, 1999) (APL 99-005), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf ; Letter from Sarah Brooks, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Feb. 3, 2017) [hereinafter APL 17-002], http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-002.pdf.
[64] APL 17-002, *supra,* note 63, at 4.
[65] 42 U.S.C. § 2000d; *see Lau v. Nichols*, 414 U.S. 563 (1974); 45 C.F.R. § 92.201; CAL. HEALTH & SAFETY CODE § 1259(c)(2) (Hospitals); Letter from Susanne M. Hughes, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Apr. 2, 1999) (APL 99-003), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL1999/MMCDPL99003.pdf.
[66] 42 C.F.R. § 438.10(h)(1)(vii).
[67] CAL. HEALTH & SAFETY CODE § 1367.27(g).
[68] 42 C.F.R. § 438.68(c)(1)(vii).
[69] *Id*. § 438.206(c)(2).
[70] 42 U.S.C. § 12101; 28 C.F.R. §§ 35.101 *et seq.*; CAL. HEALTH & SAFETY CODE §§ 18901 *et. seq.*
[71] CAL. HEALTH & SAFETY CODE §§ 18901 *et. seq.* Local codes may place more stringent rules on buildings in their localities.
[72] 42 C.F.R. § 438.10(h)(1)(viii).
[73] CAL. HEALTH & SAFETY CODE § 1367.27(g).
[74] 42 C.F.R. § 438.68(c)(1)(viii).
[75] *See* Letter from Tanya Homman, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Dec. 31, 2010) (APL 10-016), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2010/PL10-016.pdf; Letter from Sarah Brooks, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Oct. 28, 2015) (APL 15-023), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-023.pdf.
[76] For information about filing an internal plan grievance, see our companion piece: ABBI COURSOLLE, NAT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #4: INTERNAL GRIEVANCES AND EXTERNAL REVIEW (2017 ed.), http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/CA-MC-4; *see also* HEALTH CONSUMER ALLIANCE, MEDI-CAL AND MANAGED CARE: QUESTIONS AND ANSWERS TO HELP YOU GET THE BEST HEALTH CARE FOR YOU 1-2 (2017), https://healthconsumer.org/wp/wp-content/uploads/2017/12/HCA-Medi-Cal-and-Managed-Care_3.pdf.
[77] CAL. HEALTH & SAFETY CODE § 1368.01; *see also* CAL. DEP'T OF HEALTH CARE SERVS., *supra,* note 11, at Ex. A, Att. 14 §§ 5-6.
[78] CAL. HEALTH & SAFETY CODE §§ 1368(b)(1)(A), 1374.30. Most complaints about network adequacy will be resolved through DMHC's complaint process, but cases involving disputes over the medical necessity of a service or treatment, payment for an emergency or urgent care service provided out-of-network, or whether a particular service or treatment is experimental or investigational may be sent to a clinical review process known as Independent Medical Review (IMR). *See id.* § 1374.30. For information about requesting external review, see our companion piece: COURSOLLE, *supra,* note 76, at 6-7; *see also* HEALTH CONSUMER ALLIANCE, *supra*, note 76, at 2-3.
[79] 42 C.F.R. § 431.220; 22 CCR § 50951. For information about requesting a fair hearing, see our companion piece: COURSOLLE, *supra*, note 76, at 4-5; *see also* HEALTH CONSUMER ALLIANCE, *supra*, note 76, at 2.
[80] 42 C.F.R. § 431.221(d); CAL. WELF. & INST. CODE § 10951; *see also Morales v. McMahon*, 223 Cal. App. 3d 184 (1990).
[81] *See* Cal. Dep't of Health Care Servs., Medi-Cal Managed Care Division Office of the Ombudsman, http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx (last visited May 4, 2018).