Network Adequacy in Medi-Cal Managed Care (Updated 2024)

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As of July 2023, over 90% of Medi-Cal's 15 Million enrollees were enrolled in comprehensive managed care health plans statewide in Medi-Cal.[1] Over the past 30 years, California has increasingly moved beneficiaries into a capitated managed care delivery system. Nearly all beneficiaries now receive their care through a managed care plan, including those who reside in residential facilities, pregnant people, children with special health care needs, and people with other health coverage.[2] These capitated managed care plans receive a fixed per-member, per-month "capitated" fee, regardless of how many services an enrollee may actually need. These managed care plans bear the financial risk if the cost of providing services exceeds the capitated payment. On the other hand, if enrollees use fewer services, the plan keeps the excess payment. Because managed care companies have a financial incentive to limit costs and care, federal law and regulations provide an important array of consumer protections for enrollees.[3]

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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 and access rules for specialty mental health services in Medi-Cal, see: Abbi Coursolle & T. Nancy Lam, Nat'l Health L. Prog., *Access to Medi-Cal Specialty Mental Health Services: Network Adequacy Requirements and Other Beneficiary Rights* (2023), **https://healthlaw.org/resource/access-to-medi-cal-specialty-mental-health-services-network-adequacy-requirements-and-other-beneficiary-rights**. For information about network adequacy in Covered California plans, see our companion piece: Abbi Coursolle, Nat'l Health L. Prog., *Network Adequacy Laws in Covered California Plans* (2014), **https://healthlaw.org/resource/managed-care-in-california-series-issue-2-network-adequacy-laws-in-covered-california-plans**.

Specifically, there are a number of laws and policies that require Medi-Cal managed care plans to ensure that their provider networks are adequate to ensure that beneficiaries have access to the care they need. Some of these protections are specific to Medi-Cal while others are more broadly applicable to people enrolled in certain licensed managed care plans in California. This fact sheet provides an overview of the laws and regulations that require Medi-Cal managed care plans to ensure that their networks are adequate to provide access to covered services for their enrollees.

Overview of Network Adequacy

Because managed care delivery systems can give plans an incentive to limit coverage of services for their enrollees in order to maximize profits, 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. Additional protections apply to plans regulated by both the Department of Managed Health Care (DMHC) and the Department of Health Care Services (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.[4] Federal Medicaid regulations require states to develop and publish quantitative network adequacy standards, including specific time and distance, for certain types of provider.[5] 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.[6] 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.[7] California Medi-Cal law complies with the federal rules in part by requiring plans to "ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner."[8] California's specific requirements for Medi-Cal plans are described below.

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 federal rules require plans to publish online and in hard copy a regularly updated provider directory.[9]

In addition, under California rules, all Medi-Cal managed care plans must publicly publish an online provider directory that is updated weekly.[10] Provider directories must include certain data points for each provider contracted with the plan to provide Medi-Cal covered services (for list, see call out box below).[11] 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.[12] Starting in March, 2025, Medi-Cal plans will be required to specifically list in their directories whether providers provide specified gender-affirming care services.[13] Under new federal rules, starting for the first contract period after July 9, 2028, Medi-Cal plans will be required to use an independent secret shopper survey to verify the accuracy of their provider directory listings for providers of primary care, OB/GYN care, and outpatient mental health and substance use disorder services.[14]

Provider Directory Required Data Points:

- Name of provider, and any group affiliation;
- Name of medical group, if applicable;
- National Provider Identifier number;
- Street address;
- Telephone number, including the telephone number to call after business hours;
- Website URL;
- Specialty;
- Hours, including the availability of evening and/or weekend hours;
- Services and benefits available;
- Whether the office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment to be indicated using DHCS's standard accessibility symbols;
- Cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered by the provider or a skilled medical interpreter, and if the provider has completed cultural competency training;
- Whether the provider is accepting new patients;
- Identification of Providers that are not available to all or new Members; and
- A link to the Medi-Cal Rx Pharmacy Locator.

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.[15] In addition, the plan must demonstrate, to the state's satisfaction, that it provides an "appropriate range of preventive, primary care, specialty services, and [Long Term Services and Supports (LTSS)] that is adequate for the anticipated number of enrollees for the service area."[16]

Under state policy, California requires all Medi-Cal plans to meet a 1:1200 provider-patient ratio overall, and a 1:2000 ratio for primary care providers.[17] 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.[18]

In addition, all Medi-Cal plans must contract or demonstrate efforts to contract with mandatory provider types designated by federal and state statutes. These provider types include Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Freestanding Birth Centers (FBC), Certified Nurse Midwives (CNB), Licensed Midwives (LM), Indian Health Care Providers (IHCP), qualifying cancer centers, Skilled Nursing Facilities, Intermediate Care Facilities, and Subacute facilities.[19] If current Medi-Cal plans are not contracted with a mandatory provider type, then they must provide access to services customarily provided by that provider type either in or out of the county, including the provision of transportation services.[20]

Geographic Access

California law requires Medi-Cal plans to make care available within the following times and distances from the beneficiary's place of residence:[21]

- 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.
- Pharmacy services: 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 practitioners 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.
- Outpatient mental health and substance use disorder services, including 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.[22]

(For county designations for the purposes of this law, see the call out box below.[23])

County Designations:

- Dense counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
- 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 DHCS the locations of their contracted providers on a quarterly basis, or whenever there is a "significant change" to their network.[24]

California law allows Managed Care plans to use clinically appropriate synchronous telehealth to comply with these standards.[25] Specifically, plans may allocate up to 15% of their network with providers offering synchronous telehealth and still be considered in compliance with geographic access standards.[26] However, plans must always make a timely in-person available when a member requests one, and must provide transportation assistance if needed to ensure that the person can access care in-person.[27]

In certain instances, California law also allows Medi-Cal managed care plans to seek an exception to geographic access requirements, called an "Alternative Access Standard." [28] DHCS grants these exceptions at the ZIP-Code level for up to three years, upon a showing that the plan "has exhausted all other reasonable options to obtain providers to meet the applicable standard."[29] DHCS may also grant an exception to a plan that uses an integrated "delivery structure capable of delivering the appropriate level of care and access," an exception that allows Kaiser Permanente to contract as a Medi-Cal plan.[30] The request for an exception must describe how the plan intends to arrange for beneficiaries to access covered services from providers located outside of the time or distance standards.[31]

In addition to these requirements, DMHC Knox-Keene-licensed Medi-Cal managed care 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.[32]

Timely Access

Federal Medicaid rules require plans to provide enrollees with timely access to services.[33] Under those rules, California's contracts with Medi-Cal managed care 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.[34]

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.[35] The standards are also incorporated into the contracts for all plans.[36] Those standards require plans to ensure that enrollees have access to services within the established timeframes (see table below).[37] 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.[38] 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.[39]

Service	Maximum Wait Time
Urgent care, where no prior authorization is required	Within 48 hours of request
Urgent care, where prior authorization is required	Within 96 hours of request
Non-urgent primary care	Within 10 business days of request
Non-urgent specialty care	Within 15 business days of request
Non-urgent non-physician mental health and substance use disorder care	Within 10 business days of request
Non-urgent ancillary services	Within 15 business days of request

In addition to these requirements, California also requires Medi-Cal plans to provide 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:[40]

- 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.[41] Under new federal rules, starting for the first contract period after July 9, 2028, Medi-Cal plans will be required to use an independent secret shopper survey to verify compliance with state timely access standards for primary care, OB/GYN care, and outpatient mental health and substance use disorder services.[42] Plans' secret shopper survey results will be required to show a compliance rate with the timely access standards of at least 90%.[43]

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.[44] In addition, plans must provide access to emergency and urgent care out-of-network (including out-of-state), without requiring prior authorization.[45] 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.[46] Medi-Cal plans must also ensure that enrollees may access out-of-network family planning and minor consent services without prior authorization, and plans must also offer access to out-of-network STI and HIV testing services (though the plans may require prior authorization for those services).[47] Under California law, new Medi-Cal managed care enrollees also have a right to continue seeing an out-of-network provider from whom they had previously received care in certain circumstances.[48] 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.[49]

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

Medi-Cal plans must also ensure that enrollees have access to culturally-competent health care services, that is, services that meet their social, cultural, and linguistic needs.[50] Access to culturally-competent care is important to ensure that groups that experience health care disparities, including Black, Indigenous, and other People of Color; people with disabilities; and LGBTQI+ people, have access to necessary and quality health care, and utilize services appropriately and effectively.[51] Federal regulations include some requirements to ensure that Medicaid managed care enrollees have access to culturally-competent care. Plans provider directories must indicate the cultural capabilities of listed providers, and whether the provider has completed cultural competence training.[52] The federal regulations 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. Starting in 2024, California policy requires all Medi-Cal plans to provide a training program on sensitivity, cultural competency and humility, diversity, and health equity to all contracted providers, in addition to plan staff and subcontractors.[53] DHCS has set forth specific requirements that the training must meet, and requires plans to make the training available to new providers and staff within their first 90 days, and must ensure that training is provided ongoing to providers "during times of re-credentialing or contract renewals."[54]

In terms of the numbers and types of providers in a plan's network, states are required to consider provider cultural competency in developing Medicaid network adequacy standards, but the federal rules do not prescribe a particular formula for this consideration.[55] States must require contracted Medicaid 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."[56] California has long required its Medi-Cal managed care plans to identify the cultural and linguistic needs of their members and have a plan in place to meet those needs.[57] As of 2024, plans are required to submit their Population Needs Assessment (PNA) once every three years for DHCS review as part of a multi-year Population Health Management Program.[58] These PNAs must identify population-level health and social needs, including health disparities based on relevant data for its entire member population.[59] Further, Medi-Cal managed care plans must use the PNA findings to ensure that they provide and maintain culturally competent and linguistically appropriate services.[60]

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 Medi-Cal 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.[61] Knox-Keene-licensed Medi-Cal plan directories must disclose that language interpreter services are available at no cost with information about how to obtain interpretation services.[62]

Disability Accessibility of Providers and Health Facilities

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 Deaf enrollees, 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 disabled patients.[63] In addition, most health care facilities, including

doctors' offices, must comply with building code requirements aimed at ensuring accessibility to people with physical disabilities.[64] Despite these protections, it is important for disabled people to know about the accessibility features and accommodations offered by their health care providers in advance. For example, someone who uses 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 regulations require provider directories to notate whether listed providers are accessible to people with physical disabilities in their offices, exam rooms, and equipment.[65] Knox-Keene-licensed Medi-Cal plan directories must also disclose that the plan must provide full and equal access to covered services to disabled enrollees.[66] 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.[67] California requires Medi-Cal plans to perform an annual facility site review of certain contracted health care facilities to evaluate the facilities' accessibility to disabled people.[68]

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.

ENDNOTES

[1] Cal. Dep't of Health Care Servs., *Medi-Cal Monthly Eligibility Fast Facts* 11 (2023), **https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-July2023.pdf** (90.8% of beneficiaries enrolled in managed care as of July 2023). Traditionally, Medi-Cal operated using "fee-for-service" (FFS) payment and services delivery model. In FFS, each provider contracts individually with the state to furnish services to Medi-Cal beneficiaries. After the provider furnishes the covered service to the beneficiary, the provider submits a claim to the state, and the state pays a fee for that particular claim. Health care providers who participate in Medi-Cal must accept Medi-Cal payment as payment in full; they may not collect additional payment from Medi-Cal patients, with the exception of cost sharing authorized under federal law and the state plan. 42 U.S.C. § 1396a(a)(25)(C); 42 C.F.R. §§ 447.15, 447.20. In FFS Medi-Cal, a beneficiary may obtain services from any health care provider who participates in the Medi-Cal program. 42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51. Over the past few decades, many states including California have been transitioning away from the FFS model. There is a limited FFS system that continues for a few populations who are not subject to managed care enrollment and for select services that are not part of the managed care delivery system.
[2] *See, e.g.,* CAL. WELF. & INST. CODE § 14184.201 (describing populations newly required to enroll in Medi-Cal managed care starting in 2022).
[3] *See* 42 U.S.C. § 1396u-2; 42 C.F.R. Part 438.
[4] 42 U.S.C. § 1396u-2(b)(5).
[5] 42 C.F.R. § 438.68(b).
[6] *Id.* § 438.207(a).
[7] *Id.* § 438.207(d).
[8] CAL. WELF. & INST. CODE § 14197(a).
[9] 42 C.F.R. § 438.10(h); *see also* Cal. Dep't of Health Care Servs., *2024 Managed Care Boilerplate Contract* at Ex. A, Attach. III § 5.1.1.H (2024) [hereinafter *2024 Boilerplate Contract*], **https://www.dhcs.ca.gov/provgovpart/Documents/2024-Managed-Care-Boilerplate-Contract.pdf**; Letter from Dana Durham, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans 4-5 (Nov. 29, 2022) [hereinafter APL 22-026], **https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-026.pdf**.
[10] APL 22-026, *supra* note 9, at 4-5; *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 5.1.1.H.7 (requiring Medi-Cal managed care plans to comply with the provider directory requirements set forth at Cal. Health & Safety Code § 1367.27); *see also* CAL. HEALTH & SAFETY CODE § 1367.27(d)(2).
[11] APL 22-026, *supra* note 9, at 4-5; *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 5.1.1.H.7; *see* CAL. HEALTH & SAFETY CODE § 1367.27(h).
[12] CAL. HEALTH & SAFETY CODE § 1367.27(f); *see 2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 5.1.1.H.7; *see also* CAL. DEP'T MANAGED HEALTH CARE, UNIFORM PROVIDER DIRECTORY STANDARDS (2016), **https://www.dmhc.ca.gov/Portals/0/LicensingAndReporting/upds.pdf** (DMHC

guidelines for Knox-Keene licensed plans); Letter from Jenny Phillips, Cal. Dep't Managed Health Care, to All Health Care Service Plans (Mar. 23, 2023) (DMHC APL 23-007), https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2023-007%20-%20Provider%20Directory%20Annual%20Filing%20Requirements%20(3_23_23).pdf (DMHC guidance on provider directory submission and monitoring for Knox-Keene licensed plans); Cal. Dep't Managed Health Care, *Section 1367.27 Annual Compliance Filing* (2023) (Ex. E to DMHC APL 23-007), https://www.dmhc.ca.gov/Portals/0/Docs/OPL/MODEL%20Section%201367_27%20Exhibit%20E-1%20(3_23_23).pdf (same); Letter from Jenny Phillips, Cal. Dep't Managed Health Care, to All Health Care Service Plans (May 16, 2023) (DMHC APL 23-015), https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2023-015%20-%20Supplemental%20Provider%20Directory%20Annual%20Filing%20Requirements%20(2023)%20(5_16_23).pdf (same).

[13] CAL. WELF. & INST. CODE § 14197.09(c).

[14] 42 C.F.R. § 438.68(f)(1). The survey must verify the accuracy of the network status, address, telephone number, and whether the provider is accepting new patients. *Id.* § 438.68(f)(1)(ii).

[15] *Id.* § 438.206(b)(1).

[16] *Id.* § 438.207(b)(1).

[17] *See* CAL. CODE REGS., tit. 22, § 53853(a); *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 5.2.4.A; Letter from Dana Durham, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans 5 (Jan. 8, 2023) [hereinafter APL 23-001], https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-001.pdf.

[18] *See* CAL. CODE REGS., tit. 22, § 53852; *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 5.2.13; APL 23-001, *supra* note 17, at 2.

[19] APL 23-001, *supra* note 17, at 4-7 and sources cited therein; Letter from Dana Durham, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans (Mar. 14, 2023) (APL 23-004), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-004.pdf (SNFs); Letter from Dana Durham, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans (Nov. 28, 2023) (APL 23-023), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-023.pdf (ICFs); Letter from Dana Durham, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans (Sep. 26, 2023) (APL 23-027), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-027.pdf (Subacute Facilities).

[20] APL 23-001, *supra* note 17 at 4-7. For FQHCs and RHCs, Local Initiative plans only are required to offer to contract with all FQHCs and RHCs in their counties. CAL. WELF. & INST. CODE § 14087.325; CAL. CODE REGS., tit. 22, § 53800(b)(2)(C)(1).

[21] CAL. WELF. & INST. CODE §§ 14197(b), (c). When these provisions were originally enacted in 2017, they were intended to comply with 42 C.F.R. § 438.68, which, as of 2016, required states to implement "time and distance standards" for specified provider types by July 1, 2018. *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care,*

CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27873. This provision was amended in November 2020, effective December 14, 2020 to require states to implement only "quantitative network adequacy standards" without specifying that states must use time and distance standards. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care*, 85 Fed. Reg. 72754, 72840; *see also* 42 C.F.R. § 438.68(b) (as effective July 9. 2027).
[22] CAL. WELF. & INST. CODE §§ 14197(b), (c); *see also* APL 23-001, *supra* note 17, at Attach. A.
[23] CAL. WELF. & INST. CODE §§ 14197(b), (c); *see also* APL 23-001, *supra* note 17, at Attach. A.
[24] *See* CAL. CODE REGS., tit. 22, § 53852; *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 5.2.13; APL 23-001, *supra* note 17, at 2.
[25] *See* CAL. WELF. & INST. CODE § 14197(e)-(f). DHCS Guidance clarifies that telehealth may not be used to establish compliance for General Surgery, Orthopedic Surgery, Physical Medicine and Rehabilitation, or Hospitals. APL 23-001, *supra* note 17, at 9.
[26] *See* APL 23-001, *supra* note 17, at 9.
[27] *Id.*; *see also* CAL. WELF. & INST. CODE § 14197(e)-(f).
[28] CAL. WELF. & INST. CODE § 14197(f)(2).
[29] *Id.* § 14197(f)(3)-(4; *see* APL 23-001, *supra* note 17, at 11, 14.
[30] CAL. WELF. & INST. CODE § 14197(f)(3)-(4); *see* APL 23-001, *supra* note 17, at 11, 14.
[31] CAL. WELF. & INST. CODE § 14197(f)(4); *see* APL 23-001, *supra* note 17, at 11-13.
[32] CAL. CODE REGS, tit. 28, § 1300.51(c)(H)(iv).
[33] 42 C.F.R. § 438.68(e) (effective 2027, states must set timely access standards for routine primary care, OB/GYN, and outpatient mental health and substance use disorder services); *see also* § 438.206(c)(1)
[34] *Id.* § 438.206(c)(1).
[35] CAL. WELF. & INST. CODE § 14197(d)(1)(A); *see also* APL 23-001, *supra* note 17, at 10, Attach. A.
[36] *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 5.2.5.A.
[37] *See* CAL. HEALTH & SAFETY CODE § 1367.03(a)(5); CAL. CODE REGS., tit. 28, § 1300.67.2.2(c)(5); *see also* APL 23-001, *supra* note 17, at 10, Attach. A.
[38] CAL. HEALTH & SAFETY CODE § 1367.03(a)(5)(H); CAL. CODE REGS., tit. 28, § 1300.67.2.2(c)(5)(H).
[39] CAL. HEALTH & SAFETY CODE § 1367.03(a)(8)(A); CAL. CODE REGS., tit. 28, § 1300.67.2.2(c)(8).
[40] CAL. WELF. & INST. CODE § 14197(d)(2); *see also* APL 23-001, *supra* note 17, at 10, Attach. A.
[41] CAL. WELF. & INST. CODE § 14197(d)(2).
[42] 42 C.F.R. § 438.68(f)(2).
[43] *Id.* § 438.68(e)(2).
[44] *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 5.2.7.A; 42 C.F.R. § 438.206(b)(4). For individuals seeking mental health and substance use disorder treatment services, the Knox Keene Act explicitly requires that if a plan cannot provide a medically necessary treatment within the geographic and timely access standards, then it must "arrange coverage to ensure that the delivery of medically necessary out-of-network services and any medically necessary follow up services." CAL. HEALTH & SAFETY CODE §1374.72(d); *see also* Letter from Sarah Ream, Cal. Dep't Managed Health Care, to All Full Service Health Plans and Specialized Behavioral Health Plans 1 (Dec. 22, 2022) (DMHC APL 22-030),

https://dmhc.ca.gov/Portals/0/Docs/OPL/APL%2022-030%20-%20Requirement%20for%20Plans%20to%20Arrange%20for%20Covered%20Services%20(12_22_2022).pdf.

[45] 42 U.S.C. § 1396u-2(b)(2); 42 C.F.R. § 438.114(b)-(c); *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III §§ 5.2.6-5.2.7; *see also* CAL. CODE REGS., tit. 22, §§ 53216, 53855; CAL. CODE REGS., tit. 28, § 1300.67(g) (comparable provisions in Knox-Keene Act regulations); Letter from Sarah Ream, Cal. Dep't Managed Health Care, to All Full Service Health Plans and Medi-Cal Managed Care Health Care Service Plans (Nov. 7, 2022) (DMHC APL 22-027), https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2022-027%20-%20Timely%20Access%20to%20Emergent%20and%20Urgent%20Services%20When%20an%20Enrollee%20is%20Outside%20of%20California%20(11_7_2022).pdf. 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).

[46] 42 C.F.R. § 438.206(b)(3); *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 2.3.C.

[47] *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III §§ 3.39-3.3.11, 5.2.8; *see also* 42 U.S.C. §§ 396a(a)(23), 1396n(b); 42 C.F.R. § 431.51.

[48] *See* Abbi Coursolle, Nat'l Health Law Prog., *Continuity of Care in Medi-Cal* (2023 ed.), https://healthlaw.org/resource/continuity-of-care-in-medi-cal-managed-care-updated-2023.

[49] 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).

[50] Joseph R. Betancourt et al., The Commonwealth Fund, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* 3 (2002), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_oct_cultural_competence_in_health_care__emerging_frameworks_and_practical_approaches_betancourt_culturalcompetence_576_pdf.pdf.

[51] *See, e.g.,* Ashfaq Chauhan et al., *The Safety of Health Care for Ethnic Minority Patients: A Systematic Review*, 19 INTERNAT'L J. EQUITY HEALTH 118 (2020); 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.

[52] 42 C.F.R. § 438.10(h)(1)(vii).

[53] Letter from Dana Durham, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans 2 (Sep. 14, 2023) [hereinafter APL 23-025], https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-025.pdf; *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 5.2.11.C.

[54] APL 23-025, *supra* note 53, at 3-5.

[55] 42 C.F.R. § 438.68(c)(1)(viii).

[56] *Id.* § 438.206(c)(2).

[57] 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 Health Care Servs., to All Medi-Cal Managed Care Health Plans (Apr. 2, 1999) (PL 99-005), **http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf**; Letter from Sarah Brooks, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans (Feb. 3, 2017) (APL 17-002), **http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-002.pdf**; Letter of Nathan Nau, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans (Sept. 30, 2019) (APL 19-011), **https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-011.pdf**.
[58] Letter from Dana Durham, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans (Aug. 15, 2023) (APL 23-021), **https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-021.pdf**; *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 4.3.2.
[59] *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 4.3.2.
[60] *Id.*
[61] 42 U.S.C. § 2000d; *2024 Boilerplate Contract, supra* note 9, at Ex. A, Attach. III § 3.1.5.A.17; *see* Lau v. Nichols, 414 U.S. 563 (1974); 45 C.F.R. § 92.201; Letter from Susanne M. Hughes, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Apr. 2, 1999) (PL 99-003), **http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL1999/MMCDPL99003.pdf**.
[62] CAL. HEALTH & SAFETY CODE § 1367.27(g).
[63] 42 U.S.C. §§ 12132, 12182, 18116; CAL. CIV.CODE §§ 51, 54.1(a)(1); CAL. GOV. CODE § 11135.
[64] *See* CAL. HEALTH & SAFETY CODE §§ 18901 *et. seq.* Local codes may place more stringent rules on buildings in their localities.
[65] 42 C.F.R. § 438.10(h)(1)(viii).
[66] CAL. HEALTH & SAFETY CODE § 1367.27(g).
[67] 42 C.F.R. § 438.68(c)(1)(viii).
[68] *See* Letter from Dana Durham, Cal. Dep't Health Care Servs., to All Medi-Cal Managed Care Health Plans (Sep. 22, 2022) (APL 22-017), **https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-017.pdf**; Letter from Sarah Brooks, Cal. Dep't Health Care Servs., 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**.