

Provider Bulletin

Molina Healthcare of California

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June 9, 2026

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Updates to Network Adequacy Standards and Methodology – DMHC APL 25-019

This is an advisory notification to Molina Healthcare of California (MHC) network providers applicable to the Medi-Cal line of business.

This notification is based on All-Plan Letter (APL) 25-019, which can be found in full on the Department of Managed Health Care (DMHC) at: [dmhc.ca.gov/Portals/0/Docs/OPL/APL25-019-AmendmentstoRule1300_6_7_21300_67_1_31300_51andNetworkAdequacyRequirementsforRY2026\(12_12_2025\).pdf](https://dmhc.ca.gov/Portals/0/Docs/OPL/APL25-019-AmendmentstoRule1300_6_7_21300_67_1_31300_51andNetworkAdequacyRequirementsforRY2026(12_12_2025).pdf)

What you need to know:

Dear plan provider,

Molina Healthcare of California is notifying our provider network of updated regulatory requirements issued by the Department of Managed Health Care (DMHC) under All Plan Letter (APL) 25-019, which includes amendments to network adequacy standards and block transfer requirements effective January 1, 2026.

These changes impact health plan operations and require provider collaboration to ensure compliance with state regulations governing access to care and network management.

Effective Date and Applicability

- Effective date: January 1, 2026
- Applies to: New and ongoing network reviews, Annual Network Review submissions for Reporting Year 2026, and certain block transfer filings

Provider Action

To support compliance with these regulatory changes, Molina providers are expected to:

- **Maintain Accurate Information**
 - Ensure practice addresses, primary and secondary locations, office hours, and provider demographics are current and accurate
 - Promptly report changes in availability, panel status, specialty, or services offered
- **Ensure Availability to Members**
 - Actively provide services to Molina members
 - Maintain availability consistent with network adequacy requirements
- **Support Continuity of Care**
 - Cooperate with transition activities for members affected by provider changes
 - Comply with continuity of care requirements when applicable
- **Respond to Plan Requests**
 - Timely respond to requests for:
 - Directory validation
 - Participation status
 - Capacity and access reporting



Summary of Key Changes

1. Enhanced Network Adequacy Requirements

DMHC has strengthened standards to ensure members have timely access to care and accurate provider information. Key updates include:

- **Provider Availability Monitoring**
Health plans must verify that contracted providers are actively seeing patients. Providers without patient activity may be considered unavailable within the network.
- **Accurate Provider Directory Data**
Plans must maintain accurate reporting of provider **primary and secondary practice locations**, and respond to DMHC review of potential discrepancies.
- **Network Service Area Compliance**
Plans are required to ensure adequate access to services within approved service areas and address enrollment outside those areas
- **Out-of-Network Care Requirements**
When services are not available in-network, plans must coordinate access to out-of-network providers, document actions taken, and minimize member cost burden.

2. Updated Network Adequacy Standards (Reporting Year 2026)

New and revised methodologies used by the DMHC to evaluate network adequacy include:

- **Provider-to-Member Ratios** (including Primary Care Provider ratio standards)
- **Geographic Access Standards**, including updated distance thresholds for certain services such as mental health care
- **Accepting New Patients Requirements** for primary care and mental health providers
- **Mental Health Utilization Standards** to ensure providers are actively delivering services

Health plans that do not meet these standards may be required to submit corrective action plans to the DMHC.

3. Block Transfer Requirement Changes

Significant revisions to block transfer regulations expand when filings are required and establish stricter timelines:

- **Expanded Scope of Contract Terminations**
Block transfer requirements now include:
 - Partial terminations
 - Constructive terminations
 - Terminations involving plan-contracted entities (e.g., medical groups, IPAs)
- **Mandatory Filing Timeline**
Health plans must submit block transfer filings at least **75 business days prior to contract termination**.
- **DMHC Approval Required Before Network Changes**
Providers cannot be removed from the network until DMHC approval is obtained.
- **Hospital Terminations**
All hospital contract terminations now require a block transfer filing, regardless of the number of members impacted
- **Enhanced Member Notification Requirements**
Members must receive:
 - DMHC-approved notices at least 60 days prior to transfer
 - Updated notice formatting, including 12-point font

If you are not contracted with Molina and your fax number is not shared with a contracted provider, and you wish to opt out of receiving the MHC Provider Bulletin, please email mhcproviderbulletin@molinahealthcare.com.

Please include the provider's name, NPI, county, and fax number, and you will be removed within 30 days.

What if you need assistance?

If you have any questions regarding the notification, please contact your Molina Provider Relations Representative below.

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