State of California—Health and Human Services Agency
Department of Health Care Services

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TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: 2022 Federal Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS)

PURPOSE: To expand and clarify Network Adequacy Certification submission requirements for county MHP and DMC- ODS Plans.

REFERENCE: 42 CFR § 438.68, 438.206, and 438.207; Welfare & Institutions (W&I) Code Section 14197

BACKGROUND:
On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (referred to as the "Managed Care Rule"), which aligns Medicaid managed care regulations with requirements of other major sources of coverage. MHPs and DMC-ODS Plans (referred to as "Plans") are classified as Prepaid Inpatient Health Plans under federal law and must therefore comply with the Managed Care Rule (with some exceptions). The Managed Care Rule directs the state to develop and enforce network adequacy standards that meet federal requirements. Most of those network adequacy standards are set forth in 42 C.F.R. §438.68 Network adequacy standards; §438.206 Availability of services; and §438.207 Assurance of adequate capacity and services. Welfare and

Institutions Code (W&I) Section 14197 includes time and distance and timely access standards and subdivision (i) authorizes DHCS to interpret and implement W&I Section 14197 by information notice.

REQUIREMENTS

DHCS is required to monitor Plans' compliance with the network adequacy requirements set forth in W&I Section 14197 and 42 C.F.R. §§438.68, 438.206, and 438.207 to ensure that all Medi-Cal managed care covered services are available and accessible to beneficiaries of the Plans in accordance with timely access and time and distance standards.[1] In accordance with 42 C.F.R. §438.68(c)(1), the standards specified in this BHIN take into consideration the following elements:

1. The anticipated Medi-Cal enrollment;
2. The expected utilization of services;
3. The characteristics and health care needs of the Medi-Cal population;
4. The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish contracted Medi-Cal services;
5. The numbers of network providers who are not accepting new Medi-Cal beneficiaries;
6. The geographic location of network providers and Medi-Cal beneficiaries, considering distance, travel time, and the means of transportation ordinarily used by Medi-Cal beneficiaries;
7. The ability of network providers to communicate with limited English proficient beneficiaries in their preferred language(s);
8. The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities; and
9. The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

[1] W&I § 14197 (2020); See Also. § 14197(f) (2020); 42 C.F.R. §§ 438.68(a) (2020), 438.206(a),(c)(1)(i) (2020); See Also § 438.207 (2020).

NETWORK DATA AND DOCUMENTATION REPORTING REQUIREMENTS

The Managed Care Rule requires DHCS to establish network adequacy standards, and to establish requirements for Plans' network certification that expanded on previous provider network monitoring efforts and contractual provider network requirements. The Managed Care Rule requires States to ensure that Plans meet the federal requirements contained in 42 C.F.R. §§438.68, 438.206(c), and 438.207, and the State established network beneficiaries and projected, future beneficiaries. This BHIN sets forth those standards and requirements.

Plan Reporting Requirements

Each Plan is required to submit documentation and data to DHCS annually, and on DHCS' request, to demonstrate its compliance with the State's standards for access to services, including network adequacy and timely access standards.[2] The documentation and data shall demonstrate compliance for adult and pediatric services separately.[3] Section 438.207, Assurances of adequate capacity and services, requires each Plan to submit documentation to DHCS, in a format specified by DHCS, to demonstrate that it complies with the following requirements:

- Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (i.e., county); and
- Maintains a network of providers operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area (i.e. county).[4]

Additionally, each Plan must submit data and documentation any time there has been a significant change in the Plan's operations that would affect the adequacy and capacity of services, including the following:

1. a decrease of 25 percent or more in services or providers available to beneficiaries;
2. changes in benefits;
3. changes in geographic service area;
4. composition of, or payments to the plan's provider network; or
5. enrollment of a new population in the plan.[5]

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[2] W&I Code §14197(f)(1) (2020); 42 C.F.R. § 438.207 (2020).
[3] W&I Code §14197(f)(1) (2020); 42 C.F.R. § 438.207 (2020).
[4] 42 C.F.R. § 438.207(b)
[5] 42 C.F.R. § 438.207(c)

For example, a decrease in services may occur as a result of a provider reducing the number or types of services offered at a provider site (e.g. a Substance Use Disorder provider no longer offers Intensive Outpatient services, or a SMHS provider reduces the number of days the site offers Day Rehabilitative services).

The significant change may occur as a result of a termination, suspension or decertification of a Plan's network provider or subcontractor. Plans are required to notify DHCS by email to the Network Adequacy Oversight Section (NAOS) at

NAOS@dhcs.ca.gov within 10 business days, any time there has been a significant change in the Plan's operations.

DHCS Reporting Requirements
DHCS must submit an assurance to CMS that each Plan meets the State's requirements for the availability of services, on an annual basis and each time there has been a significant change in the Plan's operations. Each Plan's documentation serves as the basis for the State's assurance to CMS that the Plan is in compliance with the State's network adequacy standards. DHCS' submission to CMS must also include an analysis that supports the assurance of the adequacy of each Plan's provider network.[6]

SUBMISSION REQUIREMENTS
For the Fiscal Year (FY) 2022/2023 certification and subsequent FYs, Plans shall submit the Network Adequacy Certification Tool (NACT) and supporting documentation no later than August 29, 2022, or the next business day if the first day of the month falls on a weekend or holiday.

MHPs must upload electronic submissions of the NACT and supporting documentation into their Behavioral Health Information System (BHIS) – Client Services Information (CSI) system account 'Data Exchange' folder.

DMC-ODS Plans must submit electronic submissions of the NACT and supporting documentation via [secure] email to NAOS@dhcs.ca.gov.

DHCS has developed a standardized Network Adequacy Annual Certification Inventory (Attachment G) for Plans to detail the file names being submitted to fulfill each network adequacy requirement.

[6] 42 CFR 438.207(d)

When submitting files, each plan must use the following naming convention:

(Plan Name)_(Fiscal Year)_(Program)_(Document Name)_(Submission Date)

Examples:
Alameda_FY22-23_DMC-ODS_NACT_7.1.22
Napa_FY22-23_MHP_Language Line Attestation_7.1.22

Please note, the NACT is separate from the 274 standard and MHPs must continue to submit data via the 274 standard as outlined in BHIN 22-032, which is the Electronic Data Interchange (EDI) standard, in addition to the NACT. Once all MHPs have successfully and accurately implemented data elements of the 274 standard, DHCS intends to use that 274 standard data as the primary source for analysis and the NACT will be phased out. However, the NACT is still required until full 274 standard adoption is complete. For additional guidance, please see BHIN 22-032.

The NACT should be reported as point-in-time. DHCS defines point-in-time as a reference point in which the most current representation of the provider network is being reported by the Plan. The point-in-time is at each Plan's discretion.

Supporting documentation submissions such as 1) Timely Access Data, 2) Grievances and Appeals, 3) Language Line Encounters, and 4) Continuity of Care Requests must comply with the reporting period below. The December – February reporting period will be used for annual Network Adequacy Certification submissions until further notice:

- For State FY 2022/2023: Annual Certification – August 29, 2022 (reporting period: December 1, 2021 – February 28, 2022).

All executed agreements with contracted network providers and subcontractors, as well as supporting documentation (including agreements pertaining to interpretation, language line, telehealth services, and reserve/staffing contracts), must cover the certification year (e.g. valid July 1, 2022, through June 30, 2023). For auto-renewing contracts that have expired or will expire during the certification period, the Plan must submit an attestation on county letterhead that there are no known factors that could preclude the auto- renewal. All auto-renewing contracts must include a distinct, clear auto-renewal clause.

Any Plan that is found deficient and placed on a Corrective Action Plan (CAP) must submit an updated NACT, and any supporting documentation required to address the

CAP, by March 1, or the next business day if the first day of the month falls on a weekend or holiday, to demonstrate compliance. The submission(s) must comply with the reporting period below. The September – November reporting period will be used for annual CAP submissions until further notice. For example, the FY 2022/2023 dates are as follows:

- For State FY 2022/2023: CAP County submission - March 1, 2023 (reporting period: September 1, 2022 – November 30, 2022).

In addition, Plans are required to notify DHCS by email to NAOS@dhcs.ca.gov within 10 business days, any time there has been a significant change in the Plan's operations that would render the Plan non-compliant with standards for network adequacy and capacity including, but not limited to, the composition of the Plan's provider network.[7]

For more detail on what constitutes a significant change please see NETWORK DATA AND DOCUMENTATION REPORTING REQUIREMENTS section above.

Network Adequacy Certification Tool (NACT) – Attachments A.1 and A.2

- Plans are required to complete all exhibits in the NACT.

MHPs:

- Attachment A.1 is available by contacting NAOS@dhcs.ca.gov.

DMC-ODS Plans:

- Attachment A.2 is available by contacting NAOS@dhcs.ca.gov.

Utilizing the NACT and supporting documentation, DHCS will review each Plan's compliance in the following areas:

I. Network Capacity and Composition:
   a. MHP – Provider to Beneficiary Ratios;
   b. DMC-ODS – Availability of Services; and
   c. Additional Options to meet Provider and Capacity Requirements.

II. Time or Distance Standards.

III. Timely Access.

IV. Language Assistance Capabilities:

[7] 42 C.F.R., § 438.207(c)(3) (2020).

a. Language Capacity; and
b. Telephonic language Line Encounters.

V. Mandatory Provider Types:
a. American Indian Health Facilities;
b. Intensive Care Coordination and Intensive Home Based Services (MHPs only).

VI. Transition of Care/Continuity of Care:
a. For additional information please see IN 18-051 and IN 18-059.

VII. System infrastructure.

I. Network Adequacy Standards – Capacity and Composition

a. MHP – Provider to Beneficiary Ratios

Each MHP must maintain and monitor a network of appropriate providers that is supported by written agreements, and is sufficient to provide adequate access to Specialty Mental Health Services (SMHS) for all beneficiaries within their county, including those with limited English proficiency, or physical or mental disabilities.[8] MHPs must meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment.

The process by which DHCS determines if a MHP meets or exceeds network capacity pertaining to Outpatient SMHS and Psychiatry Services includes: 1) Provider Productivity Calculation, 2) Average Minutes Calculation, 3) Provider Ratio Calculation, 4) Anticipated Need for Specialty Mental Health Services and Psychiatry Services, and 5) Evaluation of County Provider-Beneficiary Ratios.

Productivity Calculation

DHCS assumed that each full-time equivalent (FTE) provider can work a maximum of 2,080 hours (or 124,800 minutes) per year (assumptions: 52 weeks × 40 hours per week). DHCS assumed a 60% productivity rate (i.e., time spent on direct billable services) to determine the total productive minutes (i.e., 74,880) per State Fiscal Year (SFY) for each FTE SMHS provider. The 60% productivity rate was established after convening internal and external stakeholder meetings which confirmed that, on average, most providers spend about 60% of their time providing treatment services directly, while the remaining 40% is spent on

[8] 42 C.F.R. § 438.206(b)(1) (2020)

administrative or other non-service related professional activities (e.g., participation in meetings, professional events and conferences, etc.).

Average Minutes Calculation

Using SMHS claims data (as claimed by all qualified providers listed in the California State Plan), DHCS calculated the average number of minutes claimed statewide for Mental Health Services, parsed into adults and children/youth for the FY 2017/2018.

For Psychiatry Services, each county's medication support services were isolated into those only claimed under a psychiatrist/neurologist provider taxonomy code. Then the minutes were averaged for the FY by county and age group. The averages were divided into quartiles representing all 56 county MHPs. Then, DHCS used the median value to stabilize the billing pattern variations across the counties. The percentage of medication support services billed by psychiatrists or neurologists for the adult beneficiary population was 50.6%. The median percentage of medication support services billed by psychiatrists or neurologists for the children/youth beneficiary population was 71.8%.

DHCS adjusted the statewide average of medication support services by these percentages to create a proportionate psychiatry provider ratio.

Provider Ratio Calculation

To calculate statewide ratios for Mental Health Services, DHCS divided the total **productive minutes** per year by the total **average SMHS service minutes** billed for adults and/or children/youth.

To calculate statewide ratios for Psychiatry Services, DHCS divided the total **productive minutes** per year by the percentage of **psychiatry-billed medication support minutes** calculated (as described above). The results of the provider ratio calculation are presented in Table 1.

Table 1. Provider-To-Beneficiary Ratio Standards

Measurement Category	Ratio Standard
Psychiatry – Adults	1:524
Psychiatry – Children/Youth	1:323
Mental Health Services – Adults	1:85
Mental Health Services – Children/Youth	1:43

Anticipated Need for Specialty Mental Health Services (SMHS) and Psychiatry Services

DHCS based SMHS need on the Serious Emotional Disturbance in children/youth and Serious Mental Illness in adults (SED/SMI) prevalence estimates calculated for the Bridge to Reform Waiver, developed by the Technical Assistance Collaborative (TAC) and the Human Services Research Institute (HSRI). The TAC and HSRI report is available at CA Bridge to Reform Waiver Services. While these estimates were published in 2013, they are the only available prevalence estimates specific to the SED/SMI population within Medi-Cal. However, DHCS compared prevalence estimates over time and determined that prevalence rates within the population do not vary greatly over time.

Using the Medi-Cal Eligibility Data System (MEDS), DHCS calculates the average number of eligible Medi-Cal beneficiaries in each county during the most recent FY. DHCS then applies the SED and SMI prevalence estimates to the average Medi- Cal eligibles per county and age group to determine the proportion of beneficiaries likely to need SMHS. This adjusted Medi-Cal enrollment population represents the anticipated need for SMHS.

DHCS uses this same methodology to estimate the need for psychiatry services (i.e., services provided directly by a psychiatrist). However, to determine the estimated need for psychiatry services, DHCS further calculates the proportion of beneficiaries within the existing SMHS population who received psychiatry services as a part of the beneficiary's individualized treatment plan. DHCS determined that 67% of adults and 27% of children/youth receiving SMHS receive psychiatry services as a part of their treatment. Thus, to estimate the proportion of beneficiaries that may need psychiatry services, the estimated population to seek SMHS was adjusted by this percent, respectively.

Evaluation of County Provider-Beneficiary Ratios

DHCS calculates each MHP's current provider-to-beneficiary ratio using FTE provider counts (numerator) and the anticipated SMHS and Psychiatry needs population (denominator). DHCS then evaluates the MHP's provider-to-beneficiary ratios to determine if the current provider network meets the statewide ratio requirement. For an example of this process, see Table 2.

Table 2. County Provider Network Adequacy – Example Calculation

FY 17/18	Sum Average minutes	Provider productive minutes per year	Statewide ratio requirement	Example County Needs Population	Example County Provider FTE Reported	Example County Ratio	Example Findings
Mental Health Services – Children /Youth	1,733	74,880	74,880/1,733 = 1:43	6,000	70.2	Needs Population/ FTE= 1:85	Deficient – Need to add 69.3 FTE
Mental Health Services – Adults	882	74,880	74,880/882 = 1:85	4,000	195.2	Needs Population/ FTE= 1:20	Compliant

In the example above, for Children/Youth Mental Health Services, the county has one FTE per 85 children/youth. This is evidenced by dividing 70.2 FTE reported into the 6,000 beneficiaries in need of service. To determine how many FTEs are needed to serve 6,000 beneficiaries, divide 43 (required ratio) into 6,000, which equals 139.5 FTE. By subtracting reported FTE (70.2) from required FTE (139.5), the deficiency in the example is 69.3 FTE.

For MHPs utilizing tele-psychiatry and/or locums tenens contracts to meet the need for psychiatry services, DHCS calculates the estimated FTE value of the contracts. DHCS estimates FTE by dividing the total FY budget amount by the mean hourly (i.e., business hours) rate to determine the total number of hours allotted via the contract. DHCS will consider alternate proposals from MHPs for estimating FTE on a case-by-case basis.

Calculating Full-Time Equivalents

A provider may be counted as one (1) FTE position if the individual's full-time job assignment is direct service delivery to Medi-Cal beneficiaries. In the case where an individual is assigned to direct service delivery on a part- time basis, the FTE should be calculated based on the percentage of time the individual could be dedicated to direct service delivery on an ongoing basis over the course of a year. A FTE position is 2,080 hours per year (i.e., 40 hours per week). FTE calculations shall not exceed 40 hours per week, including between service type(s) and age group(s) served (Please see the section titled "Additional Options to Meet Provider and Capacity Requirements" for instructions on how a Plan may report provider time in excess of 40 hours per week).

Only direct providers of Mental Health Services and Psychiatrist Services should be included. For each rendering provider (an employee or contracted provider), report the total FTE (capacity) available to directly provide Mental Health Services including Intensive Home Based Services (IHBS) and Psychiatrist Services as evidenced by the contract. Only report time available to provide services in outpatient settings; do not report FTE for providers who are only available to work in residential or inpatient settings. Providers who are available to work in both inpatient and outpatient settings can be counted, but their FTE should be allocated based on time available for the outpatient setting only. For providers that serve more than one age group, the percentage of FTE allotted to each age group by service type should be listed on a separate line.

In prior years DHCS solely considered psychiatrists when calculating Psychiatry FTE due to limitations on claims data for medication support services. After engaging in discussions with internal and external stakeholders, and based on feedback received, DHCS determined that psychiatric mental health nurse practitioners (PMHNPs) will be allowed to be reported by Plans as described below:

DHCS will evaluate compliance with psychiatry ratios using reported FTE for psychiatrists, psychiatric mental health nurse practitioners (PMHNPs), and physicians only. PMHNPs will fulfill requirements for counties in psychiatry ratios as long as the PMHNP ratios do not exceed 4:1 PMHNP/psychiatrist. MHPs must submit an attestation on county letterhead affirming the rendering provider is a PMHNP and the facility does not exceed the 4:1 PMHNP/psychiatrist ratio requirement.

For outpatient specialty mental health ratios, DHCS will count reported FTE for all providers the MHP listed as available to provide outpatient mental health services, including IHBS. This also includes providers who are available to provide other service types in addition to outpatient mental health services. However, DHCS will not count providers who are available only for services other than outpatient mental health services. For example, if a provider is only available to provide targeted case management or crisis stabilization services, the provider should be reported accordingly by the MHP and will not be included in the outpatient ratio calculation.

For quality and validation purposes, DHCS makes the following adjustments to the data submitted in the NACT:

- Remove FTE for providers who were reported with an FTE greater than 100% across service settings and age groups (For further guidance on how to submit an attestation for providers who work over 100%, please see Section C below.);
- Remove FTE for medication support services reported for providers that are not psychiatrists, PMHNP, or physicians; and,
- Remove FTE for SMHS/DMC-ODS providers who reported 100% FTE in the SMHS NACT (if no attestation is submitted) and are also reported on the NACT for a DMC-ODS Plan.

The MHP may request further explanation of DHCS about which FTE were excluded by reaching out to NAOS@dhcs.ca.gov.

Administrative Staff

These staff and/or members of leadership can only be included if they have capacity to serve clients on a regular and on-going basis. If an administrative staff employee is needed to function 100% in their administrative role (e.g., director, medical director, quality improvement manager) but could pick up a client on an emergency basis, the employee should not be included as they do not have regular capacity to serve clients. The FTE, if included, should accurately reflect the amount of time the individual can actually be available to directly provide services to a beneficiary over the course of a year.

If counties report administrative staff, or other providers, as having ongoing caseloads of zero, they should include information with the submission that explains why the provider does not carry a regular caseload.

Reserve/Staffing Contracts

MHPs are permitted to use reserve/staffing contracts to meet network adequacy standards and/or as a basis for Alternative Access Standard (AAS) request. Reserve/staffing providers must meet the provider requirements for the applicable SMHS, be enrolled as providers in the Medi-Cal program, and be able to comply with state and federal requirements for the Medi-Cal program.

In order to utilize reserve/staffing contracts to meet provider to beneficiary ratios, the provider must be available to provide services to beneficiaries in the defined service area.

In addition, the physical location where beneficiaries receive services must meet the State's time and distance standards or an approved AAS request.

If using reserve/staffing contracts to meet either network adequacy standards or AAS, MHPs must submit information to DHCS on their reserve/staffing providers during scheduled submission periods. This information should include a copy of the reserve ontract, the name and National Provider Identifier (NPI) number of the contracting agency, and a statement from the county describing the number of FTE that can be available under the contract maximum (if this is not explicit in the contract itself).

Submission Requirements for Residential Treatment Services, Psychiatric Health Facility Services and Inpatient Hospital Services (MHP Only)

For each provider of residential treatment services, psychiatric health facility services and inpatient hospital services in an MHP's network, the MHP must provide either an invoice from for FY 21/22, or an executed contract, covering the certification period through June 30, 2023. Providers of both crisis residential treatment services and adult residential treatment services must be included. Providers located outside of a MHP's service area (i.e., county) that are in the MHP's network must be included.

Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness.

This data is being collected for DHCS review only and counties will not be subject to new standards for inpatient/residential beds in the 2022 certification cycle.

b. DMC-ODS – Availability of Services

Each DMC-ODS plan is required to provide a list of all providers as part of their annual Network Adequacy Certification submission. To verify the network composition for the DMC-ODS plan, DHCS analyzes the list of network providers, and each provider's maximum number of beneficiaries separated by age group (i.e., 0-17, and 18+) and by service modality that can be served at any given time, as reported by the DMC- ODS plan. For providers that serve more than one age group, the DMC-ODS plan's reporting method may adjust capacity by age group according to beneficiary needs. Thus (if there is not a specific maximum beneficiary count per age group established by contract) DMC-ODS plan should review utilization patterns and trends to determine the best way to allocate the maximum number of beneficiaries per age group. DMC- ODS plans must enter the provider on separate lines in the NACT indicating each age group and maximum number of beneficiaries that the provider can serve. The proportion of maximum capacity allocated to each age group will be at the DMC-ODS plan's discretion.

DMC-ODS plans must contract with the following provider types or facilities based on contractual, state, or federal requirements:

- Outpatient substance use disorder services provided by
- DMC-certified outpatient and intensive outpatient facilities;
- Opioid use disorder services provided by DMC-certified Narcotic Treatment Program/Opioid Treatment Program facilities; and,
- Residential substance use disorder services provided by DMC- certified, state-licensed, and American Society of Addiction Medicine (ASAM) designated residential facilities as follows:
    - At least one ASAM level of care initially
    - ASAM Levels 3.5 available within two years
    - ASAM Levels 3.1 and 3.3 available within three years

Projected Utilization

DHCS' projected utilization methodology is based on monthly enrollment totals derived from MEDS. Utilizing two (2) FYs of Medi-Cal enrollment data (e.g., for this certification, DHCS is using state FY2019-20 and 2020-21), two sets of projections are produced for each county: one for children and youth (aged 0-17) and one for adults (aged 18 and over). Monthly enrollment totals are forecasted through the certification period (e.g., for FY 2022/2023 certification the projection is through June 2023).

Utilizing the 2019 National Survey on Drug Use and Health[9] combined SUD estimates, DHCS applied the percentage of those aged 0-17 (4.55%) and 18+ (9.23%) estimated to be **in need of treatment services** to the Medi-Cal enrollment projections through June 2023 for each age group. DHCS then applied a percentage of 10 to the estimated beneficiaries **in need of treatment services** to estimate the number **who will actually seek treatment**. The 10% comes from the Substance Abuse and Mental Health Services Administration.

For further validation of expected utilization, DMC-ODS plans are also required to provide projections of beneficiaries who will seek treatment through the certification period (for FY 2022/2023, this projection is to June 2023) as well as the number of beneficiaries per treatment modality.

Network Capacity

To determine DMC-ODS Plans' network capacity and sufficiency to serve the Medi-Cal population, DHCS:

1. Compares the **expected utilization** (as calculated and reported by DMC-ODS Plans) to the **Seeking Treatment Estimate.** The Seeking Treatment Estimate is a baseline estimate calculated by DHCS using MEDS data that is specific to each DMC-ODS Plan. It is expected that Plans' reported expected utilization must either meet or exceed this baseline estimate. This comparison results in either of the following 2 scenarios—item "a" and item

[9] Substance Abuse and Mental Health Administration sponsored research evaluates the use of illegal drugs, prescription drugs, alcohol, and tobacco and misuse of prescription drugs; substance use disorders and substance use treatment major depressive episode and depression care; serious psychological distress, mental illness, and mental health care using data from the National Survey on Drug Use and Health.

"b" in the list below:

a. If the DMC-ODS Plan projects a **higher** number of beneficiaries **expected to utilize** services than the **Seeking Treatment Estimate** generated by DHCS, the Plan's number is used to determine if the DMC-ODS Plan's network composition is sufficient.

    i. Sufficiency means the maximum number of beneficiaries that can be served per treatment modality (as reported by the DMC-ODS Plan within the NACT) meets or exceeds the **expected utilization.**

b. If the DMC-ODS Plan's projections are **lower** than DHCS' **Seeking Treatment Estimate**, DHCS applies the percent difference to the Plan's reported expected utilization (per treatment modality) to increase the estimate to meet or exceed DHCS' seeking treatment estimate. This new figure (**new need estimate**) is used to determine if the DMC-ODS Plan's network composition is sufficient.

    i. Sufficiency means the maximum number of beneficiaries that can be served per treatment modality (as reported within the NACT) meets or exceeds the **new need estimate.**

Additional Analysis of Residential Capacity:

If DHCS finds that a DMC-ODS Plan is deficient in the initial Network Capacity Analysis described above, DHCS will consider average length of stay in the analysis.

In prior years, when determining residential capacity, DHCS' methodology only considered the total number of residential beds available to serve Medi-Cal beneficiaries as reported by DMC-ODS Plans and compared the total numbers of beds against the total number of beneficiaries a DMC-ODS Plan expected to serve over the course of a fiscal year. A DMC-ODS Plan could be found deficient when the DMC- ODS Plan's expected utilization exceeded the total number of beneficiaries the DMC-ODS Plan reported it can serve. DHCS' methodology did not take into consideration length of stay or the number of times a residential bed could be utilized over the course of a fiscal year. Through stakeholder engagement, DHCS recognized each residential bed could be serve multiple beneficiaries within a fiscal year. Therefore, DHCS has developed a methodology utilizing average length of stay to determine residential capacity.

Utilizing the average length of stay, DHCS will grow the bed capacity by the average length of stay identified in the table. After growing the bed capacity DHCS will compare the DMC-ODS Plan's reported expected utilization to the new bed capacity.

Table 1. Statewide Length of Stay

Age Group	Average # of Days Beneficiaries Stayed in Residential Treatment	Rate of Bed Turnover 365 days per year / Average # of Days Beneficiaries Stayed in Residential Treatment
Adult	48	8
Youth	36	10

Additional Analysis of Monthly Utilization Data:

If DHCS finds that a DMC-ODS Plan is deficient in the initial Network Capacity Analyses described above, then, DHCS also analyzes monthly utilization data as follows:

1. Utilizing the Supplemental Data Tool, the DMC-ODS Plan must submit unique beneficiary counts per treatment category for the certification submission's FY, organized by month and by age group. For validation purposes, DHCS compares this data to the DMC-ODS Plan's claims data submitted. DHCS recognizes that DMC-ODS Plans may report greater monthly utilization counts than what is evident in the DHCS claims database due to the inherent lag in claims processing; however, the monthly utilization counts submitted in the Supplemental Data Tool by the DMC-ODS Plan should not be less than what is in DHCS' records. DHCS compares the DMC- ODS Plan's **expected utilization** to DHCS' annual **Seeking Treatment Estimate** (as discussed in the Network Capacity section above).
    - If the DMC-ODS Plan's expected utilization is **higher than DHCS' estimate**, DHCS uses the DMC-ODS Plan's monthly utilization to project monthly utilization through the certification year. Then, DHCS determines sufficient capacity. Sufficiency means the maximum number of beneficiaries that can be served per treatment modality (as reported within the NACT) meets or exceeds the projected monthly utilization for each treatment modality and age group.

- If the DMC-ODS Plan's expected utilization is **lower than DHCS' estimate**, DHCS uses the DMC-ODS Plan's monthly utilization to project the monthly utilization through the certification year. Then, DHCS applies the percent difference

  between DHCS **Seeking Treatment Estimate** and the DMC- ODS Plan's **expected utilization** to the projection of monthly utilization through the certification year in order to grow it to the appropriate number. Then, DHCS determines sufficient capacity. Sufficiency means the maximum number of beneficiaries that can be served per treatment modality (as reported within the NACT) meets or exceeds the forecasted monthly utilization (with applied growth) for each treatment modality and age group.

Please note – DMC-ODS Plans are **not** required to submit monthly utilization data with the August 2022 submission but can submit at their own discretion. DMC-ODS Plans opting to submit monthly utilization data must utilize the Supplemental Data Tool. For the 2022 annual submission DMC-ODS Plans will only need to submit one year of utilization data. The reporting period for 2022 is January 1, 2021, thru December 31, 2021.

If the DMC-ODS Plan is placed on a CAP for Capacity and Composition deficiencies the DMC-ODS Plan is required to submit the Supplemental Data Tool with the CAP submission on March 1, 2023. DMC-ODS Plans will only need to submit one year of utilization data. The reporting period for the CAP submission is: January 1, 2021, thru December 31, 2021.

DHCS reserves the right to refine the methodology for capacity and composition determinations to include additional analyses. DHCS continues to partner with stakeholders to ensure that all pertinent data elements have been considered (e.g., surplus of providers, residential care length of stay, etc.) when determining the adequacy of capacity and composition within a DMC-ODS Plan's network. DHCS will promptly communicate any updates to the methodology to the DMC-ODS Plans.

Table 3. DMC-ODS, Estimated Need and the Seeking Treatment Estimate – Example Calculation

Projected Average Medi-Cal Enrollment Ages 0-17	Estimated Population in Need of SUD treatment Ages0- 17 (4.55%)	Estimated Population to Seek SUD treatment Ages0-17 (10% of total in need)	Projected Average Medi-Cal Enrollment Ages 18+	Estimate in need of SUD treatment Ages18+ (9.23%)	Estimated Population to Seek SUD treatment Ages 18+ (10% of total in need)
219,775	10,000	1000	1,262,626	116,540	11,654

Table 4. DMC-ODS, Expected Utilization per Service Modality – Example Calculation

Comparison of DHCS vs. DMC-ODS Plan Estimates			
DHCS Total Expected Utilization (N) Seeking Treatment for the DMC-ODS Plan	**DMC-ODS Plan's Actual Total Expected Utilization (N)**	**Difference**	**% Diff**
1000	750	250	33.3%

DHCS' Seeking Treatment Estimate is used as a baseline that the DMC-ODS Plan must either meet or exceed. In the example above, the DMC-ODS Plan total expected utilization (which is reported in the NACT, exhibit C-1) is 750 beneficiaries, which is less than DHCS' Seeking Treatment Estimate of 1,000 beneficiaries in the children/youth age group (0-17) as shown in Table 3. Thus, DHCS calculates the numerical difference between the two estimates and then converts that difference into a percentage.

Table 4. Part II: DMC-ODS, Expected Utilization per Service Modality – Example Calculation

Outpatient Treatment			**Intensive Outpatient Treatment (IOT)**			**Residential(RES)**			**Opioid Treatment Programs (OTP)**		
Proportion Expected Utilization for **Outpatient Treatment** (*n*)	Applied % Diff	Adj. Expected Utilization	Proportion Expected Utilization for **IOT** (*n*)	Applied % Diff	Adj. Expected Utilization	Proportion Expected Utilization for **RES** (*n*)	Applied % Diff	Adj. Expected Utilization	Proportion Expected Utilization for **OTP** (*n*)	Applied % Diff	Adj. Expected Utilization
350	117	467	**200**	66	266	**150**	50	200	**50**	17	67

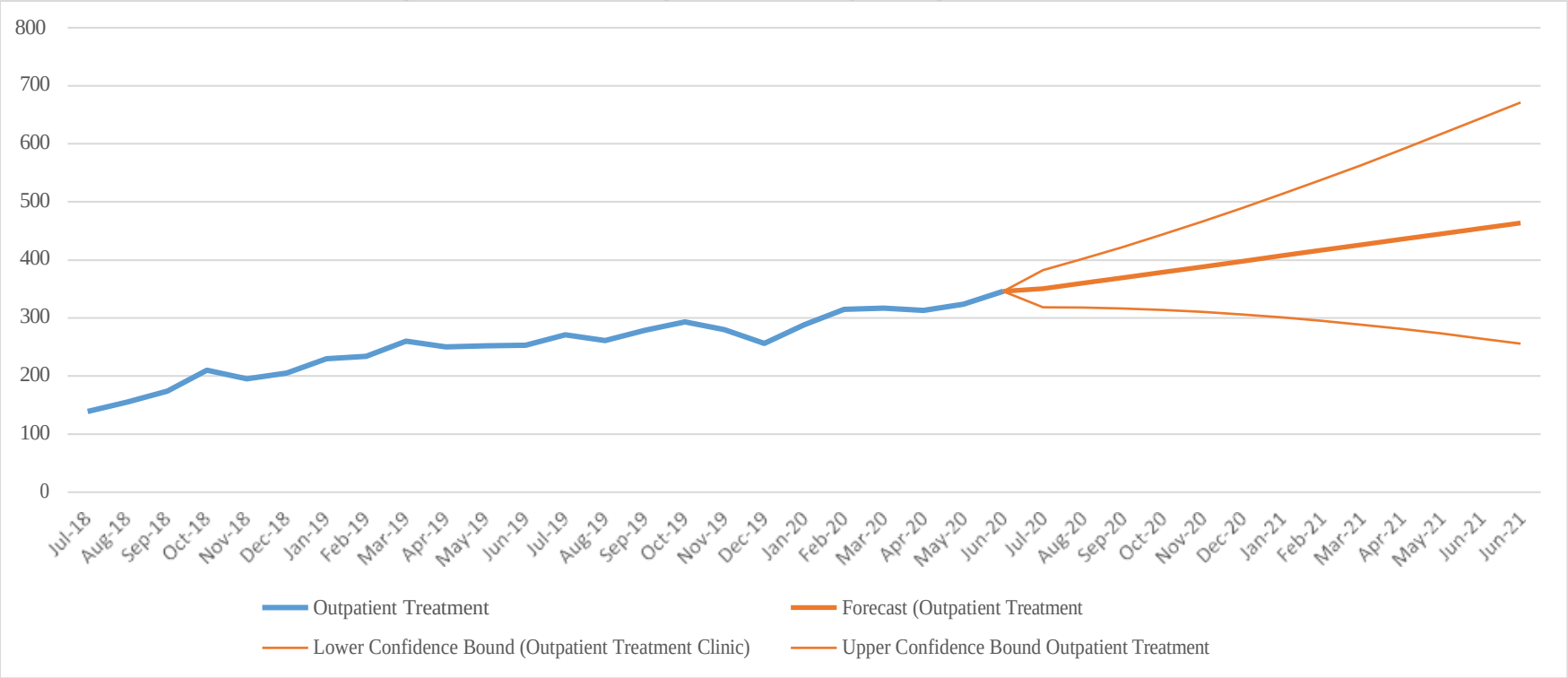
The percent difference is then applied to the DMC-ODS Plan's **expected utilization** broken out by service modality (also reported in the NACT, exhibit C-1) to grow those numbers proportionately (**adjusted expected utilization**) to meet DHCS' **Seeking Treatment Estimate.**

Table 5. DMC-ODS Plan Capacity and Composition Filter – Example

Row	Age Group(s) Served	Modality (DMC-ODS) - Outpatient Treatment Clinic	Modality (DMC-ODS) - Intensive Outpatient Clinic	Modality (DMC-ODS) - Residential	Modality (DMC-ODS) - Opioid Treatment Program	Maximum Number of Medi-Cal Beneficiaries
1	18+	Yes	No	No	Yes	70
2	0-17	No	Yes	Yes	No	12
3	0-17	Yes	No	No	Yes	24
4	18+	Yes	No	No	Yes	30
5	18+	Yes	No	No	Yes	245
6	0-17	Yes	No	No	No	300
7	18+	Yes	No	No	Yes	250
8	18+	Yes	Yes	Yes	Yes	100
9	18+	No	Yes	Yes	Yes	59
10	0-17	Yes	No	No	Yes	25
11	0-17	Yes	No	No	Yes	19
12	18+	Yes	No	No	Yes	30
13	0-17	Yes	No	No	Yes	250

In the example above, DHCS filtered the NACT (Exhibit A-2, Site Level Data) by age group, provider type, and maximum number of beneficiaries served. DHCS uses this filter to determine capacity to serve. For example, for Children/Youth (0-17) Outpatient Treatment services, DHCS can sum the Maximum Number of Med-Cal Beneficiaries for rows 3, 6, 10, 11, and 13 for a total of 618 maximum capacity. If the **expected utilization** for Children/Youth (0-17) Outpatient Treatment services (using the example in Table 4) is 467 beneficiaries, the DMC- ODS Plan has sufficient capacity to meet **expected utilization.**

Table 6. DMC-ODS Plan Monthly Utilization Data Projection – Example Projection



In the example above, DHCS uses two (2) FYs of monthly utilization data (reported by a DMC-ODS Plan, in the Supplemental Data Tool) to project utilization per month through the certification period. This data can be used to resolve the findings from the annual capacity analysis.

DHCS calculates both annual and monthly estimates to determine a DMC-ODS Plan's capacity, as there are many variables that affect the range between estimation and actual utilization. For instance, the annual estimation includes beneficiaries currently receiving DMC-ODS services and those that will be new to the system. Utilization is helpful in understanding the pattern in which services are actually accessed in a DMC-ODS Plan; however, utilization does not account for those that may have needed services but could not receive it (e.g., inadequate service capacity, obstacles to services, or variation in beneficiaries seeking services) or a growing population that could require services.

The monthly utilization is used as a mediator between the annual estimation and actual monthly utilization for the certification period and can be used to resolve CAPs. However, Plans are expected to continually grow the networks to achieve sufficient capacity to serve the annual **Seeking Treatment Estimate** figure as an eventual goal.

c. Additional Options to meet Provider and Capacity Requirements

DHCS may grant requests for AAS for Capacity and Composition requirements. If DHCS denies the request for an AAS it shall provide a written explanation for the denial.

MHPs:

- MHPs may submit an AAS request for Capacity and Composition to DHCS at any time, including at the time the MHP submits its annual certification data. For Rendering Providers with FTE in excess of 40 hours per week, MHPs **must not** submit the provider's data in the NACT. Rather, MHPs may submit a narrative request (on county letterhead) listing the provider details and FTE to be considered—including a breakout of FTE per delivery system, provider service modality, and age group(s) served.
    - To be considered, the MHP must also provide an executed provider contract for each provider listed in the narrative **and** supporting documentation, such as a signed attestation from the MHP explaining the validity of the FTE if the contract does not state this clearly. If the provider is directly employed by the MHP a contract is not required, however, the MHP must submit an attestation indicating the provider is a county employee.

DMC-ODS Plans:

- DMC-ODS Plans unable to resolve Capacity and Composition deficiencies through the CAP process will be notified by DHCS that they must submit a Corrective Action Plan Resolution Proposal (otherwise referred to as a "CAP Resolution Proposal" or "CRP"). The CRP (Attachment J) outlines how the DMC-ODS Plan proposes to ensure access to those services while working to add providers, modifying existing provider contracts to expand otherwise deficient service modalities, and/or any other network changes.
    - **Submission Requirement:** DMC-ODS Plans will have 30 days from DHCS' notification to complete and submit the CRP. DHCS then has 30 day to approve or deny the CRPs. The CRP must include a plan that describes the steps (including timelines with associated milestones) that the DMC-ODS Plans will take to obtain a provider in each required service modality. If approved, the DMC- ODS Plans will have established an AAS for Capacity for the current certification period extending through June 2023.
- **AAS Capacity and Composition Monitoring:** DHCS will monitor the timeline specified in each DMC-ODS Plan's approved AAS. It is critical that DMC-ODS Plans adhere to the timelines, and submit required documentation as proof of progress in a timely manner. DMC-ODS Plans are required to submit milestone updates and relevant supporting documentation as specified in the DMC-ODS Plan's approved AAS. DMC-ODS Plans are able—and encouraged—to submit updates and relevant material(s) ahead of any of the established milestones in the AAS, should events and activities relating to additions of new providers, amendments to existing provider contract(s) to expand services, etc., proceed more rapidly than initially proposed. DMC-ODS Plans shall submit all documentation via [Secure] email to NAOS@dhcs.ca.gov. In the event of a delay, DMC-ODS Plans must notify DHCS promptly of 1) the nature of the delay (e.g. initial contracting efforts failed, efforts temporarily suspended due to emergency budgetary constraints, etc.), 2) a proposed extension date, and 3) interim measures the DMC-ODS Plan proposes to address the treatment needs of beneficiaries.

I. Network Adequacy Standards – Time or Distance Standards (Attachment B)

42 C.F.R., §438.68 (2020), subdivision (b)(1), requires states to develop quantitative network adequacy standards, such as time or distance standards, for adult and pediatric behavioral health providers. Welfare & Institutions Code

section 14197, subdivisions (b) and (c) set forth time or distance standards for California. Time means the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site. Both standards are based on a county's population, and Plans are required to meet either the time or distance standard. Time or distance standards for Mental Health Services, Targeted Case Management, Crisis Intervention, Psychiatrist Services, Substance Use Disorder outpatient treatment, and Opioid Treatment Program services are specified in Attachment – B.

a. Time or Distance Geographical Maps Methodology

DHCS prepares geographic access maps for Plans using ArcGIS software. DHCS applies an enhancement within ArcGIS created by the Environmental Systems Research Institute (ESRI) to run the driving times or driving distances. ESRI utilizes the shortest driving time from each provider in a Plan's network to the address of the furthest Medi-Cal beneficiary in each zip code. The Department determines the beneficiaries to include in the calculation using the most current data available from the MEDS system.

DHCS plots time and distance for all network providers, stratified by provider type for MHPs (Psychiatry and Outpatient SMHS) and for DMC-ODS Plans (Outpatient Services and Opioid Treatment Programs), including geographic locations, for both adult and children/youth separately based on the NACT.

Plans may request a copy of the access maps by contacting the NAOS mailbox at NAOS@dhcs.ca.gov.

MHPs:

- Exhibit A-3: Rendering Service Provider;
- Exhibit B-1 (Field Based Services): only needed if field-based services are regularly delivered and are being used to meet time and distance standards.

DMC-ODS Plans:

- Exhibit A-2: Site

b. Alternative Access Standard (AAS) – Time or Distance

The Managed Care Rule permits states to grant exceptions to the time or distance standards. [10] If a Plan cannot meet the time or distance standards set forth in this BHIN for all coverage areas where Medi-Cal eligibles reside, DHCS will notify the Plan to submit an AAS request (Attachment – C) to DHCS within 30 days (see Alternative Access Standard Validation section below for approval timelines).[11] For each coverage area for which the Plan does not meet the time or distance standards for a provider type, the Plan shall include a description on how the Plan intends to arrange for Medi-Cal beneficiaries who reside in that coverage area to access that provider type, as specified in W&I Section 14197, subdivision (c).[12] All Plans are permitted to submit an AAS request with their annual certification package for analysis during the annual certification process.

c. Time or Distance AAS Request Template: Attachment – C

DHCS may grant requests for AAS if the Plan has exhausted all other reasonable options to obtain providers to meet the applicable standard, or if DHCS determines that the Plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.[13] If DHCS denies the request for an AAS, it shall provide a written explanation for the denial.

Requests for AAS must include a description of the reasons justifying the AAS based on the facts and circumstances surrounding a ZIP Code or Provider Type.[14] Requests may also include seasonal considerations (e.g., winter road conditions) when appropriate. Furthermore, Plans should, as appropriate, include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland). In determining whether to grant a request, DHCS shall consider whether it is reasonable for a beneficiary to travel the time or distance that would result if DHCS granted the AAS.[15]

Attachment C details the submission requirements for AAS requests. In the AAS request template, a Plan must provide the nearest in-network provider as well as the driving time or distance to that provider.

[10] 42 C.F.R. § 438.68(d) (2020).
[11] W&I, § 14197, subd. (e)(2) (2020).
[12] W&I, § 14197, subd. (e)(3) (2020).
[13] W&I, § 14197, subd. (e)(1) (2020).
[14] W&I, § 14197, subd. (e)(3) (2020).
[15] W&I, § 14197, subd. (e)(5) (2020).

To demonstrate that it has exhausted all other reasonable options to obtain providers to meet the applicable standard a Plan must submit evidence of its Out-of-Network (OON) contracting efforts. For each OON provider that a Plan attempted to contract with, the Plan must provide the name of the OON provider, including at minimum two OON provider(s) and driving time/distance from the OON provider(s) to the furthest eligible(s) in that zip code. In addition, Plans must provide reasons for inability to contract with OON provider and description of its contracting efforts, including the frequency of the contracting efforts, and the reasons the Plan was unable to contract. Plans must attempt to contract with at least two OON providers.

Plans are required to submit evidence of OON contracting efforts, including narrative detailing the name(s) of the OON provider(s) that the Plan attempted to contract with and the frequency of the contracting efforts. Plans must include documentation demonstrating contract efforts via email/letter, scheduled phone calls, good faith negotiations, contract records, marketing materials and advertisements, and follow-up attempts after initial contract efforts or outreach. For additional guidance on OON providers, please see BHIN 21-008 for MHPs and IN 19-024 for DMC-ODS Plans.

If a Plan is unable to contract with a specific provider due to a quality of care issue, the Plan must submit supporting documentation detailing the Plan's concern with the provider's quality of care. A quality of care issue may include, but is not limited to, a provider having insufficient credentials or being suspended from participation in the Medi-Cal program by DHCS, CMS, or the Office of the Inspector General for Health and Human Services.

Alternative Access Standard Validation

In Attachment C, Plans must detail the name of the two nearest identified OON providers, the date the Plan contacted the providers to discuss contracting with the Plan, and the number of contracting attempts the Plan made. Through the AAS validation, DHCS will request evidence of contracting efforts, which must include supporting documentation demonstrating contract efforts via email/letter, scheduled phone calls, good faith negotiations, contract records, marketing materials and advertisements, and follow-up attempts after initial contract efforts or outreach. The evidence of contracting efforts must reflect contracting efforts conducted since the Plan's last annual Network Adequacy Certification submission. DHCS will focus on validating AAS requests that have potential contracting options. The supporting documentation submitted must be dated prior to the AAS request in question taking effect.

DHCS approves or denies an AAS request based on an analysis of zip code and provider type.[16] The review process includes 1) verifying the AAS Request is submitted on time, 2) verifying if the AAS request is complete, and 3) verifying the Plan's efforts to identify the nearest in-network and OON providers. Additionally, DHCS compares the identified providers submitted by the Plan to the NACT and to other resources.

DHCS reviews the AAS request and all supporting documentation to assess the facts and circumstances provided by the Plan. Plans must maintain documentation of their efforts to contract with nearest OON providers and must provide all documentation to DHCS upon request. DHCS may request additional evidence of contracting efforts if DHCS identifies more than two nearer OON providers during the review process.

The use of clinically appropriate telehealth may be considered in determining compliance with the applicable standards and/or for the purpose of approving an AAS request. However, Plans cannot require a beneficiary to access services via telehealth only. Plans must inform the beneficiary about options for accessing covered non-emergency medical transportation to an in-network provider within time and distance and timely access standards for medically necessary services, when an in-person visit is requested by a beneficiary.

On an annual basis and at DHCS' request, the Plan must demonstrate how it arranges for the delivery of services such as Medi-Cal covered transportation or tele- health, if beneficiaries needed services from a provider or facility located outside of the time or distance standards specified in W&I Section 14197(c).

DHCS will approve or deny an AAS request within 90 days of submission by the Plan. DHCS may stop the 90-day timeframe on one or more occasions, as necessary, in the event of an incomplete submission, or to obtain additional information from the Plan requesting the AAS.[17] Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume where previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information.[18] Upon notification by DHCS, an approved AAS will be valid through the certification period (for FY 2022/2023 - through June 30, 2023). DHCS will monitor beneficiary access to

[16] W&I § 14197, subd. (e)(3) (2020).
[17] W&I § 14197, subd. (e)(3) (2020).
[18] W&I § 14197, subd. (e)(3) (2020).

the service type covered by the AAS on an on-going basis and report DHCS' findings to CMS.[19]

For all approved AAS requests, DHCS will monitor beneficiary access to the service type covered by the AAS request on an on-going basis and report DHCS' findings to CMS.If DHCS rejects a Plan's request for AAS, DHCS shall inform the Plan of the reason for rejecting the request. DHCS will post any approved AAS requests on the department website.[20]

d. Additional Options to Meet Time or Distance Standards

Field Based Services (MHP Only)

SMHS are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency.[21] DHCS will consider a substitute standard, other than time or distance when the provider travels to the beneficiary and/or a community-based setting to deliver services. For services where the provider travels to the beneficiary to deliver services, the MHP must ensure services are provided in a timely manner in accordance with the timely access standards. MHPs requesting a substitute standard must submit information to DHCS on the availability and provision of community-based or mobile services on Attachment A.1, Exhibit B-1 – Field Based Services. This includes fixed-location community settings (e.g., school, community center) and/or field-based, mobile, and/or community-based services (e.g., mobile units, satellite sites, community centers) to deliver services to beneficiaries in community-based settings, not including a beneficiary's home.

Telehealth Services

Plans are permitted to use telehealth services to meet network adequacy standards, including the provider ratios for both outpatient SMHS and psychiatry services, and/or as a basis for an AAS request.[22] However, 90% of beneficiaries must reside within the required time and distance standards for provider types by zip code. For example, if 100 Medi-Cal beneficiaries reside in zip code 95814, 90 of those beneficiaries should have an on-site provider available within time and distance standards.

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[19] 42 C.F.R. section 438.66 (e) requires DHCS to submit a report to CMS annually on each managed care program the Department administers. 42 C.F.RN. sections 438.68(d)(2) and 438.66(e)(2)(vi) require the Department to include the results of the monitoring in that report.

[20] W&I, § 14197, subd. (e)(3) (2020).

[21] State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2c; W&I Code section 14713, subd. (a) (2020).

[22] W&I, § 14197, subd. (e)(4) (2020).

Although DHCS proposes that telehealth will be permitted to meet time or distance standards, all members have the right to an in-person appointment, and telehealth can only be provided when medically appropriate, as determined by the provider and as allowed by the applicable delivery systems' provider manual.

Plans are not allowed to restrict in-person appointments in favor of telehealth. Telehealth services must comply with DHCS' Medi-Cal Provider Manual telehealth policy.[23]

In order to utilize telehealth to fulfill network adequacy requirements for time or distance standards, telehealth services must be provided to beneficiaries in the defined service area. In addition, the physical location where beneficiaries receive telehealth services must meet the State's time or distance standards or approved AAS.

If using telehealth to meet either network adequacy standards or AAS, Plans must submit information to DHCS on their telehealth providers. However, Plans cannot require a beneficiary to access services via telehealth only.[24] Plans must inform the beneficiary about options for accessing covered non-emergency medical transportation to a provider within time and distance and timely access standards for services, when an in-person visit is requested by a beneficiary.

Telehealth providers for Plans must be included in the NACT, in the appropriate exhibit, as follows:

MHPs:

- Exhibit A-3: Rendering Provider

DMC-ODS Plans:

- Exhibit A-2: Site

II. Network Adequacy Standards – Timely Access

42 C.F.R. §438.206(c)(1), Availability of Services, requires Plans to meet State standards for timely access to care and services, taking into account the urgency of the need for services. California Welfare & Institutions Code section

[23] W&I, § 14197, subd. (e)(4) (2020); Medi-Cal Provider Manual. "Medicine: Telehealth."
[24] W&I § 14197, subd. (e)(4); Health & Saf. Code, §2290.5, subd. (b) (2020).

14197, subdivision (d), sets forth timely access standards for MHPs and DMC-ODS Plans; it requires them to comply with the appointment time standards set forth in Health & Safety Code section 1367.03 and Title 28, California Code of Regulations, section 1300.67.2.2. The specific appointment time standards for which the Department is currently collecting data are set forth in the Timely Access Data Tool (TADT) Attachments D.1 and D.2.

a. Timely Access Data Tool (TADT): Attachment – D.1 and D.2

MHP: Attachment D.1 - MHP TADT

To ensure that MHPs provide timely access to services, DHCS requires each MHP to have a system in place for tracking and measuring timeliness of care, which includes the timeliness to receive a first appointment or first specialty mental health service. For this purpose, DHCS developed the TADT, a uniform data collection tool. For additional guidance, please see IN 19-020 and BHIN 20- 062E.

Please note, the TADT is separate from the DHCS Client and Services Information (CSI) Assessment Record submission requirement, although the data elements are in alignment. As explained in BHIN 20-062E, DHCS intends to use the TADT to analyze timely access until the CSI Assessment Record data is robust and accurate enough to be used as a sole source for timeliness analysis.

MHP Reporting Requirement

August 2022 submission: MHPs must use the TADT for new beneficiaries who request services during the reporting period. MHPs are required to report Phase One and Phase Two CSI data elements. The reporting period is December 1, 2021, through February 28, 2022.

March 2023 CAP submission: MHPs must use the TADT for new beneficiaries who requests services during the reporting period. MHPs are required to report Phase One and Phase Two CSI data elements. The reporting period is September 1, 2022 through November 30, 2022.

DMC-ODS Plan: Attachment D.2 - DMC-ODS TADT

To ensure DMC-ODS Plans provide timely access to services, DHCS requires each DMC-ODS Plan to have a system in place for tracking and measuring timeliness of care, which includes timeliness to receive a first appointment for outpatient or OTP treatment. For this purpose, DHCS developed the TADT, a

uniform data collection tool. While DMC-ODS Plans have previously not been required to submit timeliness data as a part of the certification process, a TADT submission is now required commencing with the FY 22-23 Annual Network Adequacy Certification submission due August 29, 2022.[25]

For additional guidance and more information, please see IN 19-020 and BHIN 20-062E.

DMC-ODS Reporting Requirement

August 2022 Submission: DMC-ODS Plans must use the TADT to submit timely access data for new beneficiaries who request services during the reporting period, and are required to report the following timely access data elements:

- County Client Number,
- Date of First Contact to Request Services,
- Assessment Appointment First Offer Date,
- Assessment Appointment Second Offer Date,
- Assessment Appointment Third Offer Date,
- Assessment Appointment Accepted Date,
- Assessment Start Date,
- Assessment End Date,
- Treatment Appointment First Offer Date,
- Treatment Appointment Second Offer Date,
- Treatment Appointment Third Offer Date,
- Treatment Appointment Accepted Date,
- Treatment Start Date,
- Closure Reason,
- Close out Date,
- Referred to _____.

Reporting Period: December 1, 2021, through February 28, 2022. DMC-ODS

Plans will not be placed on a CAP for timely access standards for the FY 22-23 Annual Network Adequacy Certification. However, they will receive findings from DHCS regarding the percentage of requests meeting the standard.

[25] HSC § 1367.03(a)(5)(F) HSC Chapter 2.2. Article 5. Standards [1367 - 1374.195]

DMC-ODS Plans who do not meet the timely access standard will receive technical assistance accompanying their findings. Compliance monitoring for DMC-ODS Timely Access standards will commence in FY 23-24.

b. Methodology for Determining Plan Compliance with Timely Access Standards

MHP

MHPs are required to submit data for all "new" beneficiaries that request:

- an initial non-urgent appointment with a non-physician mental health care provider of an outpatient SMHS; or
- an urgent or non-urgent appointment with a provider of psychiatry SMHS.

The definition of what constitutes a new beneficiary is at the discretion of the Plan. The data will be used to determine compliance with timely access standards. The definition of what constitutes a new beneficiary is at the discretion of the MHP.

DHCS calculates compliance using the Date of First Contact to Request Services and the number of days between that date and the Assessment Appointment First Offer Date. For example, if a beneficiary requests an initial non-urgent appointment with a non-physician mental health care provider (for an outpatient SMHS) on the first of the month, and is offered an appointment on the 11th of the month, the MHP would be considered to have met the 10 business day standard. For an MHP to be in compliance with this requirement 80% of beneficiaries must have been offered an appointment within the applicable time frame.

Furthermore, if the MHP is determined not to meet network adequacy requirements and the provider network is unable to provide timely access to necessary services, the MHP must adequately and timely cover these services out-of-network for the beneficiary. The MHP must permit out-of-network access for as long as the MHP's provider network is unable to provide the services in accordance with the standards.[26] For further guidance please see BHIN 21-008.

DMC-ODS Plan

DHCS requests that DMC-ODS Plans submit data for all "new" beneficiaries that are requesting outpatient and OTP services. The definition of what constitutes a new beneficiary is at the discretion of the Plan. The data will be used to determine the timeliness in accordance with timely access standards. The definition of what constitutes a new beneficiary is at the discretion of the DMC- ODS Plan.

[26] 42 C.F.R. § 438.206(b)(4).

DHCS calculates compliance using the Date of First Contact to Request Services and the number of days between that date and the Assessment Appointment First Offer Date, wherein, 80% of beneficiaries must have been offered an appointment within the appropriate standard (for example, when a client calls on the 1st of the month and is offered an appointment on the 11th of the month, the client was offered an appointment within 10 days).

Furthermore, if the DMC-ODS Plan is determined not to meet network adequacy requirements and the provider network is unable to provide timely access to necessary services, the DMC-ODS Plan must adequately and timely cover these services out-of-network for the beneficiary. The DMC-ODS Plan must permit out-of-network access for as long as the DMC-ODS Plan's provider network is unable to provide the services in accordance with the standards.[27] For further guidance, please see BHIN 19-024.

III. Language Assistance Capabilities

Plans must submit to DHCS subcontracts with interpreters for interpretation and language line services. In addition, Plans are required to report, in the Plan's provider directory[28] and in the NACT, the cultural and linguistic capabilities of network providers, including languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

a. Language Capacity

Plans are required to maintain and monitor a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services for all beneficiaries, including those with Limited English Proficiency (LEP).[29] Plans are also required to make oral interpretation and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), available to beneficiaries, free of charge, for any language.[30]

- While DHCS does not require a fixed number of language subcontracts from Plans, regardless of quantity, the Plan's language assistance subcontracts must cover—whether within a singular contract or several - the following types of language assistance services at a minimum:

[27] 42 C.F.R. § 438.206(b)(4).
[28] 42 C.F.R. § 438.10(h)(1)(vii) (2020).
[29] W&I § 14197, subd. (d)(1)(A) (2020); Cal.Code Regs., tit. 28 § 1300.67.2.2(c)(5)(D) (2021).
[30] 42 C.F.R. § 438.10(h)(1)(vii) (2020).

- Oral Interpretation – services offered for spoken language processed in real time, whether in-person, via video call, phone, or other medium.
- Written Translation – services offered for written language content, often processed separately from the time of the request for assistive language services.
- American Sign Language (ASL).

b. Telephonic Language Line Encounters Analysis

Plans must submit an analysis of monthly telephonic language line encounters. The analysis must detail the utilization of telephonic (i.e., language line) interpretation services to provide language access to beneficiaries in non-English languages. For each of the following, Plans must report, by language, the total number of encounters for which the telephonic language line was used:

- 24/7 access line encounters;
- Face-to-face service encounters; and
- Other telehealth or telephone service encounters.

Telephonic language line utilization should be reported for all network providers in relevant categories. **Language Line Utilization for 24/7 Access Line**	**Language Line Utilization for Face-to-Face Service Encounters**	**Language Line Utilization for Telehealth or Telephonic Service Encounters**
Exhibit Name: Language Line Utilization	Exhibit Name: Language Line Utilization	Exhibit Name: Language Line Utilization
MHP Name	MHP Name	MHP Name
Reporting Period	Reporting Period	Reporting Period
Total # encounters requiring language line services	Total # encounters requiring language line services	Total # encounters requiring language line services
# of encounters requiring language line services, stratified by language	# of encounters requiring language line services, stratified by language	# of encounters requiring language line services, stratified by language
Reason services could not be provided by bilingual provider/staff or contracted interpreter	Reason services could not be provided by bilingual provider/staff or via face-to-face interpretation	Reason services could not be provided by bilingual provider/staff or via face-to-face interpretation

IV. Mandatory Provider Type

Plans must demonstrate compliance with federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 C.F.R. §438.14).

a. American Indian Health Facilities

American Indians and American Indian Health Facilities (AIHF) are not required to contract with Plans; however, Plans must document good-faith efforts to contract with all AIHFs in the Plan's service area (i.e., county). If a Plan does not have a contract with any of the AIHFs in the Plan's county, the Plan must submit an explanation to DHCS that includes supporting documentation, to justify the absence of the mandatory provider type in the Plan's network. Please see Attachment – A NACT:

MHP NACT – Attachment – A.1

- Exhibit B-2

DMC-ODS NACT – Attachment – A.2

- Exhibit B-1

DHCS will review the Plan's submission to determine compliance.

b. Mandatory Provider Type – Intensive Care Coordination and Intensive Home Based Services Providers (MHP Only)

Per the MHP Contract,[31] MHPs are required to provide, or arrange for the provision of, all covered SMHS, including Intensive Care Coordination (ICC), and Intensive Home Based Services (IHBS). Each MHP's network must include providers responsible for delivering ICC and IHBS. ICC and IHBS providers should be included in NACT Exhibit A-3.

V. Continuity of Care (CoC) Report

Per IN 18-059, MHPs are required to report to DHCS all continuity of care requests. DHCS has developed a standardized tool for collecting continuity of care requests, see CoC Report Template (Attachment F). For the FY 22-23 annual

[31] MHP Contract, Att. 11, section 3, E.

Network Adequacy Certification submission, it is optional for MHPs to submit their CoC data utilizing the CoC Report Template. Any MHP that is found deficient and placed on a CAP will be required to submit the CoC Report Template in March as part of the MHP's CAP submission to address the deficiency and demonstrate compliance.

MHPs that opt out of utilizing the CoC Report Template for the FY 22- 23 Annual Network Adequacy Certification submission must ensure the following required data elements are submitted:

- The date of the request;
- The beneficiary's name;
- The name of the beneficiary's pre-existing provider;
- The address/location of the provider's office;
- Whether the provider has agreed to the MHP's terms and conditions; and
- The status of the request, including the deadline for making a decision regarding the beneficiary's request.

This data is considered Protected Health Information and must be submitted using the Secure Data Portal [Behavioral Health Information Systems (BHIS)]. Submission of the report by email or through another method will constitute a breach of the federal privacy rules and the Department will report it to the Department's Privacy Office as a breach.

Beginning with the FY 23-24 annual Network Adequacy Certification submission, MHPs will be required to submit their continuity of care requests utilizing the Continuity of Care Report Template.

If the MHPs do not have any data to report for any of the data requirements during the reporting period, MHPs can submit a statement on county letterhead, or on the submitted report, stating, **"No data for the reporting period."**

VI. System Infrastructure

Each Plan must also submit the following additional supporting documentation on an annual basis unless noted otherwise:

- DMC-ODS Plans only:
  - Grievances and appeals related to:
    - Access to care,
    - Availability of services,
    - Accessibility of services, and/or
    - Timeliness of services.
- MHPs only:
  - **Please note** - Grievances should correspond with the following Annual Beneficiary Grievance and Appeal Report (ABGAR) categories:
    - Services not available,
    - Services not accessible,
    - Timeliness of services,
    - 24/7 Toll-free access line,
    - Linguistic services,
    - Other access issues,
    - Authorization delay notices, and/or
    - Timely access notices.
- MHP and DMC-ODS:
  - If a Plan did not receive any grievances or appeals during the reporting period, the Plan must include an attestation indicating that.

Organizational Provider Contract Submission Requirements:

In order to streamline the validation process of network provider contracts, DHCS is requiring Plans to submit a sample of provider contracts from the providers listed on the NACT in Exhibit A-1: Organization. Sample size requirements are detailed in Table 7 and Table 8 on the following pages.

Table 7. DMC-ODS Service Provider Contract Submission Requirements

DMC-ODS Service Provider Contract Submission Requirements				
County Size *****WIC §14197 is used to establish county size.*	**Outpatient Setting**			**Inpatient Setting**
	Outpatient Treatment *Adult & Youth*	**Intensive Outpatient Treatment (IOT)** *Adult & Youth*	**Opioid Treatment Program (OTP)** *Adult & Youth*	**Residential** *Adult & Youth*
# of Contract Submissions <u>Required</u>				
Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne ***Per WIC §14197(4)(A)(iii)*	Please submit between 3-5* contracts which cover an array of services for FY22/23. *If the Plan has fewer than three contracts the Plan must submit all contracts.			Please submit <u>ALL</u> current Contracts.
Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba ***Per WIC §14197(4)(A)(iii)*	Please submit between 6-10* contracts which cover an array of services for FY22/23. *If the Plan has fewer than six contracts the Plan must submit all contracts.			Please submit <u>ALL</u> current Contracts.

Table 7. DMC-ODS Service Provider Contract Submission Requirements (Continued)

DMC-ODS Service Provider Contract Submission Requirements		
# of Contract Submissions <u>Required</u>		
Marin, Placer, Riverside, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura ***Per WIC §14197(4)(A)(ii)*	Please submit between 11-15* contracts which cover an array of services for FY22/23. *If the Plan has fewer than 11 contracts the Plan must submit all contracts.	**<u>3 Contracts</u>** Provider Contracts submitted must include: • Youth and Adult
Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara ***Per WIC §14197(4)(A)(i)*	Please submit between 16-20* contracts which cover an array of services for FY22/23. *If the Plan has fewer than 16 contracts the Plan must submit all contracts.	**<u>5 Contracts</u>** Provider Contracts submitted must include: • Youth and Adult
***Note:** *Note: A single contract may be sufficient to adequately satisfy the requirement if the contract covers more than one service type and/or age group.		
****WIC §14197**. (a) It is the intent of the Legislature that the department implement and monitor compliance with the time and distance requirements set forth in §§ 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations and this section, 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, as those standards were enacted in May 2016.		

Table 8. MHP Service Provider Contract Submission Requirements

MHP Service Provider Contract Submission Requirements			
MHP Provider Contracts			
County Size *****WIC §14197 is used to establish county size.*	**Psychiatry & Specialty Mental Health Services (SMHS)****	**Intensive Care Coordination (ICC)**	**Intensive Home Based Services (IHBS)**
Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne ***Per WIC §14197(3)(D)*	Please submit between 3-5* contracts which cover an array of services (Psychiatry and Outpatient Services) for FY22/23. *If the Plan has fewer than three contracts the Plan must submit all contracts.	1	1
Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba ***Per WIC §14197(3)(C)*	Please submit between 6-10* contracts which cover an array of services (Psychiatry and Outpatient Services) for FY22/23. *If the Plan has fewer than six contracts the Plan must submit all contracts.	1	1

MHP Service Provider Contract Submission Requirements			
MHP Provider Contracts			
County Size ********WIC §14197 is used to establish county size.*	**Psychiatry & Specialty Mental Health Service (SMHS)****	**Intensive Care Coordination (ICC)**	**Intensive Home Based Services (IHBS)**
Marin, Placer, Riverside, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura ***Per WIC §14197(3)(B)*	Please submit between 11-15* contracts which cover an array of services (Psychiatry and Outpatient Services) for FY 22/23. *If the Plan has fewer than 11 contracts the Plan must submit all contracts.	1	1
Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara ***Per WIC §14197(3)(A)*	Please submit between 16-20* contracts which cover an array of services (Psychiatry and Outpatient Services) for FY 22/23. *If the Plan have fewer than 16 contracts the Plan must submit all contracts.	1	1
***Note:** A single contract *may be sufficient to* adequately satisfy the requirement if the contract covers more than one service type and/or age group.			
****WIC §14197**. (a) It is the intent of the Legislature that the department implement and monitor compliance with the time and distance requirements set forth in §§438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations and this section, 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, as those standards were enacted in May 2016.			

Plans are required to include a Contract Cover Sheet (Attachment – H) for each contract submitted. The Contract Cover Sheet must include the following information:

- Organizational Provider's Name and page number located in the contract;
  - **Organizational provider name listed in NACT Exhibit A-1 must match the name of the provider name stated in the contract.**
- Contract Term/Length [Start Date – End Date] and page number located in the contract;
- Contract Number and page number located in the contract;
- Modality/Provider Type(s) and page number located in the contract; and
- Age Group(s) Served and page number located in the contract.

For auto-renewing contracts that have expired or will expire during the certification period, the Plan must submit an attestation on county letterhead that there are no known factors that could preclude the auto renewal. All auto-renewing contracts must include language pertaining to the auto-renewal.

Note: The contract terms and conditions must align with data reported in the NACT Exhibit A-1: Site. Additionally, DHCS reserves the right to request additional contracts during the annual Network Adequacy Certification process.

- Policies and procedures addressing the following topics:
  - Network adequacy monitoring - submit policies and procedures related to the Plan's procedures for monitoring compliance with the network adequacy standards;
  - OON access - submit policies and procedures related to beneficiary access to OON providers;
  - Timely access - submit policies and procedures addressing appointment time standards and timely access requirements;
  - Service availability - submit policies and procedures addressing requirements for appointment scheduling, routine specialty (e.g., psychiatry) referrals, and access to medically necessary services 24/7;
  - Physical accessibility - submit policies and procedures regarding access for beneficiaries with disabilities pursuant to the Americans with Disabilities Act of 1990;
  - Telehealth services - submit policies and procedures regarding use of telehealth services to deliver covered services;
  - 24/7 Access Line requirements - submit policies and procedures

regarding requirements for the MHP's 24/7 Access Line; and,
- 24/7 language assistance - submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.

If the Plans do not have any data to report for any of the data requirements during the reporting period, Plans can submit a statement on county letterhead stating, "**No data for the reporting period.**"

CERTIFICATION OF NETWORK ADEQUACY DATA AND DOCUMENTATION SUBMISSION

The Plan's Director, Chief Administrative Officer, or equivalents, must certify that the information submitted by the Plan in their county is accurate, complete, and truthful. The certification must be submitted with the NACT and supporting documentation. Submission of the NACT and supporting documentation and the accompanying certification is a condition for receiving payment.[32]

NETWORK ADEQUACY NON-COMPLIANCE

Non-Compliance with Submission Requirements

DHCS must certify the adequacy of every Plan's provider network to CMS on an annual basis. DHCS has the authority, in accordance with W&I Section 14197.7, to sanction Plans that are out-of-compliance with the submission requirements, including completeness, accuracy, and timeliness or lack of submission.

Non-Compliance with Network Adequacy Standards

If DHCS determines that a Plan does not meet the network adequacy standards, or a DHCS approved alternate access standard, the Plan will be required to submit a CAP to DHCS demonstrating steps the Plan will take to come into compliance with the standards. DHCS will monitor the Plan's corrective actions and require updated information from the Plan on a monthly basis until the Plan meets the applicable standards.

If the Plan is not making satisfactory progress toward compliance with applicable standards, DHCS may impose sanctions pursuant to W&I Section 14197.7, including monetary sanctions, and the temporary withholding of payments.

[32] 42 C.F.R. § 438.600(b) (2020).

Furthermore, if the Plan is determined not to meet Network Adequacy requirements because the provider network is deficient in capacity and composition, or is unable to provide timely access to necessary services, including meeting the applicable time and distance standards or an approved AAS request, the Plan must adequately and timely cover these services out-of-network for the beneficiary. The Plan must permit OON access for as long as the Plan's provider network is unable to provide the services in accordance with the standards. For additional guidance on OON providers, please see BHIN 21-008 for MHPs and IN 19-024 for DMC-ODS Plans.

ONGOING NETWORK ADEQUACY MONITORING

DHCS will regularly monitor compliance with Network Adequacy standards on an ongoing basis. Network Adequacy monitoring activities include, but are not limited to, the following:

- Annual NACT data submissions for Plans;
- Triennial reviews of each MHP;
- Annual reviews of each DMC-ODS Plan;
- Annual program assessment reports submitted to CMS in accordance with 42 CFR §438.66;
- MHP performance dashboards;
- Corrective action monitoring and follow-up; and,
- Any other monitoring activities required by DHCS.

In addition, W&I Section 14197.05 requires DHCS' external quality review organization to annually gather data and assess whether each Plan's network met the network adequacy requirements set forth in W&I Section 14197 during the preceding 12 months.

DHCS will post Network Adequacy documentation for each Plan on its website, including any approved AAS in accordance with W&I Section 14197.

For questions regarding this BHIN, please contact the Medi-Cal Behavioral Health Division at (916) 322-7445 or NAOS@dhcs.ca.gov.

Sincerely,

Original signed by

Shaina Zurlin, PsyD, LCSW, Chief
Medi-Cal Behavioral Health Division

Attachments A through J:

- Attachment A.1 – MHP NACT;
- Attachment A.2 – DMC-ODS NACT;
- Attachment B – Time and Distance Standards;
- Attachment C – Alternative Access Standards Request Template;
- Attachment D.1 – Timely Access Data Tool (MHP);
- Attachment D.2 – Timely Access Data Tool (DMC-ODS);
- Attachment E – Certification of Network Adequacy Data;
- Attachment F – Continuity of Care Report Template;
- Attachment G – Network Adequacy Annual Certification Inventory;
- Attachment H – Supplemental Data Tool;
- Attachment I – Provider Contract Cover Sheet;
- Attachment J – DMC-ODS CAP Resolution Proposal Instructions and Template.